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The Honourable Marc GarneauThe Honourable Yonah Martin



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• (0850)

[English]

The Joint Chair (Hon. Yonah Martin (Senator, British Columbia, C)): I call this meeting to order.

Good morning, colleagues. Welcome to the meeting of the Special Joint Committee on Medical Assistance in Dying.

I'd like to begin by welcoming our witnesses, as well as those who are watching via the web, and letting you know that we are continuing our study, which is our examination of the statutory review of the provisions of the Criminal Code relating to medical assistance in dying and their application.

My name is Yonah Martin. I am the joint chair for the Senate for this committee, and I'm joined by the Honourable Marc Garneau, the House of Commons joint chair.

I have just a few items for our witnesses.

We'd like to remind members and witnesses to keep their microphones muted unless recognized by name by one of the joint chairs, and I will remind you that 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 either floor or English or French.

Again, welcome to our witnesses. We do one witness, Ms. Gabrielle Peters, whose video is not on, but we should be able to hear her voice. She is assisted by an individual who will be assisting with interpretation as needed.

Welcome to Ms. Peters as well.

Our witnesses are as follows.

From the Barreau du Québec, we have Ms. Sylvie Champagne and Ms. Catherine Claveau. I understand that you will be sharing your five-minute time for the testimony.

From Disability Filibuster, we have Ms. Gabrielle Peters, co-founder, but as I said, her video may be off during her testimony. We will see how it works.

Then, from Inclusion Canada, we have Ms. Krista Carr, executive vice-president, also by video conference, at 5:45 in the morning. Thank you for getting up early to join us.

We will begin with opening remarks by Ms. Champagne and Ms. Claveau, who will share the five minutes, followed by Ms. Peters and then Ms. Carr.

Ms. Champagne and Ms. Claveau, you will each, I am assuming, have two and a half minutes for your opening remarks.

Thank you very much. You may begin.

[Translation]

Ms. Catherine Claveau (President of the Quebec bar, Barreau du Québec): Madam Chair, Mr. Chair, deputy chairs and members of the committee, my name is Catherine Claveau, and I am president of the Barreau du Québec. With me today is Ms. Sylvie Champagne, secretary of the order and director of the legal department. Thank you for inviting us to participate in the consultation on issues related to medical assistance in dying for persons with a disability.

From the beginning, which was 2010 in Quebec, the Barreau du Québec contributed actively to the discussions about the issue of medical assistance in dying. Medical assistance in dying, as well as broadening it, raised serious legal and ethical questions. That is why the following fundamental principles guided our thinking: an individual's right to self-determination and dignity; the right to access end-of-life care and medical assistance in dying throughout Quebec's territory, which is inalienable when it is time to fully realize the right to life and the right to autonomy for every individual capable of consenting to medical assistance in dying; and, finally, protection against discrimination by refusing to perpetuate stereotypes targeting groups of persons considered vulnerable, which conclude from the outset that they are unable to fully consent to medical assistance in dying.

In the Carter decision, the Supreme Court of Canada confirmed the decriminalization of medical assistance in dying and its legal framework. In its ruling, the court recognized that medical assistance in dying had to be accessible to any capable adult, in cases where the person:

(1) clearly consents to the termination of life and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition.

In 2016, the Criminal Code was amended to respond to this decision. Consequently, paragraph 241.2(2)a specifically indicates that a person with a grievous and irremediable disability meets the criteria outlined in paragraph 241.2(1)c. In other words, they have "a grievous and irremediable medical condition".

In 2019, in the Truchon decision, the Quebec Superior Court concluded that criteria regarding end-of-life and reasonably foreseeable natural death compromised the right to life and the right to the respect of the dignity of the person. We highlight that the court also concluded that this compromised the right to equality, particularly for those considered vulnerable. Indeed, they were wrongly considered as incapable of consent, because they were vulnerable due to the simple fact of their disability. Persons with a disability can be perfectly capable of exerting fundamental choices regarding their life or death, and their capacity requires individual assessment.

Furthermore, the Superior Court stated the following:

Individuals [affected by a disability] must be allowed to exercise full autonomy not only at the end of life, but also at any moment during their life, even if this means death, where the other eligibility conditions for medical assistance in dying are met.

We also invite the committee to take note of the position outlined in this decision, specifically:

[...] like any other capable and well-informed person, disabled persons may have a rational and legitimate desire to end their lives because of their condition, but also, and especially, because of the enduring and intolerable suffering they are experiencing. [...]

While caution is required, it is far from obvious that a person could or would want to receive medical assistance in dying solely because of his or her disability.

We recognize that the equal right to medical assistance in dying presents very real challenges. It must be offered to everyone, taking into account the specific nature of a disability. The health care team requires adequate tools to assess consent to care and to offer the means and resources necessary for persons with a disability to make an informed decision about their situation.

That said, we think that the Carter ruling and the Truchon decision are sufficiently clear and consistent to guide the committee's deliberations around persons with a disability and medical assistance in dying.

To conclude, the lack of harmonization between the Criminal Code and the Act Respecting End-of-Life Care cannot be ignored. Since 2015, a multitude of bills and legislative amendments have been introduced. This makes it difficult, even perilous, for legal experts, patients and doctors to navigate. We have given you a document entitled "Ligne du temps de l'aide médicale à mourir", which clearly outlines the situation.

Since 2016, the Barreau du Québec and five other professional associations have asked several times for these laws to be harmonized. To ensure the public's protection and to guide professionals administering medical assistance in dying, it is essential for these conditions to be clear, precise and, above all, consistent.

• (0855)

In this respect, provincial and federal constitutional jurisdictions can be exercised concurrently without relevant legislation being considered incompatible. Quebec's deliberations around medical assistance in dying are very advanced and benefit from a social and nonpartisan consensus.

We therefore invite you to support provinces' processes to broaden medical assistance in dying, such as those under review by the Government of Quebec with respect to advance requests for medical assistance in dying.

We thank you for listening, and we are ready to answer your questions.

[English]

The Joint Chair (Hon. Yonah Martin): Thank you. I misunderstood. You were presenting for both of you, so we will go on to the next witness.

Ms. Peters, I think we can hear you, and if you are able to turn your video on, that would also be helpful.

Go ahead. You will have the floor for five minutes.

Mrs. Gabrielle Peters (Co-Founder, Disability Filibuster): My name is Alex Cosh . I'm acting on behalf of Gabrielle Peters as her echo today.

Good morning, I'm joining you very early in the day from the unceded territories of the Squamish, Musqueam and Tsleil-Waututh nations.

Modern western ableism, and particularly scientific ableism, serve as historical and ongoing links between colonialism and MAID. Modern western ableism forms the basis and provides the rhetorical and pseudoscientific framework for constructing hierarchies, defining other and establishing lesser, as well as delineating arbitrary lines between "deserving" and "undeserving". Within your ableist system, track two MAID extends the coercive but seemingly arm's-length power of the state to provide a designated class of citizens with premature death at the hands of the state.

I'm speaking to you today as the co-founder of the Disability Filibuster, a national grassroots initiative started by Catherine Frazee and myself on the eve of the passing of Bill C-7 and the creation of its second track for MAID.

Disability Filibuster was in part a response to disabled people being marginalized from the discussion and decision-making around Bill C-7 and our frustration that our collective anger was cordoned off and isolated, much like our lives.

Disability Filibuster was the only space created for the only people targeted by the expansion of MAID to voice their views. The media locked down and was dominated by the endless public relations work of those lobbying for its expansion.

Concerns about the social contagion of covering the ending of one's life were tossed aside. The line between editorializing was blurred to the point of romanticizing and lionizing those who made the choice not to continue to be a "burden on those around them" and to "end things on their own terms". You could hear Frank Sinatra singing between the lines.

No mention was made of the previously publicly articulated and enthusiastic supports for involuntary euthanasia of disabled people during the time of Tracy Latimer's murder in reshaping the narrative to make these same people the champions of autonomy. The political sphere was dominated by the disproportionate representation of politicians enthusiastic for expanding MAID and all for being seen in a favourable light by its well-connected and well-heeled proponents. A foundation sharing the same name and lineage as the Prime Minister played more than a minor role in propelling supports to the forefront.

Disabled people are a large minority, but we are still the minority, a minority that is disproportionately poor, racialized and not noted for its strong political value and influence, as is evidenced by our policy absence in political platforms and campaigns during elections. We didn't have a chance. There was no place for disabled people in the discourse around the policy that specifically and solely affects disabled people and no one else.

Even today, the only place for us in media coverage is as human interest stories about those among us who have resigned ourselves to applying for MAID after tiring of seeking non-existent supports and unable to gulp down the prospect of a future of subsistence-level poverty inflicted and normalized as a component of our broader dehumanization and oppression. In order to be allowed a presence, you have to agree to die.

So removed, uninterested and ill-informed are our politicians and media about our lives and the discussions that we have that we've found ourselves regularly characterized as right-wing religious fanatics. This characterization is so laughably incorrect that I struggle to express the absurdity of it.

Over the course of two years, Disability Filibuster has hosted approximately 80 hours of Zooms. These included panels, readings, arts, casual conversations and live processing of our grief and exhausted rage. A great deal of knowledge was shared.

However, the truth is that I didn't come here today under the illusion that I can alter minds or inform those who have consistently, persistently and wilfully chosen to do the least possible to inform themselves about the lives of disabled people, particularly those living in poverty and on the extreme margins of society—your society.

I came to put it in on the record: Canada's expansion of MAID to disabled people whose deaths are not reasonably foreseeable reifies and builds on the existing dehumanization of disabled people in Canada, breathes new life into the goals of never-dismantled eugenics and is based on the ableism that formed this country's foundation, and as such, represents a serious threat.

The material and social conditions and absence of positive liberty facing disabled people in Canada are fundamentally different from those of non-disabled people. The very different social contract offered to disabled people has yet to provide us with a guarantee of freedom to live in the community, to not be forced into institutions should our needs exceed those deemed appropriately human, the denial of our equal right to travel, and the provision of infrastructure that would make us intended participants—not unintended participants—in society.

• (0900)

I didn't come here with illusions. I came here to remind you that history changes and that one day our roles will be reversed and you will be the ones answering questions.

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

Next we will have testimony from Ms. Krista Carr.

Ms. Krista Carr (Executive Vice-President, Inclusion Canada): Thank you for the opportunity to be here today. I am coming to you today from the traditional and unceded territory of the Lkwungen, Songhees and Esquimalt peoples.

Inclusion Canada is a national grassroots organization made up of 13 provincial-territorial associations and 300 local associations representing over 40,000 individuals with intellectual disabilities and their families. For over six decades, we've advocated for children and adults with intellectual disabilities to be recognized as inherently human and of equal worth and value. Our federation has been at the forefront of trying to end institutionalization, protect lives and secure equal access to health care.

Canadians with disabilities do not yet enjoy a life of rights and opportunities equivalent to those without disabilities. This is the deeply rooted nature of ableism. Not a single national organization of persons with disabilities supported the expansion of MAID, and over 200 independent, non-affiliated organizations representing persons with disabilities actively opposed the expansion.

One organizational voice appears to have prevailed over all our voices. This one organization is not constituted of or by persons with disabilities and has never been on the front lines of advocating for needed supports, funding or systemic change to improve the lives of persons with disabilities, yet its voice prevails by claiming the dignity of persons with disabilities lies simply in their death. I can't think of a more telling example of paternalism and ableism, which together are as insidious and ugly as racism, and now as deadly.

We know a Canada where persons with intellectual disabilities were warehoused by the tens of thousands in institutions—institutions run by health care practitioners who segregated, isolated, maltreated, forcibly sterilized and anonymously buried persons with intellectual disabilities. We know a Canada where Canadians with disabilities were denied equal access to life-saving transplants, where infants with treatable conditions went untreated and were allowed to die from preventable conditions and where others had or have DNR orders imposed on them without their or their families' consent. We know a Canada where, if a parent murders their child with a disability, they are characterized as a “mercy killer”, and where, during COVID, people with disabilities were threatened by triage protocols.

This is the context in which we see MAID. It is impossible for the lives of persons with disabilities to be safeguarded by a system reliant on the subjective opinion of health care practitioners as if they live, work and think outside our culture of endemic ableism.

As Canadians, we acknowledge the vastly higher rates of suicide among indigenous youth and adults to be a tragic consequence of historical and societal devaluation, one that is crying out to be remedied. No one suggests that so many indigenous people kill or attempt to kill themselves as a function of being indigenous, but rather because of factors outside of themselves that lead to their suicide. Instead, we recognize this crisis as a tragedy at the personal, family, community and national levels to be prevented through action that remedies the socio-historical and current factors that lead to far too many indigenous people committing or attempting to commit suicide.

In this case, an individual's choice to end their life does not outweigh the necessity to maintain this group and others' protection under the Charter of Rights and Freedoms by prohibiting assisted suicide on the basis of being indigenous or of race or gender or any other specific population. Only persons with disabilities, as an identifiable group, are now less protected under our charter.

Imagine a line of people seeking to end their lives and being sorted into two: those whose suicides need to be prevented and those with a disability who are simply offered death. Let's be honest: It's not their perceived suffering that separates one from the other, but judgment as to the worth of one life in contrast to another, given one's disability.

Persons with disability struggle to be perceived as equally valued, escape poverty, obtain essential supports, find an affordable and accessible place to live, secure employment and obtain equal medical care. Then, when overwhelmed by all these challenges, the answer we give them is “death”. This is the manifestation of cruelty in a law now being considered for extension to those with a mental illness, and to mature minors and others, all inclusive of children and adults with disabilities.

● (0905)

In closing, we do not support the expansion of MAID and call upon Parliament to reinstate the legislation that restricted it to those near the end of their lives, legislation that does not discriminate on the basis of disability by only permitting MAID for those near the end of life equally. In this context, disability is not a prejudicial factor. It is increasingly urgent that we return Canadians with disabili-

ty to their inherent and full rights by restricting MAID to Canadians near the end of their life.

Thank you.

● (0910)

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

I should also thank Ms. Peters for getting up so early. You are also on the west coast. Thank you very much for your testimony.

We'll now move into our first round of questions. We have Mr. Cooper for five minutes.

Mr. Michael Cooper (St. Albert—Edmonton, CPC): Thank you very much, Madam Chair, and thank you to the witnesses.

I'll direct my questions to Ms. Peters.

Ms. Peters, you said that modern ableism and scientific ableism are the basis of our current track two MAID regime. Can you elaborate on this point?

Mrs. Gabrielle Peters: Scientific racism was the rationale for white colonialism. Scientific and medical ableism is similarly used to support MAID for people with disabilities. For example, scientific ableism made it that not long ago, homosexuality was considered a disability. Presumably, we would now be discussing the possibility of MAID for people because they are gay if that hadn't changed.

Today more than 80% of U.S. physicians reported that people with significant disabilities have a worse quality of life. This false assumption is believed to contribute to the health disparity experienced by disabled people.

Medical ableism provides MAID with a false facade of legitimacy and rigour that our suffering can't be mitigated and that we are better off dead.

Mr. Michael Cooper: Thank you for that.

Can you elaborate on the point you made about the absence of positive liberty for persons with disabilities and the impact in terms of personal autonomy?

Mrs. Gabrielle Peters: Lobbyists for euthanasia/assisted suicide/MAID reference concepts like freedom, autonomy and dignity. With MAID, the state provides the funding and infrastructure for it to take place, a positive freedom. They argue that people have the freedom to make this choice, but imagine a country having elections but setting up only one polling station in the entire country and opening it for only one hour on one day. There may be no laws barring anyone from voting, but there are also no laws making it possible.

It is necessary for the conditions to exist that make living as a disabled person genuinely possible and desirable. A choice between forced institutionalization, poverty and MAID is not a free choice.

Mr. Michael Cooper: Could you maybe speak to the fact that when we look at MAID, we see a great focus on individual suffering with respect to setting up the regime that affects not only individuals who are suffering but society as a whole?

Mrs. Gabrielle Peters: One of the hardest thing about this so-called “debate” has been the way those of us who oppose MAID have someone who has received MAID pitted against us in some sort of suffering competition. Are disabled people an oppressed group? Yes. If so, is it possible to safely designate another group to be given the legal rights to cause their death? Do the conditions for choice to occur exist? Are those even possible?

You need to understand that we are nowhere near being in the position as a society to make death by state safe for disabled people at a policy level.

Mr. Michael Cooper: Ms. Carr, can you elaborate upon the lived experience of Canadians who live with disabilities since the passage of Bill C-7, specifically the removal of what I believe is the most important safeguard, namely that death be reasonably foreseeable?

Ms. Krista Carr: We have been inundated with calls to our offices across the country. People are desperate, and there are a number of reasons behind that.

People always say, “Well, give us examples.” We have documented cases, with people's names, people's faces and people's stories, and they're just piling higher and higher and higher. These are all people with disabilities who want to live and who have been trying to live a dignified life in this country and have not been able to do that. There is no right to disability supports and services. There is no right to anti-ableism in the health care system. There is no right to palliative care, yet we have a right to, quote-unquote, “end their suffering” by causing their death, when really what they want to do is live, but they want to be able to live on an equal basis with others.

We've given this special right to only one group of charter-protected people in our country, and that is people with disabilities. That is not a right that's available across the spectrum for anybody else. For everybody else, we want to do suicide prevention and we want to support them and we want to try to get them what they need and make sure they know they're valuable to our society.

Let's not fool ourselves by pretending that we're giving people autonomy here. There can be no autonomy when you do not have access to supports and services; you're homeless; you're living in poverty; you're inadequately housed; you're isolated; you're marginalized; and you can't even get your basic needs met. That is not giving people autonomous choices.

● (0915)

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

We'll now move on to Mrs. Brière, who has five minutes.

Mrs. Élisabeth Brière (Sherbrooke, Lib.): Thank you, Madam Joint Chair.

[*Translation*]

Welcome to all the witnesses.

My questions will be for Ms. Claveau.

First of all, thank you for your comments.

In your opening statement, you talked about the importance of the right to self-determination and the right to equality. You said that one must not conclude from the outset that a person with a disability is unable to consent to medical assistance in dying.

Do you think that legislation should include additional measures in these cases?

Ms. Catherine Claveau: Thank you for your question.

I will give my colleague, Ms. Sylvie Champagne, the opportunity to answer you.

Ms. Sylvie Champagne (Secretary of the Order and Director of the Legal Department, Barreau du Québec): Good morning.

Indeed, we believe that the safeguards outlined in the Criminal Code and the Quebec Act Respecting End-of-Life Care, as Ms. Carr said, can ensure that all citizens, including those with a disability, can make a choice based on free and informed consent.

In our view, it is not necessary to add new safeguards.

Mrs. Élisabeth Brière: Have you personally met with different groups or organizations of people with a disability to outline your point of view and see if they share it?

Ms. Sylvie Champagne: We closely followed the debates about medical assistance in dying from the beginning. As the president of the bar said, we are aware of real challenges on the ground, that is to say issues surrounding care and the difficulties that people with a disability may have with social services.

Obviously, we believe that governments must be sure to offer a full suite of services and care to people with a disability. While doing so, obviously, we need to strike a balance. We think that discrimination should be avoided when it comes to a right offered to all citizens.

Mrs. Élisabeth Brière: If a person is declared incapable when certifying a mandate or starting a protection regime, whether it be a trusteeship, now called a guardianship, we ask for a psychosocial report and a medical report. We rely on a social worker's and a doctor's expertise.

In your opening statement, Ms. Claveau, you also spoke of the importance of giving the care team the right tools.

Currently, do you think that training is sufficient?

Do you consider that our doctors are able to accurately assess whether a request is made in a rational and informed way?

Ms. Sylvie Champagne: The Barreau du Québec works with all five professional associations involved in medical assistance in dying.

Today, representatives from the Collège des médecins du Québec will appear before you, and you will be able to ask them that question. I can, however, tell you that in Quebec, training is offered to all professionals involved in cases of medical assistance in dying. I can't say how other provinces in Canada do it, but I know that in Quebec, there is training.

• (0920)

Mrs. Élisabeth Brière: During previous testimony, we heard that we could include the consent of a parent, loved one or caregiver.

Is that something that might be included in the medical assistance in dying process?

[English]

The Joint Co-Chair (Hon. Yonah Martin): Answer very briefly. There are about 30 seconds.

[Translation]

Ms. Sylvie Champagne: If the individual is capable of making the decision, we believe that they are the one who should give consent. Obviously, the care team is involved in these discussions, and loved ones are usually involved in the process.

Nonetheless, from a legal standpoint, the person involved is the one who has to give their consent.

Mrs. Élisabeth Brière: Thank you very much.

[English]

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

Now we will go to Monsieur Thériault for five minutes.

[Translation]

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

Ms. Carr, you spoke a great deal about autonomy. The state could decide to exclude any person with a disability from accessing medical assistance in dying. Does that line up with the position among people with a disability? Is that your testimony's conclusion?

[English]

Ms. Krista Carr: My ultimate thought on the matter is that when we first—

[Translation]

Mr. Luc Thériault: I'm losing a lot of time because of interpretation. I hope the chair will consider the fact that I need all of my speaking time, and that interpretation delays won't count.

Go ahead, Ms. Carr.

[English]

Ms. Krista Carr: Okay, thank you.

As far as autonomy goes, our position as an organization and the position in the disability community writ large is that when we brought MAID in, it was restricted to end of life. It was available on an equal basis to anybody whose death was reasonably foreseeable—

[Translation]

Mr. Luc Thériault: That is not my question, Ms. Carr. I asked if you agreed with the position that the state should not allow medical assistance in dying for people with a disability.

Is that in fact your testimony's conclusion?

[English]

Ms. Krista Carr: The conclusion of my testimony is that MAID should not be provided to anybody whose death is not reasonably foreseeable and who is not at the end of their life, because that is the great equalizer that does not single out one group of people who are not dying.

Thank you.

[Translation]

Mr. Luc Thériault: Yes, thank you.

You talked about autonomy. The term autonomy, in its ethical and moral sense, cannot be reduced to physical, social or psychological autonomy. Autonomy, in the moral sense of the term, relates to capacity, and respecting a person's capacity to make the most accurate critical judgment about their human condition.

Do you agree with that?

[English]

Ms. Krista Carr: I agree that there is more to autonomy than... In order to be able to make an autonomous decision, you have to be able to do that on an equal basis with others.

My point was that when you are living in poverty—unhoused or marginalized intersectionally because of race, indigeneity, gender or other factors—you can't make an equal choice on the same basis as someone else can make it when you are living in those conditions. Your intolerable suffering is being caused by the socio-economic and community-based factors of your life. It isn't actually being caused by the disability. That is what we see time and time again.

I don't get to make—

[Translation]

Mr. Luc Thériault: Thank you.

What, then, motivated Ms. Gladu and Mr. Truchon, both people living with serious disabilities, to request medical assistance in dying at the end of a full and complete life?

Did they request it because they were the victims that you described?

• (0925)

[English]

Ms. Krista Carr: I know the story of both individuals very well.

Monsieur Truchon was living his life in the community, but he had a progressive disability. Based on the system they have in Quebec for supporting people with disabilities, he ended up institutionalized. He lived in an institution for five years, fought like heck to get out of that institution and couldn't. Finally he gave up and said, "If I have to live my life this way, I want to be able to choose death instead." Those were the factors that led Monsieur Truchon to that decision.

Madame Gladu also had a progressive condition and knew or felt that when her condition got to a certain point, she too would be forced to leave her home and community and live in an institution. She didn't want to have to do that.

Those factors—

[*Translation*]

Mr. Luc Thériault: Excuse me, but Ms. Gladu waited for more than a year, and she said that she was relieved to finally have a choice. You want to take that choice away from her.

[*English*]

Ms. Krista Carr: This is not a choice that we're giving to everybody. Do you not see that this choice is being given to only one group of people who have a very specific set of conditions?

Madame Gladu didn't want to have to live in an institution at some point in her life. That's why she wanted the choice. If she would have been able to live the rest of her life in her home, in her community, that would have been a very different thing, but remember, we're only.... You're marginalizing this to one particular protected group of people on a particular set of characteristics.

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

Lastly, we'll have Mr. MacGregor for five minutes.

Mr. Alistair MacGregor (Cowichan—Malahat—Langford, NDP): Thank you very much, Madam Co-Chair.

I appreciate the testimony from all of our witnesses today.

When this motion was passed in the House of Commons, this committee was tasked with exploring five different themes. Yes, it's within the context of medical assistance in dying, but I also think that our committee has a bit of leeway and freedom to consider many things that are also related to MAID.

I know that when we talked about the protection of persons with disabilities, we looked at this theme earlier in the year, so we already have some great testimony on record, but I think it's important in this committee's study of this particular theme to understand that it is taking place in the context of the federal government's disability inclusion plan. Also, of course, there's another House committee that's now examining Bill C-22, the Canada disability benefit act.

Maybe, Ms. Carr, I'll change tack a bit. Do you have anything you can add to...? Has your group been consulted on or involved in those other areas, in the disability inclusion plan and the Canada disability benefit act?

I know that when it comes to economic security, that's just one small part of it, but I've spoken with a lot of constituents of mine

out in Cowichan—Malahat—Langford who've been real advocates on trying to get a federal disability benefit of about \$2,200 a month. They think that.... Well, I think it's a fact that when you look at the disability rates in each province, you see that there's a state of "legislated poverty", as they put it.

Do you have any thoughts on the Canada disability benefit act and the disability inclusion plan that you would like to see our committee concentrate on when it issues its final report and recommendations?

Ms. Krista Carr: There were lots of questions in there.

The first is, yes, we've been consulted. I presented to HUMA earlier this week, and we have been involved, obviously, in the consultations around the Canada disability benefit and the disability inclusion action plan. We have been very heavily involved in all of those discussions.

Certainly these are good things to be doing and we're very supportive of them. Anything this committee can do to support those things, I think is really good.

The only thing I would say is that a Canada disability benefit will certainly support economic security if it's done well and is adequate in all of those things. Lots of Canadians with disabilities—73% of the people I serve who live outside the family home—are living in poverty.

However, it's not a substitute for keeping our MAID legislation at end of life, so I don't want to pit one off against the other and say, "Oh well, you're going to make the MAID regime okay in track two if you go ahead and do these things." You will certainly make the lives of people with disabilities better by doing those things, and we will continue to fight for those things, but the issue still remains that the lack of supports and services, the lack of housing options, the institutionalization, and all the other factors that people face will still weigh heavily in the whole conversation we're having today. The only "safeguard" we have is that people are supposed to be told what's available to them. I can guarantee you that when people are showing up and asking about MAID, they know what is "available", but they have never been able to get it; or it isn't available, or they have been on a wait-list for 10 years, etc.

• (0930)

Mr. Alistair MacGregor: I appreciate that.

I'm just saying that because there is no legislation before the House right now, I think our committee has a fair bit of latitude in each of these five themes of how expansive we want to be in terms of our recommendations in the final report.

Ms. Peters, I have 45 seconds, and I don't want to leave you out.

If you want to add anything to this, please go ahead.

Mrs. Gabrielle Peters: We're going to have to bear with my voice.

I think that first of all there is a lot of misrepresenting of what is necessary for autonomous decision-making. In terms of poverty, you have to understand that poverty is both a cause of our oppression and also a manifestation of the position that disabled people hold in society.

There is no one who is not disabled who would qualify for track two, so the question of.... No, that makes absolutely no sense.

In terms of poverty—the problems and the concerns—there are many concerns we are hearing at the Disability Filibuster about the disability benefit. They're about gatekeeping, the criteria, how these things will be enacted. There are lots of unknowns, but it doesn't even seem to offer the hope of moving above the poverty line.

There is new research out that has shown that the poverty line has an ableist bias. There is a paper in a peer-reviewed journal showing something that disabled people have said all along, which is that it costs more to live as a disabled person in Canada—

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

I will turn this over to my co-chair for the next round of questioning.

The Joint Chair (Hon. Marc Garneau (Notre-Dame-de-Grâce—Westmount, Lib.)): Thank you, Senator Martin.

[*Translation*]

Senator Mégie, you have the floor for three minutes.

Hon. Marie-Françoise Mégie (senator, Quebec (Rougemont), ISG): Thank you to all the witnesses for being with us today.

Ms. Carr, during the Senate review of Bill C-7, we heard witnesses from the disability community. They said many among you think that they are vulnerable. From their point of view, putting this label on them means stigmatizing them. They have the right, like anyone else, to give their consent or to request medical assistance in dying.

What is the state's role in terms of drawing a line between protecting persons with a disability who may be vulnerable, and the necessity of respecting the individual choices they might make? How do we avoid infantilizing them? They were the ones to use that term. By saying that they are vulnerable, we are trying to infantilize them.

What do you think?

[*English*]

Ms. Krista Carr: People with disabilities are not vulnerable; they are made vulnerable. They are put in situations of vulnerability based on the socio-economic...and all the things we have already talked about, so I won't repeat that again.

I think the question you're asking me is whether or not there are some people with disabilities who want to be able to choose whether or not they can make a decision about dying. I'm not trying to infantilize anyone. What we're talking about here is that we have two tracks. We have a track for people at end of life who are suffering intolerably and whose lives are going to be finished soon, and they get to choose the timing, etc., but we have this other track that

has pigeonholed one particular group of people. Anybody else in the country, by virtue of being any other marginalized population—indigenous, racialized or whatever—who says they are suffering intolerably from factors that are external to their personal characteristics isn't getting offered death. We're giving them support to live good lives.

That's the point I am making here. It's that we are more marginalizing and more devaluing and facing people.... We're basically telling people with disabilities that having a disability is a fate worse than death.

We're not just getting people asking for MAID. We are having people with disabilities constantly being offered MAID now as a health care choice. They show up in the health care system with a health care issue that is not terminal and they are living in difficult conditions. We have story after story of people being offered MAID as a solution to their health care situation.

• (0935)

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

We will now go to Senator Kutcher for three minutes.

Hon. Stanley Kutcher (Senator, Nova Scotia, ISG): Thank you very much, Chair, and thank you to the witnesses.

I want to make sure that I understand the Barreau du Québec's position, so I have two questions.

This is the the first one.

Should a person with a disability be denied access to MAID solely because of their disability, if they meet all established legal and medical criteria?

[*Translation*]

The Joint Chair (Hon. Marc Garneau): The question is for representatives of the Barreau du Québec.

Ms. Sylvie Champagne: That's correct.

The same criteria apply to a person with a disability. In other words, they must have a grievous and irremediable health problem. Consequently, a person without a grievous and irremediable health problem due to their disability would not be eligible for medical assistance in dying. The grievous and irremediable problems would have to cause enduring suffering that is intolerable to them. The medical assessment remains the same, as we mentioned earlier, for a person in a situation like Mr. Truchon or Ms. Gladu, as well as for a person who is not disabled. The bar's criteria remain the same, and the care team's evaluation also remains the same.

As for free and informed consent, it is the same thing. When a person requests medical assistance in dying, they must be offered the care and services necessary to see if there are alternative solutions and ensure that their consent is free and informed.

[*English*]

Hon. Stanley Kutcher: Thank you.

For the second question, you talked earlier about legislative safeguards, but there are also clinical safeguards.

Do you think there should be a similar report conducted that addresses the needs of people with disabilities—which are extensive needs, and we're not filling them well—the same way that an expert panel conducted a review of a mental disorder as a sole underlying condition? Would a review of that nature be useful for helping to guide this discussion?

[*Translation*]

The Joint Chair (Hon. Marc Garneau): Please give a brief answer to the question.

Ms. Sylvie Champagne: Yes, of course.

It should be noted that in Quebec, the Commission on End-of-Life Care receives the applications and forms, records statistics and ensures that safeguards are followed.

Should there be a similar commission that could actually follow more medical conditions, to explain the reasons behind receiving medical assistance in dying?

The Commission on End-of-Life Care's annual activity report from April 1, 2020, to March 31, 2021, provided some statistics on people who requested medical assistance in dying. The numbers show that 73% of them had cancer, and 83% had a prognosis of six months or less to live.

We therefore still have some medical information to establish a profile of people who receive medical assistance in dying in Quebec, and for what reasons.

● (0940)

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

It is Senator Dalphond's turn.

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

I also thank our guests this morning.

My questions are for the representatives of the Barreau du Québec. A special thanks to you for participating in our work. We always benefit from the Barreau du Québec's participation.

I think that the Barreau du Québec was involved in the Truchon and Gladu cases before the Quebec Superior Court.

Within that framework, what would you say to those who consider that people like Ms. Gladu, who was born with medical problems that left her seriously disabled for her entire life, cannot make a free and informed choice, and as a result, should be legally excluded from medical assistance in dying?

In your opinion, would that pass the test of the Canadian Charter of Rights and Freedoms and the Quebec Charter of Rights and Freedoms?

Ms. Sylvie Champagne: No, the Barreau du Québec was not involved in Ms. Gladu's case. However, it was involved in Ms. Leblanc's case, but she died before the court could render a decision.

The Barreau du Québec supports the decision by the Quebec Superior Court, which invalidated the reasonably foreseeable death criterion, because it violated the Canadian Charter of Rights and Freedoms and was not justified by section 1.

We maintain that position today.

Hon. Pierre Dalphond: So, you think it would run counter to the Canadian Charter of Rights and Freedoms to exclude people with a disability from medical assistance in dying because they are vulnerable.

Ms. Sylvie Champagne: Yes, exactly.

Hon. Pierre Dalphond: Thank you.

[*English*]

The Joint Chair (Hon. Marc Garneau): We'll go to Senator Wallin for three minutes.

Hon. Pamela Wallin (Senator, Saskatchewan, CSG): Thank you very much, Mr. Chair.

[*Technical difficulty—Editor*]

The Joint Chair (Hon. Yonah Martin): I'm sorry for interrupting, Senator Wallin. Your sound is not coming through. It's very hard to hear and understand what you're saying.

If you raise the volume, it might sound a bit better.

Go ahead.

Hon. Pamela Wallin: [*Technical difficulty—Editor*]

The Joint Chair (Hon. Yonah Martin): No.

The Joint Chair (Hon. Marc Garneau): Raise it a little bit higher, please.

Hon. Pamela Wallin: [*Technical difficulty—Editor*]

The Joint Chair (Hon. Yonah Martin): It's not better.

The Joint Chair (Hon. Marc Garneau): Unfortunately, we're not going to be able to take your questions, Senator Wallin. The quality of the sound is not good enough.

We'll now go to Senator Martin.

The Joint Chair (Hon. Yonah Martin): Ms. Carr, in your advocacy organization for disability rights, your group rallied in opposition to Bill C-7. You talked about how, since then, you have been inundated with calls, etc.

Do you believe that the voices of those you represented were heard by those who needed to hear your concerns?

Ms. Krista Carr: No, they were not, and they're still not really being heard.

In the lead-up to Bill C-7, the whole disability community, including us, predicted that we would get to exactly where we are now. Besides the calls that come in to our office and our federation across the country, you can't open up a newspaper without seeing a story or multiple stories every day that are public and in the news about these situations. It's really quite devastating to our whole community.

The Joint Chair (Hon. Yonah Martin): You are here today on behalf of those you represent. There are other advocacy groups, including Ms. Peters' group.

I have limited time, but is there anything you wish to say to this committee? We're listening, and we'd like to know what concerns and/or other recommendations you have.

● (0945)

Ms. Krista Carr: We had over 200 organizations representing persons with disabilities sign an open letter. This is not a religious rights issue; it's a disability rights issue. While you may feel that you are giving this particular protected group of people a right to die, what they really need is a right to live on an equal basis with others. Without that, the right to die is only going to mean that we will have far, far fewer people with disabilities alive in our country, and that is frankly a travesty.

The Joint Chair (Hon. Yonah Martin): Ms. Peters, you mentioned that you have done 80 Zooms. What are some of the key findings, or maybe the common thread that we should be aware of, that you've heard from the Zoom gatherings you've held?

Mrs. Gabrielle Peters: I heard fear—a great deal of fear, and overwhelming....

You have to understand that none of you understand what it's like to go to a doctor, ask for help and have them suggest death, and how that irrevocably alters your relationship. Many are avoiding the medical care that they need. Others are struggling with suicidal ideation being set off that they finally had under control after years and years of therapy.

It's taunting us. People are suggesting.... The questions in this panel of what people are saying we are saying make no sense to me. How can you discriminate? How can you ask if we're saying only disabled people shouldn't be allowed, when the only people who are eligible are disabled people? This is not a matter....

You have singled us out, not us. It's you who have singled us out.

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

Thank you, Senator Martin. It's back to you as the chair.

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

Again, we want to thank all of our witnesses for appearing before us today. This is a very difficult topic for all of us. We thank you for your testimonies.

With that, we'll suspend for a few minutes to prepare for our second panel.

● (0945)

(Pause)

● (0950)

The Joint Chair (Hon. Yonah Martin): Colleagues, we're ready to resume. We want to thank our witnesses who are here in person, as well as those joining us by video conference.

We have with us, as individuals, Alicia Duncan and Christie Duncan, by video conference.

[*Translation*]

From the Collège des médecins du Québec, we have Dr. André Luyet, executive director, and Dr. Mauril Gaudreault, president.

[*English*]

From ARCH Disability Law Centre, we have Kerri Joffe, staff lawyer, also by video conference.

Thank you for being here with us, everyone.

We will begin with opening remarks. You each will have five minutes. If there are two of you sharing that time—last time, I thought there were two people sharing—please indicate that.

We will begin with opening remarks by Alicia and Christie Duncan.

Will you be sharing your time or will there be one person speaking?

Ms. Christie Duncan (As an Individual): We will be sharing our time. I will start, and my sister will continue.

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

That will be followed by Dr. Luyet and Dr. Gaudreault and, lastly, Ms. Joffe.

We will begin with a five-minute testimony from Alicia and Christine Duncan.

Go ahead.

Ms. Christie Duncan: Thank you.

Good morning. My name is Christie Duncan. I am here today with my sister Alicia to share our family's experience regarding medical assistance in dying.

While we are not philosophically opposed to MAID, our concern is that the current legislation is written in such a way that many Canadians are accessing MAID out of desperation and not dignity, as it was originally intended.

Our mother, Donna Duncan, chose to end her life through MAID on October 29, 2021. This was hours after being released from a psychiatric unit for a suicide attempt 72 hours earlier. Today we will focus on the facts that we've uncovered through her medical records and the police investigation we initiated into whether the safeguards for MAID were followed before she was given a lethal injection.

In February of 2020, as a result of a minor car accident, our mother was diagnosed with post-concussion syndrome by her general practitioner of more than 20 years. However, due in part to the global pandemic, she was not able to access immediate counselling and physical rehabilitation.

As her symptoms worsened, she was referred to a complex chronic disease clinic with a wait-list over a year long. During this time, her sensitivity to touch, sight and smell worsened. She claimed that she felt pain when eating, which led to her refusal to eat most foods, and as a result, she lost a significant amount of weight.

On October 14, 2021, she asked her GP to assess her for MAID, but he refused, as he did not feel that she had followed his medical recommendations and he did not believe she was on a trajectory for death. On October 24, 2021, our mother had her initial assessment for MAID by Dr. Grace Park and, two days later, by Sean Young, a nurse practitioner, who approved her to die 48 hours later after meeting her only once.

How did the opinion of someone who had been caring for my mother for over 20 years carry less weight than the opinion of two people who had just met her and simply ticked off boxes in a MAID assessment form?

Upon her approval, my sister and I were able to delay her death through the courts, as her mental health was in question. Following this, she was further assessed by several psychiatrists, who all documented that they believed the decision for MAID was being made in haste, but there was nothing they could legally do to prevent her from accessing it as she was found to be of sound mind. Our mother had been a psychiatric nurse her entire career, and our family believes that she manipulated the psychiatrists because she knew what answers to provide.

As of today, we have been denied access to our mother's documents related to her MAID death, despite the fact that my sister is the executor of my mother's estate. As such, we have been unable to confirm which track our mother applied for and was approved for, and therefore which safeguards were followed or violated.

I will turn to Alicia.

• (0955)

Ms. Alicia Duncan (As an Individual): Thank you.

Today in Canada, in order to qualify for MAID, you must have an incurable medical condition and experience suffering that is intolerable to you. By that definition, the majority of Canadians qualify for MAID. The core legislation itself is problematic.

Based on our experience, we have outlined the following recommendations for your final report.

First, there should be mandatory access to health care. If not giving Canadians access to MAID infringes on their human rights, then not giving them access to much-needed health care in a timely manner also infringes on those rights. We require clear definitions. "Imminent" is defined as "about to happen". This needs to be clearly defined in our legislation in the context of MAID and where imminent death is foreseeable.

We also require clearly defined safeguards. The current safeguards are just too ambiguous.

Second, there should be an increased number of independent witnesses. There should be a requirement for at least three independent witnesses to be formally interviewed as part of the assessment.

Third, there should also be a pre-death assessment review. Doctors should be required to submit all assessments to an independent review board prior to a patient's death.

Fourth, there should be continuity of care. Multiple assessments should be completed by the same medical professional. The primary doctor's opinion should hold the most amount of weight in a MAID assessment.

Fifth, there should be mandatory wait periods. There should be no exemptions for patients with mental health or non-terminal disabilities.

Sixth, there should be mandatory release of records. Hospitals and health authorities should be required to release unredacted copies of their MAID assessment records to those who are entitled to them.

Donna Duncan was our mother's name. Please don't forget her, and help us ensure her death was not in vain.

Thank you.

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

Next, we will—

• (1000)

Mr. Gary Anandasangaree (Scarborough—Rouge Park, Lib.): I have a point of order, Madam Chair.

Can we advise our witnesses, or those in the gallery, not to take pictures during this session? There are pictures and recordings being taken. I believe the rules indicate that you cannot take any pictures during a meeting.

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

Dr. Luyet and Dr. Gaudreault, will you be sharing your time as well?

Okay, thank you. You have five minutes in total.

[Translation]

Dr. Mauril Gaudreault (President, Collège des médecins du Québec): Thank you.

[English]

Mr. Gary Anandasangaree: Was the ruling made on the point I raised? I didn't hear—

The Joint Chair (Hon. Yonah Martin): Yes, I agreed. That is indeed the rule.

Hon. Pierre Dalphond: I didn't hear a warning to the witnesses.

Mr. Gary Anandasangaree: Were people warned and told not to do that?

The Joint Chair (Hon. Yonah Martin): I assumed everyone was listening. I'm sorry.

The warning is that during our proceedings, there should be no photographs taken.

Mr. Gary Anandasangaree: I believe someone took pictures, but there is also someone recording, Madam Chair.

The Joint Chair (Hon. Yonah Martin): Oh, pictures and recordings are definitely not allowed. Everyone has an understanding of that.

Hon. Stanley Kutcher: Before we proceed, can we have assurances that recording is not happening and that pictures are not being taken?

The Joint Chair (Hon. Yonah Martin): I can't see the full screen. Are you saying that someone is recording online, or is it someone in this room?

Does everyone understand that? I see nodding heads.

Thank you for that reminder.

Next we will go to Dr. Luyet.

[*Translation*]

Dr. Mauril Gaudreault: If I may, Madam Chair, I'll begin.

Madam Chair and Mr. Chair, members of the committee, good morning.

I am Dr. Mauril Gaudreault, the president of the Collège des médecins du Québec, whose membership is over 30,000 Quebec doctors and aspiring doctors, in all specialties. I am accompanied by the executive director of the Collège, Dr. André Luyet. I have been a family doctor for over 40 years. Dr. Luyet has been a psychiatrist for over 30 years.

Thank you for having us so that we can address the issue of disability and medical assistance in dying.

To begin with, I would remind you that the Collège's mission is to protect the public by providing quality medicine. We are a professional body that ought not to be confused with medical federations that defend the interests of their members.

The Collège appeared here before, just a few weeks ago, on the topic of medical assistance in dying, represented by Dr. Louis Roy. It did not go unnoticed. Even the federal minister of disability inclusion, Carla Qualtrough, was upset when we explained the Collège's position on 0 to 1 year-old babies to her.

Let's reset the clock, please. Medical assistance in dying is a form of care. It's a medical procedure that may be appropriate in certain circumstances. It is not a matter of politics, morality or religion, but rather a medical matter.

Medical assistance in dying is governed by the Criminal Code, guided by court decisions and has been the focus of ethical and deontological discussion for more than two decades. It has been accepted. Society has evolved. There has been growing individualization in care. Every individual is now treated as such, rather than simply on the basis of belonging to a reference group.

On the issue of 0 to 1 year-old babies, the Collège now believes that for them as well, medical assistance in dying may offer a responsible ethical solution to avoiding an unacceptable and ineluctable end of life in unbearable circumstances.

In 2021, we drafted a report on medical assistance in dying. It's a rigorous report that required a year of deliberation by recognized experts, including Dr. Luyet. We submitted it to the Government of Quebec in December 2021. The report said that in the event of a very negative prognosis and horrendous living conditions, in instances of serious malformations or polysymptomatic syndromes with no prospect of relief or survival, medical assistance in dying could be included among the options for parents to consider.

The Collège never mentioned euthanasia for babies, nor the idea of administering medical aid in dying, without the consent of parents. What it did say was that it was an avenue to be explored and that the suffering of parents also had to be taken into account, and that's the extent of it.

Similarly, for mature minors aged 14 to 18 years, our thinking was based on the following considerations. First of all, suffering does not pay any attention to age. Suffering has no age. Then, the act already acknowledges that minors, aged 14 and over, have the right to consent on their own to certain types of care, such as abortion. The consent of parents or the guardian is compulsory, of course, when care represents a serious risk to a minor's health.

As for disabilities, the view of the Collège is that they also, for certain patients, lead to suffering that is unfortunately as unbearable and untreatable as the suffering caused by certain serious illnesses. From the medical standpoint, physical and mental suffering can be assessed clinically, whether by direct observation, or a questionnaire and clinical examination by the doctor. It's also a fact that patients experiencing the suffering can sometimes express what they are feeling. This also applies to vulnerable clients like people who are under guardianship or unable to give consent.

We conclude by taking advantage of this forum to remind everyone of how urgent it is to harmonize Quebec and Canadian statutes with respect to the concept of disability. The Canadian act uses the terms "illness", "disease" and "disability", whereas the Quebec act uses only the word "illness". This limits the ability of certain Quebecers to obtain the care to which they would have been entitled had they lived elsewhere in Canada. The Collège des médecins believes that there should no longer be two acts for the same form of suffering.

Thank you for hearing us out and we'll be happy to answer any questions you may have.

• (1005)

[*English*]

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

Next we will hear from Ms. Joffe.

Ms. Kerri Joffe (Staff Lawyer, ARCH Disability Law Centre): Thank you.

Good morning, members of the committee. I am a lawyer working at ARCH Disability Law Centre. ARCH is a specialty legal clinic that provides legal services to people with disabilities in Ontario. ARCH is a poverty law clinic, meaning that the majority of the legal services we provide are to low-income people with disabilities. ARCH also works on national and international disability rights.

We are deeply concerned about the availability of MAID for people with disabilities whose death is not reasonably foreseeable. At ARCH we have clients who have died by MAID, who have applied for MAID or who are contemplating MAID. This is not because they want to die; it's because they cannot get the housing, medical care, disability services or supports they need, and they are too poor to afford to purchase these services privately.

I'll give you just one example, with details and identifying information changed in order to protect the privacy of the person. It's a person in their thirties with a degenerative neurological condition. They have very limited mobility. They need assistance with all activities of daily living. That includes getting out of bed, getting dressed, toileting, cooking, cleaning, grocery shopping, etc. This person has, quote-unquote, "high support needs", but they live a full life in their own apartment. They work part time and spend time with friends and volunteers. This is possible because they receive some provincial funding to hire their own attendants and they have family who fill in the extra hours of support.

Recently, however, their family member died, leaving them without support for many hours each day. They've been refused additional funding for attendant services. They've been told that the only way to get their high support needs met is to move into a long-term care facility. Moving would require the person to leave their community, give up most of their employment, give up their independence and live in a completely inappropriate setting among seniors more than double their age.

Facing this choice, which is not really a choice, the person has decided to apply for MAID. They've been very clear: They don't want to die. They are not suffering because of their disability. They want to continue living in a dignified way in the community, but that's not possible, because the supports they need are not available.

These kinds of client experiences, and numerous similar cases that have been reported in the media, leave us deeply concerned about the dangerous impact that track two is having on low-income disability communities. The track two safeguards built into the legislation may be intended to protect vulnerable people and ensure that decisions about MAID are free, informed and unambiguous, but in our experience, the reality is that there is no real free choice for people with disabilities who exist in pervasive socio-economic deprivation and who have no alternatives for living a dignified life in the community.

I am not expressing an ideological position that is anti-MAID, nor am I expressing a position that seeks to undermine autonomy or the right to make decisions about one's own life. Everyone must be free to choose, especially when it comes to deeply personal decisions about life and death. What I am pointing out today is that based on the experiences of the clients and disability communities that ARCH works with, our law appears to offer freedom to choose

medical assistance in dying, but in fact there is no freedom of choice for many disabled people.

At a UN conference in June, Professor Gerard Quinn, the UN special rapporteur on the rights of persons with disabilities, said that when it comes to autonomy, it is important to distinguish between "myth" and "operation". There's a myth that MAID law gives us all equal rights to make decisions about our death, but in operation, in reality, for many people with disabilities, choices are weighed down by accumulated disadvantages. We cannot talk about free, uncoerced choice if we are not at the same time radically addressing social and economic supports, expanding access to health care and housing systems, and, in short, giving people with disabilities the wherewithal to live the lives they want to live in the communities of their choosing.

Canadian law has recognized this concept too. The Supreme Court of Canada has said that equality looks not only at the choices that are available to individuals but also at the social and economic environments in which they play out. In Canadian law, inequality analysis recognizes that some people may be disproportionately affected by structural conditions that constrain their choices.

ARCH urges the committee in its final report to government to be clear that some people with disabilities are being induced to consider, apply for and go through with MAID not because they are suffering because of their disability but because of social and economic inequality.

Thank you.

• (1010)

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

Once again, thank you to all of our witnesses as we continue our study of this very important topic.

I will begin with Mr. Cooper for the first five minutes.

Mr. Michael Cooper: Thank you, Madam Co-chair.

To Alicia and Christie Duncan—whoever wishes to answer—you mentioned in your testimony that you've not been able to access the MAID records of your mother's case.

Can you tell us more about that?

Ms. Alicia Duncan: I can answer that question.

I submitted a freedom of information request for my mother's assessment, and I'll read to you their response.

They subjectively decided that I was not acting on my mother's behalf and they stated, "When an applicant is not clearly acting on behalf of the deceased, we must treat the request as an ordinary request by one individual for another person's information."

They continued to go on and say that—

Mr. Michael Cooper: I'm sorry to interrupt. Who is "they"?

Ms. Alicia Duncan: This is from Fraser Health.

As the executor of my mother's estate, I have a legal right to her medical records. I requested her documentation for MAID, and they've denied me. They've subjectively decided that I am not acting in my mother's benefit. I'm trying to ensure that the safeguards were followed and I don't even know if she applied under track one or track two because I can't gain any information on this.

The police were also denied this information.

Mr. Michael Cooper: The police were denied this information? You've got to be....

Can you elaborate on that and what the status of the investigation is? That just seems incredible.

Ms. Alicia Duncan: I'll let my sister speak to that.

Ms. Christie Duncan: Currently the police investigation is concluded pending further information. The police did state to us that they were stonewalled by all of the organizations and Fraser Health. They went to the privacy commissioner requesting this information. They were not provided this information.

Mr. Michael Cooper: Which information specifically?

Ms. Christie Duncan: Access to my mom's medical assessments and communication regarding her MAID assessment. They advised us that they would need a production order to access this information. However, they weren't able to gain enough information to be able to write a production order. They basically said they were stonewalled and not able to get what they needed for their investigation.

Mr. Michael Cooper: They didn't have enough information to get a production order because they were being stonewalled.

In essence, they were going in a circle, basically.

Ms. Christie Duncan: Correct.

Mr. Michael Cooper: Can you elaborate on some of those efforts to thwart the investigation and who was involved in thwarting the investigation? It smells of a cover-up.

• (1015)

Ms. Christie Duncan: If there was no negligence, then it would be in their benefit to release this documentation. So far, they have not, which makes me feel the same way. It smells like a cover-up to me.

I do have the police report in front of me. I can read out exactly what....

Mr. Michael Cooper: Please read that into the record.

Ms. Christie Duncan: Let me just get to this.

Ms. Alicia Duncan: While my sister's looking this up, I'd like to add that it's the Abbotsford Police Department that's been investigating my mother's death, and they have said to us that should we find any other information that would allow them to reopen this case, they'd be more than happy to do so. However, as we mentioned, we've been stonewalled, and with zero access to any additional information, they can't continue the investigation.

Mr. Michael Cooper: Go ahead.

Ms. Christie Duncan: I have the concluding remarks here from Monday, August 29, 2022, at 14:39.

"After a full investigation into the matter of MAID in their role in assisting Duncan at the end of her life, investigators could not find any criminality on the part of MAID that was contrary to the Criminal Code of Canada.

"After reviewing all the materials and procedures from Duncan's doctors' hospital records, Fraser Health and MAID involvement with Duncan at the end of her life, police learned that Duncan was of clear operating mind, based on several medical opinions, including Duncan's family doctor, and that she was capable and able to make her own decision throughout the process with MAID.

"Detective Poulin was unable to find any grounds to support the allegation by Duncan's daughters that MAID went outside of the Criminal Code, causing Duncan to end her life against her will."

However, what they said to us in person was that they were not able to find any grounds to support the allegation because they were not given the documentation.

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

Monsieur Arseneault, you have five minutes.

[Translation]

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

Thank you to all our witnesses.

This is a very difficult subject for members of the committee. That's why I'm very pleased to have you, the witnesses, here with us to help us think things through.

I will begin with the Duncan sisters. In your case, it's an extremely cruel circumstance and you're experiencing a lot of frustration.

From the outset, I understood that you were not opposed to medical assistance in dying, but that your situation was a specific one. You explained that your mother was a brilliant person who had worked in this field. As a result of her professional experience she was able to say exactly what someone analyzing her request for medical assistance in dying needed to hear.

I don't want to be rude. I hope the interpreter will be able to accurately summarize what I'm about to say. If I have properly understood what you told us, she had the same family doctor for 20 years. He refused to give her medical assistance in dying and your mother did some successful "shopping around", meaning that she went to seek assistance elsewhere. Is that right?

You mentioned all kinds of safety measures or safeguards and I'd like to thank you for that. However, for someone like me who comes from a rural area, safeguards ought not to impede anyone who appropriately asks for medical assistance in dying. In fact, overly rigorous or strict safeguards more suitable to urban areas could mean that someone in a remote region would be unable to obtain medical assistance in dying.

Am I right to suggest that one of the first safeguards for someone requesting medical assistance in dying should be for the team to consult the family doctor first?

Either one of you can answer.

[*English*]

Ms. Alicia Duncan: My sister and I do believe that one of the major contributing factors in my mother's passing was that there was no continuity of care. Each assessment was done by a different psychiatrist. We've now noted that at one point in her medical records, she was diagnosed with psychosomatic disorder. At that point, my mother's partner took control of her medications. My mother immediately called for another assessment. She knew all of the things to say to have that taken back so she could continue on.

She was very unwell and—

• (1020)

[*Translation*]

Mr. René Arseneault: Excuse me for interrupting, but I don't have very much time.

Do you know whether this psychiatrist consulted your mother's family doctor's notes? Do you know the answer to that, yes or no?

[*English*]

Ms. Alicia Duncan: Christie, you can answer.

Ms. Christie Duncan: Yes, I do believe that the first psychiatrist did call the general practitioner and they had a discussion regarding that. They both had concerns for my mom's mental health.

Another thing to note is that they all worked together in a professional manner as well. They knew my mom from a professional standpoint, as well as having a person-doctor relationship, so they could see her deterioration. They both have said—it's documented in her medical records—that they did not believe she should go through with MAID.

[*Translation*]

Mr. René Arseneault: Thank you very much.

I'll now move on to Dr. Gaudreault and Dr. Luyet.

For people with a disability who request medical assistance in dying, how is it possible to clearly determine that the circumstances might be precarious and that there may not be resources to help with mental suffering? How can we clearly see and make sure that people are truly aware when they request medical assistance in dying?

Dr. André Luyet (Executive Director, Collège des médecins du Québec): I'll let my colleague handle this one.

Dr. Mauril Gaudreault: I'll answer that. Then Dr. Luyet, who is a psychiatrist, can take it from there.

The important thing in a situation like this is the relationship between doctor and patient. That's also true for the Duncan sisters, who spoke earlier. There must be an established relationship between a doctor and the doctor's patient, particularly when this doctor has been treating the person for 20 years. I believe that the most important thing is the relationship between the patient and the doctor, and the understanding and empathy the doctor shows towards the patient.

Dr. Luyet, It's over to you now.

[*English*]

The Joint Chair (Hon. Yonah Martin): Please answer very briefly, Dr. Luyet.

[*Translation*]

Dr. André Luyet: We further feel that there can evidently also be a great deal of suffering in connection with a mental health disorder. It's very important to acknowledge this.

However, there are conditions on access to medical assistance in dying. The decision should never be made because of a lack of access to services. Nor should it be seen as a way of putting an end to suffering when the more promising, effective and recognized alternatives were not on offer.

We have had the opportunity to reflect on this issue and have developed five criteria for assessing a request for medical assistance in dying linked to mental health. I know that time is short, but I think it's important to summarize them for you.

To begin with, it's a decision that is made at the end...

[*English*]

The Joint Chair (Hon. Yonah Martin): I'm sorry, Dr. Luyet—

[*Translation*]

Dr. André Luyet: ... of a fair and comprehensive assessment of the situation by the applicant, and not as a result of a single care episode.

[*English*]

The Joint Chair (Hon. Yonah Martin): I apologize. We are one minute over the time. Would you submit to the committee those five points that you were about to articulate?

Merci.

Next we'll go to Monsieur Thériault for five minutes.

[*Translation*]

Mr. Luc Thériault: Thank you, Madam Chair.

My questions are going to be for the representatives of the Collège des médecins du Québec. Thank you for being here in person.

First of all, I'd like to say that although I heard what you were saying about 0 to 1 year-old patients, the committee is not considering that particular issue.

You mentioned the problem of harmonizing the two acts in the event that no additional guidelines are developed with respect to discussions of illness, disease or disability.

What caused all the turmoil in Quebec? What was the problem? For Mr. Truchon and Ms. Gladu, the court said that they had infringed upon their right to life. These were severely disabled people. Where there is no illness, or, to give another example, a car accident, people would have been upset immediately. People said that they should not be given access to medical assistance in dying, and that there had been no debate on the matter in Quebec.

What's your position on this? Could you clarify what created the issue in question and what led the health minister to back down?

• (1025)

Dr. Mauril Gaudreault: In Quebec, the discussion is still only about illness, and neither disease nor disability has come into it. So we have the Canadian act and the Quebec act. The doctors and other members of the order I am privileged to preside over may find themselves in difficult situations with respect to patient requests of this kind. In Quebec, the Quebec act takes precedence over the Canadian act. That's why I say that there ought not to be two acts for the same condition.

Doctors are often in contact with patients who deserve medical assistance in dying and whose requests ought to be accepted, but the Quebec act does not allow it.

Mr. Luc Thériault: Why did people say there was no debate on it in Quebec when the Truchon decision allowed someone with a disability to receive medical assistance in dying?

What was the problem?

Dr. Mauril Gaudreault: I think that the Quebec government will be revisiting this issue in a new bill that would include it. The problem is that a doctor in Quebec cannot currently administer medical assistance in dying to someone with a disability in the province, but could do so if a patient in the same condition were in another province. That's why the acts need to be harmonized. I believe that the Barreau du Québec said the same thing here this morning.

Mr. Luc Thériault: In my view, the Criminal Code takes precedence in matters of medical treatment. Who in Quebec would sanction behaviour that complies with the Criminal Code?

Dr. Mauril Gaudreault: To be honest, it has never happened. Doctors and the Collège said that doctors could choose to follow one or other of the two acts, but we were upbraided for having said so. Our opinion has not changed, and there have not been any problems in this regard.

Doctors nevertheless find themselves in difficult circumstances that generate unnecessary anxiety.

Mr. Luc Thériault: I understand your point of view. But what's the problem? I was very surprised to hear parliamentarians tell us that the debate had not taken place.

People often refer to the example of a young person who might become quadriplegic after a car accident. That person would be denied medical assistance in dying.

From the clinical standpoint, what would happen if you had a request for medical assistance in dying further to an accident that occurred two months ago?

Do you think that a young quadriplegic, should, after two months, have access to medical assistance in dying under Canada's current act?

How do you view that from a clinical standpoint?

[English]

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

[Translation]

Dr. Mauril Gaudreault: What we think, and we explained this earlier, is that there is no age attached to the request. It all depends on the specifics of each case, and every request needs to be individualized. Medical assistance in dying is care. We see it all from the standpoint of care.

Medical assistance in dying needs to be considered one of the care options available.

Mr. Luc Thériault: Are you telling us that after two months, this young person should have access to medical assistance in dying?

The clinical situation means that all of the options available to this young person have been attempted and exhausted, and that there has been confirmation that the patient is not suicidal or depressive, and as for time, it would involve a continuum that would greatly exceed two months.

That's the clinical reality...

Dr. Mauril Gaudreault: That's not what I'm saying. What I'm saying is that there is a range of care to which the patient is entitled and that perhaps, if the problem deteriorates over a certain number of years, medical assistance in dying might be one of these care options.

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

[English]

Lastly, we'll go to Mr. MacGregor. You have the floor for five minutes.

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

Thank you to all of our witnesses for joining us today.

I'll start with the ARCH Disability Law Centre and Ms. Joffe.

I was listening to your opening statement and taking down a number of notes. Because, of course, you're involved in law, perhaps you could provide us with an informed opinion.

On the safeguards part for a natural death that is not foreseeable, in the Criminal Code the person has to be "informed of the means available to relieve their suffering, including...counselling services, mental health and disability support services, community services", etc. I know that in many parts of the country this is lacking.

In your experience with the clients you are serving, how is it that physicians are meeting that criterion? Do they have to identify specific services? I'm wondering what kind of feedback you're getting from your clients in how that part of the Criminal Code, that requirement, is being met.

• (1030)

Ms. Kerri Joffe: Thank you for the question.

I can't say that I've had in-depth conversations with my clients about all of the steps that physicians are taking to inform them of services that might be available to alleviate their suffering, but I can tell you, from a broader perspective, the concern of the clients I've worked with is not so much that they're not being informed of what's available, but it's that they have, for years or months or really extended periods of time, tried to avail themselves of the services that are in fact available to them, and either they have encountered extensive barriers in not being able to access those services or the supports they needed were simply not available.

This goes to the example I was talking to in my opening remarks about a person who has high support needs, needs attendant services, and has been told by the state, by the provincial authorities, that we're not going to provide you with that level of care in the community, and if you want that level of care, you need to institutionalize yourself.

While I can't speak specifically to the steps that physicians are taking, I would imagine that physicians are put into a very difficult position. They are required to inform people of what's available, but what's available often does not meet people's needs. That's the crux of the issue that we're talking about here when we talk about whether people are truly able to make a real decision.

Mr. Alistair MacGregor: Yes, I think I understand you. This safeguard is triggered only after our request for MAID is made, and that's usually at the end of a very long road where a person has gone through with a lack of services. Your point is very well taken.

To the Duncan sisters, I think, Alicia, you had made some recommendations at the end there. There was the need for clearer definitions, mandatory access to health care, clear safeguards, and so on. On that same point, for track two—this is when death is not naturally foreseeable—there is a requirement that the person who is assessing has to make sure the person is aware of all of these different services. Do you have any comments on this? It's the same sort of thematic question.

Ms. Alicia Duncan: I do have some comments on that.

Mainly, our mother was fully aware that she had these options. Her condition had deteriorated so far at that point that she had suicidal ideation. Because she couldn't access the care she needed in a timely manner—I think that's an important part to put in there—it had gone so far that even though she knew there was access to all of these clinics, it seemed like such a daunting thing to her that it was just easier to end her life at that point.

I think it speaks again to what Kerri was just saying: that doctors are put in a hard position. They can ask, "Do you understand that there are these treatments available?" Then the MAID assessor goes, "Check."

I asked them if they know about these—not asking "What were the steps that you took?" but "Were you able to access this?" and "Why?", looking into it more as opposed to just ticking check marks on a box. There's no in-depth assessment.

• (1035)

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

I will turn this over to you, Mr. Joint Chair.

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

[*Translation*]

I am now giving the floor to Senator Mégie for three minutes.

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

My question is for the representatives of the Collège des médecins.

Apart from anecdotal information in the media, have you heard, from among your members who provide medical assistance in dying, anything like the situation described earlier by Ms. Joffe? She spoke about a young man with a disability who wanted to live, but who, because he would have to be placed in a long-term care institution, is requesting medical assistance in dying.

If any of your members were to speak to you about that, what advice would you give them?

Dr. Mauril Gaudreault: I'll give you an example, and Dr. Luyet will give you one as well.

Everyone, under all circumstances, must have access to the entire range of medical care suited to their circumstances, from prevention to rehabilitation, including medical assistance in dying. In their relationship with patients, doctors have to ensure that the entire range of options is discussed.

Dr. André Luyet: Moreover, it's important to clarify the consent. Patients need to be told about the possibilities and consequences of the various options available, of the assistance that can be provided under the circumstances, and of access to this assistance. All of these things need to be addressed with the full transparency and honesty that is central to the relationship between the patient and the professional providing this care.

Hon. Marie-Françoise Mégie: Thank you.

My next question is for Ms. Joffe.

When a doctor assesses a patient for medical assistance in dying, certain criteria come into play. Could some people challenge the doctor's assessment by alleging that it is based on the level of stigmatization in which all disabled people find themselves? Everything that you are saying might generate a form of public mistrust of health professionals. Before the existence of medical assistance in dying, these same people had the same doctor or the same nurse.

Could having medical assistance in dying as a possibility perhaps create a feeling of patient mistrust of the health professional? That could be the case for the 31-year-old man you spoke about.

[English]

The Joint Chair (Hon. Marc Garneau): Ms. Joffé, you have a short time to answer that question if you've heard it.

Ms. Kerri Joffe: Thank you for the question. I did hear it.

I think that without a doubt it does create a very difficult relationship between people with disabilities and their health care providers.

In the work I do, what I've heard expressed by clients in my communities of people with disabilities is a feeling of abandonment by the government and a sentiment of "Why are governments not providing us with the supports we need to address suffering rather than offering death as an end to suffering?", so I would just say, as I said before, that I think it is putting some health care professionals in very difficult positions.

We've seen op-eds in the media, and I think the committee has heard testimony from physicians about some of those difficult positions they're put in because of the regime.

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

Senator Kutcher, you have the floor.

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

I have two questions, first for the Collège des médecins du Québec and then for Ms. Joffé.

The previous panel talked about MAID safeguards for people with disabilities. They focused on legislative safeguards. The expert panel on MAID for mental disorder as a sole underlying condition came up with a very thorough report that included various safeguards.

Would you think that a similar kind of process, a similar kind of report, would be useful to address these really legitimate concerns of people with disabilities?

• (1040)

[Translation]

Dr. André Luyet: I mentioned these briefly earlier, and had just begun listing them. I could give you something in writing that identifies the five criteria that provide guidance in safely making a decision in such very specific situations.

[English]

Hon. Stanley Kutcher: I would imagine that's yes then, is it?

[Translation]

Dr. André Luyet: Yes.

[English]

Hon. Stanley Kutcher: Thank you so much.

Ms. Joffé, we've had very legitimate fears raised that large numbers of persons with disabilities would be forced to seek MAID because of intolerable components of their life conditions. You spoke about some people whom you have worked with who have shared that concern with you.

We suffer from a lack of good data on what these numbers would be. Europe has had MAID for a much longer time than Canada.

Would you have any data that's available that will let us know how many people who have received MAID in Europe have been identified as having a disability or would have had MAID provided to them because they weren't able to access resources in those countries? I understand that some of those countries might have better resources than we have. Would you have any of that data available for us?

Ms. Kerri Joffe: I do not have that data available for you. I can provide information based on the experiences and the legal practice that I do and that ARCH does, based also on the information that we are receiving from some of our partners, disability advocacy groups, from across the country.

I also want to say a couple of more points.

Senator Kutcher, you referred to fears of the impact of the legislation on people with disabilities. I am here today to tell you that it's not just a fear; it's a reality. We have clients who are living in poverty, who are people with disabilities, who are either seriously contemplating MAID, have applied for MAID or who have gone through with MAID and have clearly expressed that it's not based on physical suffering because of their disability; it is entirely related to suffering because they cannot get their disability-related needs met, whether on a social basis or an economic basis.

I can't give you data, but I can speak from my experience.

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

Go ahead, Senator Dalphond.

Hon. Pierre Dalphond: My questions will be for Ms. Joffé to follow up on what Senator Kutcher was asking.

You gave the example of the 30-year-old person who unfortunately lost the family support needed, so the only option provided by the provincial health care was to go to a long-term health facility.

Are you saying that we should not extend track two access to MAID, which you argue is not acceptable?

The provincial health system not only provides long-term health care facilities. Are you saying that the person should go to the health care facilities and stay there without any option to ask for MAID? We are dealing here with the Criminal Code; we're not dealing with the provisions of health services.

Ms. Kerri Joffe: I am not suggesting that a person should accept going into an institution and living out their entire life in an institution in a setting that's entirely inappropriate for them. I am telling you that that is the exact kind of discrimination and the exact kind of deprivation of the ability to live your life in dignity that is driving the people who I work with to consider, apply for or go through with MAID. That is the—

Hon. Pierre Dalphond: I'm sorry to interrupt, but my time is limited.

In that case, I guess you went to the rental board or some other authority on behalf of your client to get more provincial support.

Ms. Kerri Joffe: Yes. My role is to advocate as hard as I possibly can on behalf of my client to get the supports and the funding in place so that person doesn't have to consider MAID.

Hon. Pierre Dalphond: I understand.

• (1045)

Ms. Kerri Joffe: The problem is that it's often unsuccessful.

Hon. Pierre Dalphond: For you, then, because it's unsuccessful, it's a reason to deny access to MAID. I understand your point.

My next question is for the other witnesses.

For the Duncan family, I understand that your mother had a common-law partner. Mr. Rick Hansum was reported in the press as talking about the unbearable suffering that your mother went through for months. Is he part of your criminal allegations? Does he think that she was the subject of a faulty system?

Ms. Christie Duncan: I'm sorry...? Is it that Rick doesn't believe that it was part of a faulty system?

Hon. Pierre Dalphond: No. You say that the system faulted your mother, and I was asking if her common-law partner, Mr. Hansum, was also sharing your views and was part of your attempts to have legal inquiries and to have police investigations or have the college of medicine to investigate.

Ms. Christie Duncan: No.

Ms. Alicia Duncan: I—

Ms. Christie Duncan: He does not support us. He had caregiver's fatigue. It was a lot. He was taking care of my mom. Besides my sister and me coming in on the weekends to help bathe her, he was there 24 hours a day, and we believe that he had caregiver's fatigue.

Ms. Alicia Duncan: He specifically told us that as hard as it would be—

Ms. Christie Duncan: As horrific—

Ms. Alicia Duncan: —as horrific as it would be for our mother to pass, at least he could get his life back. He said that to us two weeks before she died.

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

Senator Wallin, we'll try this again. I hope your voice quality is higher.

Hon. Pamela Wallin: Okay. [*Technical difficulty—Editor*]

The Joint Chair (Hon. Marc Garneau): I regret to say that it's not any better. I'm terribly sorry.

Next is Senator Martin.

The Joint Chair (Hon. Yonah Martin): For Christie and Alicia Duncan, first of all, I just want to say that I think how both of you are working so hard to take on the system to in essence get to the

bottom of what happened is very admirable. My sister and I suffered through a situation of thinking we should do the same after our father's death, but we just didn't have the energy, nor the means. I empathize with you greatly.

Would you explain how the Abbotsford police did get involved? Was it just through your request? To launch an investigation, there must have been a reason or grounds for that.

Ms. Alicia Duncan: Yes. Thank you.

I had contacted the Abbotsford Police Department. My sister works for the RCMP, and we decided that we were going to review the Criminal Code after we received my mom's medical records. They didn't indicate any.... There was no terminal illness noted. The doctors had done extensive testing to rule out all forms of terminal illness. As well, we had an autopsy completed after her death to confirm that there was no terminal illness.

There are so many contradictions in the Criminal Code itself, and we just didn't understand how she was not facing a foreseeable death but then didn't have to go through the 90-day assessment period. It was fast-tracked. She died within a week of initially applying. The doctor who assessed her subjectively decided that her death was foreseeable.

My mom was essentially starving herself. She was paranoid. I have records. She spent over \$6,000 contacting a psychic to find out if foods were contaminated with lead poisoning. She was energy-testing her food before she ate it. She was highly paranoid. It didn't make sense. We went to the police with all the information we had. They also agreed that there was no clear information, which is why they initiated the investigation.

Ms. Christie Duncan: They did a very thorough investigation. They spent almost eight months on this, because they also couldn't understand why it wasn't followed. There are so many contradictions between what we've been told and what's in the documentation that it seemed suspicious to them too. That is why they spent eight months investigating.

• (1050)

The Joint Chair (Hon. Yonah Martin): You mentioned there wasn't continuity of care, so there is also that challenge in trying to piece the parts together.

You also said you weren't sure whether she qualified under track one or two, because of how quickly it was done. Is that correct?

Ms. Alicia Duncan: That's correct. She had no terminal diagnosis, so we assumed it was under track two, but she didn't have to go through the 90-day assessment period.

We just need clarification. We need the documentation to confirm that all the safeguards were followed.

Ms. Christie Duncan: She wasn't at risk of losing her ability to consent. She was of sound mind, but that does not mean she wasn't suicidal. Being depressed doesn't make you not of sound mind. It makes you want to die, and that is what she got.

Ms. Alicia Duncan: When we went through the courts and had her application postponed, she was so upset that she slit her wrists. It was then she was considered to be suicidal and put in a psychiatric unit for the last two days of her life. Within four hours of being released, MAID killed her.

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

Thank you, Senator Martin. I'll turn it back to you now.

The Joint Chair (Hon. Yonah Martin): I want to thank all the witnesses who appeared before our committee today.

Thank you so much for taking the time, as well as for sharing with us your very important words.

With that, colleagues, I will bring this meeting to a close.

The meeting is adjourned.

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