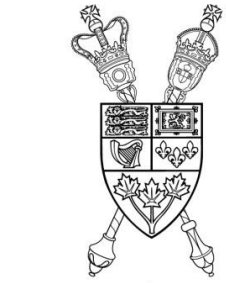

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MEDICAL ASSISTANCE IN DYING AND MENTAL DISORDER AS THE SOLE UNDERLYING CONDITION: AN INTERIM REPORT

Report of the Special Joint Committee on Medical Assistance in Dying

Hon. Marc Garneau and Hon. Yonah Martin
Joint Chairs

JUNE 2022

44th PARLIAMENT, 1st SESSION

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SPECIAL JOINT COMMITTEE ON MEDICAL ASSISTANCE IN DYING

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THE SPECIAL JOINT COMMITTEE ON MEDICAL ASSISTANCE IN DYING

has the honour to present its

FIRST REPORT

Pursuant to its Orders of Reference from the Senate on Thursday, March 31, 2022, and Wednesday, May 4, 2022, and from the House of Commons on Wednesday, March 30, 2022, and Monday, May 2, 2022, the committee has studied mental illness as a sole underlying condition in the context of the statutory review of the provisions of the criminal code relating to medical assistance in dying and their application and has agreed to report the following:

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MEDICAL ASSISTANCE IN DYING AND MENTAL DISORDER AS THE SOLE UNDERLYING CONDITION: AN INTERIM REPORT

INTRODUCTION

Medical assistance in dying (MAID) is a complex and often emotional topic. The evolution of Canada's laws relating to MAID has involved balancing many factors, including individual autonomy, respect for life, equality rights and protecting vulnerable people. MAID encompasses moral and ethical concerns as well as legal issues and engages questions regarding adequate access to health care and social supports. Discourse on MAID is complicated by the division of powers: the practice of MAID is permitted provided that it meets the provisions set out in the federal *Criminal Code*, while provinces and territories regulate nurses and physicians and provide the majority of health care services to their residents.

Both Bill C-14 and Bill C-7, which created and amended the MAID regime, required parliamentary reviews.[1] In April 2021, motions were adopted in the House of Commons and the Senate to establish a joint committee to review the provisions of the *Criminal Code* pertaining to MAID. Two meetings were held before the dissolution of Parliament.[2]

The Special Joint Committee on Medical Assistance in Dying (the Committee) was re-created in March 2022 and tasked with reviewing "the provisions of the *Criminal Code* relating to medical assistance in dying and their application, including but not limited to issues relating to mature minors, advance requests, mental illness, the state of palliative care in Canada and the protection of Canadians with disabilities."[3] While the Committee was initially required to submit its final report by 23 June 2022, that deadline was extended to 17 October 2022.[4] However, by 23 June 2022, the Committee is still required to submit an interim report on mental disorder as a sole underlying medical condition (MD-SUMC) for accessing MAID.

1 See Clause 10 of Bill C-14 and Clause 5 of Bill C-7.

2 House of Commons, *Journals*, 16 April 2021; and Senate, *Journals*, 20 April 2021.

3 House of Commons, *Journals*, 30 March 2022; and Senate, *Journals*, 31 March 2022.

4 House of Commons, *Journals*, 2 May 2022; and Senate, *Journals*, 4 May 2022.

The Committee began hearing witnesses on 13 April 2022. However, it postponed hearing from witnesses relating to mental disorder until after the Expert Panel on MAID and Mental Illness (Expert Panel) tabled its report on 13 May 2022. The Terms of Reference required the Expert Panel to make recommendations regarding:

- Protocols and guidance for the assessment and provision of MAID for persons with a mental illness for use by national, provincial and territorial health professional bodies and medical practitioners; and

- Additional safeguards for inclusion in federal legislation to support the safe implementation of MAID for persons with a mental illness.

The Expert Panel concluded that:

> the existing MAiD eligibility criteria and safeguards buttressed by existing laws, standards, and practices in related areas of healthcare can provide an adequate structure for MAiD MD-SUMC so long as those are interpreted appropriately to take into consideration the specificity of mental disorders.

As a result, none of its 19 recommendations propose amendments to the *Criminal Code*. The Chair of the Expert Panel, Dr. Mona Gupta, appeared before the Committee on 26 May 2022. Dr. Gupta's testimony relating to the report is included in the section, "What We Heard," below, and the Expert Panel's recommendations are attached to this report in Appendix A (recommendations from other panels and groups are in Appendix B).

While the *Criminal Code* provisions refer to "mental illness," which is the term used in the Expert Panel's mandate and the motion creating this Committee, the Expert Panel uses "mental disorder", noting that there is no standard definition of "mental illness" and that using it could cause confusion. In addition, the Expert Panel explains that:

> A comprehensive review of the knowledge available on the topic of MAiD for mental illness required by the 2016 MAiD legislation (Council of Canadian Academies, 2018) recommended the use of the standard clinical term, 'mental disorder'. Therefore, throughout this report, the Panel uses 'mental disorder' as that is the term used in both major diagnostic classification schemes relied upon in Canadian psychiatric practice: the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) and the World Health Organization's International Classification of Diseases (ICD).

The Committee agrees that using the standard clinical term "mental disorder" is preferable to "mental illness," and has used that term throughout this interim report, except where directly quoting a witness or referring to the *Criminal Code* provisions. An additional challenge relating to terminology that witnesses raised is that "irremediable,"

"incurable" and "intolerable suffering," all terms used in the relevant *Criminal Code* provisions, do not have scientific or medical definitions.[5]

Hearings on mental disorder took place on 25 and 26 May 2022, though some witnesses appearing on other themes also spoke to mental disorder in the context of MAID. Delaying meetings on this important topic until after the Expert Panel report was tabled allowed Committee members time to consider the report prior to hearing from witnesses on this topic, and also meant that witnesses could respond to the report.[6] To date, the Committee has heard from 13 witnesses specifically on this topic, including psychiatrists, other physicians, and advocacy and other organizations. The Committee has also received hundreds of briefs, some of which relate to MAID and mental disorder. These briefs will be considered for our final report.

Given the need to carry out additional work on this theme, and the importance of allowing sufficient time to consider the many briefs that have been submitted to the Committee in addition to witness testimony, this interim report does not contain final recommendations. Instead, it summarizes the testimony presented to the Committee.

We wish to thank all of the witnesses who have appeared before the Committee to date. The medical and legal experts, advocacy organizations and individuals with lived experience we heard from have provided rich testimony that includes both information and opinion. While we are providing a summary of what we heard in this interim report, we note that the testimony does not necessarily reflect the opinion of the Committee. The Committee has attributed all statements to the individuals and organizations that shared the information, but has not verified the accuracy of the information provided. In our final report, to the extent possible, we will provide greater context for information presented by witnesses when it conflicts with other testimony or with our understanding of current knowledge on this topic.

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5 See AMAD, *Evidence*, 26 May 2022 (Mark Sinyor, Professor; Mona Gupta, Chair, Expert Panel on MAID and Mental Illness; Alison Freeland, Chair of the Board of Directors, Co-Chair of MAID Working Group, Canadian Psychiatric Association).

6 For example, Derryck Smith, Clinical Professor Emeritus, Department of Psychiatry, University of British Columbia agrees with the Expert Panel's recommendation (AMAD, *Evidence*, 25 May 2022); Ellen Wiebe agrees with the recommendations with the exception that provinces and regulatory bodies should be responsible for standards guidelines (AMAD, *Evidence*, 26 May 2022); Tyler Black, Clinical Assistant Professor, University of British Columbia agrees with most of the report (AMAD, *Evidence*, 26 May 2022); while John Maher, President, Ontario Association for ACT & FACT, and Mark Sinyor are concerned by the report's conclusions (AMAD, *Evidence*, 26 May 2022).

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LEGISLATIVE BACKGROUND

Bill C-14

As explained in the Library of Parliament's *Legislative Summary for Bill C-7: An Act to amend the Criminal Code (medical assistance in dying)*:

> Bill C-14 was introduced in the House of Commons on 14 April 2016 and received Royal Assent on 17 June 2016.[7] The bill defined "medical assistance in dying" (MAID) as:
>
> - the administering by a medical practitioner or nurse practitioner of a substance to a person, at their request, that causes their death; or
>
> - the prescribing or providing by a medical practitioner or nurse practitioner of a substance to a person, at their request, so that they may self-administer the substance and in doing so cause their own death.
>
> Bill C-14 included amendments to the *Criminal Code* (the Code) providing exemptions from criminal liability for a number of people, including medical practitioners and nurse practitioners (NPs) who provide MAID and persons who assist them, such as pharmacists.
>
> …
>
> The Department of Justice stated in *Legislative Background: Medical Assistance in Dying (Bill C-14)* that
>
> > people with a mental illness or physical disability would not be excluded from the regime but would … be able to access medical assistance in dying [only] if they met all of the eligibility criteria.[8]

7 Bill C-14, An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying), 42nd Parliament, 1st Session (S.C. 2016, c. 3).

8 Department of Justice, "IV. Eligibility Criteria for Medical Assistance in Dying," Legislative Background: Medical Assistance in Dying (Bill C-14).

Bill C-7

The Library of Parliament's *Legislative Summary for Bill C-7: An Act to amend the Criminal Code (medical assistance in dying)* explains the changes to the law brought by Bill C-7, which received Royal Assent on 17 March 2021:

> Bill C-7 includes the federal response to the September 2019 Superior Court of Quebec decision in *Truchon c. Procureur général du Canada*,[9] which related to the federal *Criminal Code* (the Code) provisions on medical assistance in dying (MAID)[10] and Quebec's *Act respecting end-of-life care*.[11] That decision declared that the Code requirement that a person could be eligible for MAID only if natural death was "reasonably foreseeable" was contrary to the *Canadian Charter of Rights and Freedoms* (the Charter).
>
> …
>
> The bill amends the Code provisions on MAID by establishing a separate set of procedural safeguards for individuals whose natural death is not reasonably foreseeable and making some amendments to the safeguards that apply in the case of individuals whose natural death is reasonably foreseeable.
>
> Bill C-7 also amended the eligibility criteria by establishing that mental illness is not an illness, disease or disability for the purpose of determining eligibility for MAID.

However, the provision that excludes mental illness as a grievous and irremediable medical condition has a sunset clause. This means that, unless that clause is amended, some mental illnesses may be considered to be a grievous and irremediable medical condition and grounds for eligibility for MAID as the sole underlying condition, if the other eligibility criteria are satisfied, as of 17 March 2023 (clause 6). In addition, a clause was added to the bill to require an independent review to be conducted by experts "respecting recommended protocols, guidance and safeguards to apply to requests made for medical assistance in dying by persons who have a mental illness" (clause 3.1(1)). The review was conducted by the Expert Panel mentioned above.

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9 *Truchon c. Procureur général du Canada*, 2019 QCCS 3792 (CanLII) [Unofficial translation].

10 *Criminal Code*, R.S.C. 1985, c. C-46, ss. 241.1–241.4.

11 Quebec's law relating to medical assistance in dying (MAID) received Royal Assent in June 2014. Quebec, *Act respecting end-of-life care*, R.S.Q., c. S-32.0001.

WHAT WE HEARD

The Committee heard a range of views relating to MAID MD-SUMC, including:

- the appropriate balance between respecting autonomy and protecting the vulnerable;
- ensuring the patient is fully informed and has the capacity to understand and make an informed decision;
- establishing irremediability of an individual's mental disorder, and how much uncertainty is acceptable;
- distinguishing between a request for MAID and suicidality;
- addressing situations where a MAID request is influenced by inadequate healthcare and social supports; and
- questioning whether someone suffering solely from a mental disorder is eligible for MAID.

These discussions are summarized below.

International Experiences

Witnesses discussed MAID MD-SUMC in the Netherlands, Belgium and Switzerland. Dr. Gupta noted that there are no safeguards specific to MD-SUMC in countries that permit it. Those countries have few requests for MAID MD-SUMC approved.[12] Dr. Brian Mishara, Professor and Director of the Centre for Research and Intervention on Suicide, Ethical Issues and End-of-Life Practices at the Université du Québec à Montréal, explained that in the Netherlands, MAID MD-SUMC evaluations take approximately ten months; only 5% of requests are granted.

Some witnesses noted that in the Netherlands and Belgium, a patient is denied MAID if they have not tried all available treatments to alleviate their suffering. In contrast, patients in Canada must only be informed of alternatives to MAID; they are not required

12 Black; Smith; AMAD, *Evidence*, 25 May 2022 (Brian Mishara, Professor and Director, Centre for Research and Intervention on Suicide, Ethical Issues and End-of-Life Practices (CRISE), Université du Québec à Montréal).

to accept treatment to be eligible.[13] In contrast, the Expert Panel noted that the Dutch due care criteria require that "the physician must…have come to the conclusion, together with the patient, that there is no reasonable alternative in the patient's situation." [14]

Capacity

Eligibility for MAID in Canada requires that a person is "capable of making decisions with respect to their health." Dr. Derryck Smith, Clinical Professor Emeritus, UBC Department of Psychiatry, said doctors do competency and capacity assessments before providing any service. He noted that, for MAID, they "may need to up the ante a little bit," and take more time with the patient, but no unique skill set is required.

Dr. Smith also noted that all patients, including psychiatric patients, are presumed competent until proven otherwise.[15] Dr. Gupta noted that there is a movement out of the United Nations to respect the will of individuals who lack capacity through supported decision-making.[16] While there have been supported decision-making efforts in Canada, applying it to MAID requires further reflection and research.

Dr. Smith seeks a second opinion when unsure about capacity. If capacity is unclear, Dr. Gupta felt that MAID should not be offered, but that uncertainty in some cases should not justify a complete ban on MAID MD-SUMC.

Irremediability in the Context of Mental Disorder

To be eligible for MAID, a patient must have a grievous and irremediable medical condition. This requires the illness to be incurable, and the person to be in an advanced

13 Maher; Mishara; AMAD, *Evidence,* 13 April 2022 (Jay Potter, Acting Senior Counsel, Department of Justice).

14 *Final Report of the Expert Panel on MAID and Mental Illness*, p. 104.

15 Also see Freeland.

16 Supported decision-making is discussed in the Expert Panel's report at pp 60-61:

> In law, a person is either capable or not capable. However clinically, in the course of assessing a person's capacity, it may be apparent the person is in an intermediate situation as they have diminished capacity rather than being completely incapable. In these situations, with assistance, a person could be helped to make their own capable decisions. This is consistent with the United Nations Convention on Rights of Persons with Disabilities (CRPD), which declares that people with disabilities have legal capacity on an equal basis with others in all aspects of life. This type of 'supported decision-making approach' has already been used from time to time in MAiD assessments.

state of irreversible decline and intolerable suffering. Dr. Gupta outlined the debate on irremediability and mental disorder:

> I think a large part of the debate between those who say that an illness cannot be deemed irremediable and those who say it can is the result of the fact that they use different definitions.
>
> …
>
> Of course, we know there are illnesses that we will never be able to cure. We are 100% sure of that. Yet there are many other illnesses that we know less about, especially as regards their long-term evolution. In such cases, what is the degree of certainty required? The devil is in the details. On the whole, that is our view. If we think about what an incurable condition is and draw a parallel with other chronic illnesses, we can say that the threshold is met once all the conventional treatments have been exhausted.

The debate on irremediability relates in large part to the assessment of acceptable risk given uncertainty. In response to a question about whether it is acceptable that someone with a mental disorder could end their life when they might have improved, Dr. Gupta said:

> I think you're asking about the very heart of MAID. I think the question is, who should decide whether that's an acceptable risk? In allowing MAID in our country, we've said that is a choice for that individual to make that request.
>
> …
>
> I think it's acceptable for the individual to make that decision, yes.

Dr. Tyler Black, UBC Clinical Assistant Professor in psychiatry, said "there are many psychiatric disorders that are not curable with present science." Dr. Alison Freeland, Chair of the Board of Directors and Co-Chair of the MAID Working Group, Canadian Psychiatric Association, agreed, noting that despite treatment many people continue to have symptoms and varying degrees of suffering.

Dr. Smith outlined his understanding of irremediable:

> [It is] used when there are no more treatments available that are "acceptable" to the patient. Under law, the patient cannot be forced to take any types of treatments that

> are available. They must agree. If a person refuses additional treatment, I would, therefore, consider them to be irremediable.[17]

Dr. Ellen Wiebe, a family doctor, said a patient must have been offered several reasonable treatments and have tried or seriously considered them. Assessments take place in context; if there is a five-year wait to access specialist services and the patient is unwilling to wait, she would conclude that the illness is irremediable.

Dr. Freeland said that a patient who refuses recommended treatment without good reason is unlikely to be found to be eligible for MAID. Dr. Smith and Dr. Gupta told the Committee that, to be eligible, patients would have to be ill for years and have tried many treatments. Dr. Gupta recognized that, while individuals with capacity cannot be forced to receive treatment, establishing that an illness is incurable requires trying treatments. The number of treatments required should be established by the patient and practitioner.

Sean Krausert, Executive Director, Canadian Association for Suicide Prevention, felt that a patient's treatment refusal does not equal irremediability. Dr. John Maher, President, Ontario Association for ACT & FACT, said:

> Certainly, the Quebec legislation that was just tabled got it right when they said that you can't determine whether psychiatric disease is irremediable… There is no exhausting treatment possibilities like there is with a terminal cancer where this chemo no longer works. I literally have hundreds of combinations, and when people have tried things, it helps narrow down what will work over time.

Dr. Mishara stated:

> If it were possible to distinguish the very few people with a mental illness who are destined to suffer interminably from those whose suffering is treatable, it would be inhumane to deny MAID. But any attempt at identifying who should have access to MAID will make large numbers of mistakes, and people who would have experienced improvements in their symptoms and no longer wish to die will die by MAID.

According to Dr. Mark Sinyor, Professor of psychiatry:

> Nothing in life or in medicine is certain. All of our treatments carry potential benefits and potential harms. In medicine, we deal in probabilities. Doctors help patients make decisions in cancer treatment, for example, by sharing that chemotherapy might result in survival 90% of the time or only 10% of the time. In neither case do we know the outcome for certain, but those numbers are crucial in helping patients make informed

17 Also see AMAD, *Evidence*, 25 May 2022 (David E. Roberge, Member, End of Life Working Group, Canadian Bar Association).

> decisions. In physician-assisted death for sole mental illness, we have no numbers at all. Neither we nor our patients would have any idea how often our judgments of irremediability are simply wrong. This is completely different from MAID applied for end-of-life situations or for progressive and incurable neurological illnesses, where clinical prediction of irremediability is based in evidence.
>
> In the context of physician-assisted death for sole mental illness, life or death decisions will be made based on hunches and guesswork that could be wildly inaccurate. The uncertainties and potential for mistakes in mental illness are enormous and, therefore, the ethical imperative to study harms in advance of legislation is accordingly immense.

Dr. Sinyor called for studies to learn more about irremediability of illness and suffering.

Dr. Valorie Masuda, a palliative care physician, disagreed with the Expert Panel's suggestion to examine past response to treatment in assessing future irremediability of a mental disorder. Similarly, Dr. Maher said:

> In every other case, we're looking at future treatments that don't work. What the panel said was that we look at past treatments that didn't work, but that's helpful and critical information for guiding next steps.
>
> Let me quote a line from the panel that I thought was remarkably apropos your question.
>
> This is from the Gupta report: "There is limited knowledge about the long-term prognosis for many conditions, and it is difficult, if not impossible, for clinicians to make accurate predictions about the future for an individual patient." They said it in their report—they said it right in their report—and then they add that it's an ethical decision. Unlike every other case of MAID in in Canada, where you're trying to gauge the clinical reality of whether treatment will work, they say it's an "ethical choice".

Dr. Sonu Gaind, Professor in psychiatry, agreed:

> …our law does not say grievous and irremediable conditions are determined by an ethical decision. It should be a scientific decision…there is no question that we cannot make those predictions in mental illness.

Similarly, Dr. Mishara criticized the Expert Panel for not identifying specific criteria or providing evidence that practitioners can be certain that a specific individual will improve.

Dr. Black suggested that the patient should consider the uncertainties outlined above and decide what is right for them:

> If we can't say 100% for certain what's going to happen, we also can't say that treatments will be 100% effective. This is why we put the patient at the core of our

> decision-making. We give them the best information we can and they make the best decision they can.

MAID and Suicide

Some witnesses told the Committee that, while suicidality may be a symptom of a mental disorder, many people with a mental disorder are not suicidal, while others with no mental disorder are suicidal.[18] Dr. Black said that the motivation is rarely the same for MAID and suicide:

> In suicide, it's very rare to have a combination of fatalistic motivation, which is a controlled response to a perceived stress, an agreed-upon lack of remedy and a rational calculation of the likelihood of change, whereas in MAID this is almost always the case. In the literature, psychiatrists generally agree with the patient's unbearable suffering and futility of treatment in psychiatric MAID cases in the countries where this has been studied.

Dr. Smith reminded the Committee that the *Truchon* decision recognised that physicians can distinguish suicidal patients from those requesting MAID; he agreed with this conclusion.[19] Dr. Gupta noted that suicidality can be present for physical illness where death is reasonably foreseeable, so these issues are already being addressed in cases where MAID is permitted.

Dr. Black said that 40-50% of those who die by suicide do not have a serious mental health diagnosis. In contrast, Dr. Mishara told the Committee that almost all high-risk suicidal individuals he has spoken with would be eligible for MAID and that over 90% of those who die by suicide have a diagnosable mental disorder. He expressed concern that the Expert Panel report says there are no fixed rules in differentiating suicidality from a rational request for MAID and that they did not offer diagnostic criteria. He challenged the idea that anyone can differentiate between the two.[20] Dr. Sinyor said experts can try to distinguish a request for MAID and suicidality, but no rigorous scientific study has established how accurately they are able to make that distinction.

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18 Black; Gupta; AMAD, *Evidence*, 13 April 2022 (Abby Hoffman, Senior Executive Advisor to the Deputy Minister, Department of Health).

19 Also see Wiebe; Black. *Truchon c. Procureur général du Canada*, 2019 QCCS 3792 (CanLII) [Unofficial translation], para. 466.

20 Also see AMAD, *Evidence*, 26 May 2022 (Georgia Vrakas, Psychologist and Professor).

Mr. Krausert noted that he likely would have chosen MAID in his "darkest days" of depression and anxiety and now has a rich life with successful medication and therapy. Similarly, Dr. Georgia Vrakas, Psychologist and Professor, said:

> In this context, giving people like me the green light to get medical assistance in dying is a clear signal of disengagement from mental illness. It sends the message that there is no hope and that we are disposable.

Dr. Maher challenged the idea that suicide is always impulsive and said suicide rates have increased where MAID is permitted in Europe and that women have higher suicide rates than men.[21] Dr. Black provided data that demonstrated that suicide rates have not increased in countries where MAID was adopted, including in Canada. He noted:

> One study estimated suicidal thinking as an 8% lifetime risk for adults in the Netherlands, yet 65 or 0.0004% of adults in the Netherlands have died of MAID in any given year due to psychiatric reasons.

Dr. Gupta acknowledged the differences of opinion but made comparisons to other areas of medicine. If a patient refuses treatment that will result in death, that person is not considered suicidal and forcibly treated; the same principles and practices apply in the MAID context. Where a person may actually be suicidal, that person may be found ineligible.

Structural Vulnerability and Social Determinants of Health

Some witnesses expressed concern that individuals are requesting MAID due to suffering related to poverty, lack of adequate housing, social exclusion and other social determinants of health, rather than due to their illness.[22] Witnesses generally thought greater social supports were important, regardless of whether MAID MD-SUMC should be legal or not. Dr. Maher said, "[d]eath is not an acceptable substitute for good treatment, food, housing, and compassion." Dr. Kwame McKenzie, Professor of Psychiatry, was concerned with

> … mak[ing] sure that we don't end up in a situation where we haven't done enough and MAID is considered an off-ramp for social suffering. I don't think we're there yet, but I don't want us to get there, so it's about being mindful, rather than saying there is data

21 Also see Sinyor.

22 Maher; AMAD, *Evidence*, 25 May 2022 (Dr. Valorie Masuda); AMAD, *Evidence*, 28 April 2022 (Dr. Sandy Buchman, Chair and Medical Director, Freeman Centre for the Advancement of Palliative Care, North York General Hospital and Past President, Canadian Medical Association).

> at the moment showing that we have high numbers of [I]ndigenous or racialized or low-income people who are applying for MAID at the moment.

While a MAID death allows individuals to exercise their autonomy and decide when to end their suffering, Dr. Harvey Max Chochinov, Distinguished Professor of Psychiatry, University of Manitoba, expressed his opinion on the challenge for some:

> Exercising autonomy means having real and viable options. If you're dying in the absence of quality and available palliative care; if you're disabled but don't have access to supports and services, or social, housing, and employment opportunities; if you have chronic pain or uncontrolled symptoms and don't have timely access to a specialist; if you're struggling with a mental illness and can't find a therapist who is prepared to help you grapple your way towards recovery, can we really say you're exercising an autonomous choice?

Some saw allowing MAID outside of the end-of-life context as stigmatising because of an underlying assumption that some lives are not worth living.[23] As noted above, individuals with a mental disorder are presumed to be competent unless an assessment shows otherwise. Dr. Freeland noted that vulnerability is not limited to those with a mental disorder.

Dr. Smith noted that international data shows that it is typically white, well-educated and well-off individuals who receive MAID and that marginalized communities may actually face barriers accessing MAID. Dr. Sandy Buchman, Chair and Medical Director, Freeman Centre for the Advancement of Palliative care, said in his experience, vulnerable patients want aggressive medical care given their lack of trust in the healthcare system; requests for MAID from vulnerable people are uncommon. In contrast, Dr. Gaind offered his opinion:

> Evidence shows that when death is foreseeable, people seek MAID to preserve dignity and autonomy to avoid a painful death. Those seeking MAID in these situations tend to be, in researchers' words, white, more educated and more privileged. That's been used to suggest that MAID is safe to expand to other situations.
>
> However, when expanded to the non-dying disabled for mental illness, that association completely flips. A different group gets MAID. These are the group of non-dying marginalized, who have never had autonomy to live a life with dignity. Rather [than] death with dignity, they are seeking an escape from life's suffering.

23 Krauser; Maher; Vrakas; AMAD, *Evidence,* 25 April 2022 (Dr. Félix Pageau, Geriatrician, Ethicist and Researcher, Université Laval).

He also noted that twice as many women as men receive MAID in the Netherlands for non-terminal conditions.[24]

Dr. McKenzie was not aware of reports discussing differential impacts of MAID on different racial groups, but felt that these communities must be engaged to ensure that their needs are reflected in any legislative changes. Some witnesses highlighted the importance of consulting Indigenous communities.[25] While the Committee notes that consulting with Indigenous communities on the issue of MAID MD-SUMC was not part of the Expert Panel's mandate, the Expert Panel stated that "Indigenous peoples in Canada have unique perspectives on death which need to be considered in the context of the emergence of MAiD including MAiD MD-SUMC. However, engagement with Indigenous peoples in Canada concerning MAiD has yet to occur."[26]

Myeengun Henry, Indigenous Knowledge Keeper, University of Waterloo shared the following with the Committee:

> I have been speaking to our members and the [I]ndigenous community at large, and it's a very tough situation. …. I would guess we wouldn't have everybody agreeing.
>
> When we go back to our history and think about how we dealt with these issues throughout our spiritual journeys, that's where we align. We let the Creator decide that. It's a tough situation. Every single case has its own scenario.

The Committee is mindful of the testimony that cultural beliefs and tradition play a significant role in a patient's attitude toward MAID and will seek additional testimony from First Nations, Inuit and Métis witnesses before we present our final report.

Access to Healthcare Services

Witnesses recognized that access to adequate healthcare, and particularly mental healthcare, is a challenge for many Canadians and that this needs to be addressed. As Dr. McKenzie said, "[a]t the moment, we say they need to know about [services], but the question is, do we assure they actually have full access?"

Dr. Gupta explained that access to adequate care is highly variable depending on whether a person is seeking first-line resources or tertiary-level care and where a patient

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24 Also see AMAD, *Evidence*, 28 April 2022 (Dr. Harvey Max Chochinov, Distinguished Professor of Psychiatry, University of Manitoba).

25 See for example Gupta; Hoffman.

26 *Final Report of the Expert Panel on MAID and Mental Illness*, p. 35.

lives. She said many patients receive excellent care once they are being treated and deficiencies need to be identified to target funding to the services that are most lacking.

Dr. Maher told the Committee that individuals are waiting five years to be treated by his teams, stating that "This is stigmatization entrenched in our system." Some witnesses were of the opinion that MAID saves healthcare costs and can create perverse disincentives to providing care.[27]

Mr. Krausert recommended only allowing MAID for individuals whose death is not reasonably foreseeable if sufficient funding is in place to ensure that no patient's illness is irremediable due to lack of access to treatment.

Dr. Smith emphasized that everyone must be assessed individually, and that a patient with a psychiatric illness requesting MAID would likely have accessed many services without improvement before making that request. If not, he would recommend treatment and try to arrange it.[28]

Dr. McKenzie "would balance people's rights to make their own decisions with what can be reasonably offered by the state. I'd like as much offered as possible, but in a democracy, everybody can't have everything. We know that, so I think there's a balance."

Dr. Jocelyn Downie, University Research Professor, Faculties of Law and Medicine, Dalhousie University, called for greater supports and services for people with disabilities and mental disorders:

> …by having a conversation about MAID, we now have an opportunity for people to listen to a conversation about supporting persons with disabilities and mental illnesses in Canada. That's where I hope this committee is bold and figures out ways to use the federal purse and convening powers. You have all kinds of tools. Use those to fix the problems that are coming to light and that people are finally paying attention to. Don't constrain access to MAID, because you should never make individuals hostage to fixing systemic problems.

27 Sinyor; Vrakas; AMAD, *Evidence*, 25 May 2022 (Sean Krausert, Executive Director, Canadian Association for Suicide Prevention).

28 Also see Hoffman.

Under What Circumstances Should MAID be Allowed Where a Mental Disorder is the Sole Underlying Medical Condition?

The Committee acknowledges that the existing law provides that MAID MD-SUMC will be available to eligible individuals in March 2023. We did hear, however, as summarized above, that witnesses had different views on a variety of specific topics that relate to their overall conclusions about whether MAID MD-SUMC should be permitted.[29] Below is testimony on more general conclusions regarding whether MAID MD-SUMC should be permitted.

Dr. Sinyor said MAID MD-SUMC should only be allowed if the benefits outweigh the harms and that studies are needed before any conclusions can be drawn. In contrast, Dr. Black suggested using principle-guided medicine to move forward. He identified the principles of respect for patient autonomy; cognizance of systemic racism, systemic ableism and lack of access to mental healthcare; non-discrimination against people with a mental disorder; recognition that not all conditions respond to treatment; awareness of the legacy of paternalism in psychiatry; and the importance of decision-making based on both medical expertise and the lived experience of the patient.

Dr. Gupta mentioned that there are already individuals with mental disorders accessing MAID where they have a physical illness as well and that suicidality, capacity and structural vulnerability may be at play in such cases.[30] In addition, individuals with physical conditions where incurability and irreversibility of decline are difficult to assess are currently eligible for MAID. She said:

> Based on these observations, the panel concluded that there is no single characteristical problem that attaches to all people with mental disorders and only people with mental disorders. “Mental disorders” is merely an imprecise proxy for these concerns. If the hope is that by excluding people with mental disorders as a sole underlying medical condition from accessing MAID we can avoid having to deal with these difficult issues, clinical experience with MAID shows us that this is not the case. We are already facing these problems in practice.

29 For example, Krausert, Masuda, Maher and Vrakas were against and Wiebe, Smith and Dr. Georges L’Espérance (AMAD, *Evidence*, 5 May 2022, President and Neurosurgeon, Quebec Association for the Right to Die with Dignity) were supportive.

30 Also see Wiebe.

Others also challenged the notion that there is a significant distinction between physical and mental disorders. According to Dr. Wiebe:

> Most of the suffering that people talk about is not pain but lack of ability to have a normal life. That's true of people with mental illness as well as those with physical illness.[31]

Dr. Gupta said:

> If I may digress a bit, I want to broach a more clinical and technical topic.
>
> In the case of certain paradigmatic illnesses, such as advanced cancer, when there is a clear diagnosis from a biopsy or MRI, for instance, we can get an idea of what will happen to the patient from the outset.
>
> In the case of other illnesses, however, we cannot know how things will evolve when the diagnosis is made. It depends on the treatment the patient receives, their response to the treatment, and the side-effects, among other things. We cannot predict much without trying treatment.
>
> That is why, in the report, we try to align the need to try treatments in order to establish that the trajectory of the illness is bleak, with the need to respect the fact that a person has already tried many treatments and has had enough. Where exactly do we draw that line? I think it will differ from one person to another. We also have to consider their general health and the circumstances in their case.

Dr. Stefanie Green, President, Canadian Association of MAiD Assessors and Providers (CAMAP), expressed concern that preventing access to MAID based on a specific diagnosis is discriminatory. Dr. Georges L'Espérance, President and Neurosurgeon, Quebec Association for the Right to Die with Dignity, said a ban on MAID MD-SUMC would lead to legal challenges.

Mr. Krausert, a patient advocate, argued that a mental disorder should not result in eligibility for MAID:

> MAID should not be provided to patients suffering from a condition that does not have reasonable foreseeability of death, unless there is clear scientific evidence that the condition is irremediable. Irremediability must always be objective and never subjective. There is no evidence that concludes that mental illness falls into this category.

31 Also see Freeland; Gupta; Smith.

Dr. Mishara claimed:

> I have personally—…known hundreds of thousands of people who have convincingly explained that they wanted to die to end their suffering and are now thankful to be alive. If you proceed to allow MAID for persons with a mental illness, how many people who would later have been happy to be alive are you willing to allow to die?

Similarly, Dr. Maher said, "The rallying cry is autonomy at all costs. But the inescapable cost is people dying who would get better. What number of mistaken guesses is acceptable to you?"

Safeguards and Practical Considerations if MAID is Allowed for Mental Disorder as the Sole Underlying Medical Condition

Abby Hoffman, Senior Executive Advisor to the Deputy Minister, Department of Health, said that MAID MD-SUMC guidance is primarily required at the clinical level, rather than in the *Criminal Code*. While David E. Roberge, End of Life Working Group, Canadian Bar Association, recognized that some issues are best left to medical experts, he outlined considerations if *Criminal Code* amendments were made for MAID MD-SUMC to eliminate ambiguity. He suggested that at least one assessor should be a psychiatrist, although this could lead to delays due to lack of access. He also said to be "mindful of the risk of arbitrariness in setting time limits irrespective of the nature of the mental disorder." Dr. Freeland agreed that at least one independent psychiatrist should complete an assessment and Dr. Green thought expertise is required.

For assessments and lack of clarity, Dr. Smith said:

> As with all patients about whom I'm not certain, I'd get a second opinion. There's nothing that says you have to have only two assessors. I don't do a lot of assessments. The assessments I get involved with involve in cases which where there are two assessors and they can't decide on an issue when it involves a psychiatric illness. We're at liberty to call up our colleagues and bring in other assessors. We want to make sure we get this right.
>
> This is an irrevocable decision. This is not a decision that anyone — the people who assess, the patient, their family, the providers — takes lightly. We must make sure we get it right. I think using the skills of the psychiatrist and the backup of our colleagues in the community, we have ample resources to get this right in assessing an individual patient.

Dr. McKenzie recommended multidisciplinary teams making individual assessments over time. Dr. Masuda said:

> If this special joint committee on MAID recommends proceeding with allowing access to MAID for chronic mental conditions, I would recommend that there be a robust, multidisciplinary review process involving physicians, psychiatrists, social workers and ethicists involved in a patient's MAID application, and that there be a transparent review of MAID cases shared between health authorities and provincial and federal oversight so that we ensure we are not treating social problems with euthanasia.

Dr. Vrakas did not believe any safeguard would make MAID MD-SUMC safe.

Dr. Weibe supported, as suggested by the Expert Panel, a national prospective oversight framework of case review for educational and quality assurance purposes.[32] Dr. Gupta recognized the challenges of national standards given the division of powers between federal and provincial governments and emphasized CAMAP's important work establishing practice standards, guidelines and best practices.

According to Ms. Hoffman, substantial human resources will be required to provide a proper assessment in MAID MD-SUMC.[33] Training for assessors and providers was recommended, such as the national program being developed by CAMAP, supported by Health Canada.[34]

CONCLUSION

Reviewing the issue of MAID for individuals who have a mental disorder as a sole underling condition is a demanding task, and the Committee recognizes that the short timelines associated with presenting its interim report, coupled with scheduling difficulties, means that there is still work to be done on this complex topic. We also recognize the value of the Expert Panel's recommendations to our deliberations on this topic. While we are currently required to present our final report on all themes on 17 October 2022, out of respect for Canadians and those whose lives or whose family members' lives have been or might be affected by our recommendations, we insist on taking the time to do as thorough a review as possible, without adding unnecessary delay. We are currently considering how best to achieve this objective.

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32 Recommendation 16 of the Expert Panel report.

33 Also see AMAD, *Evidence*, April 25 (Diane Reva Gwartz, Nurse Practitioner, Primary Health Care).

34 Hoffman; Wiebe; AMAD, *Evidence*, April 25 (Dr. Stefanie Green, President, MAID Practitioner, Advisor to BC Ministry of Health, CAMAP).

We also note that, if the Expert Panel's recommendations are to be implemented, the work must proceed quickly as March 2023 is fast approaching. We must have standards of practice, clear guidelines, adequate training for practitioners, comprehensive patient assessments and meaningful oversight in place for the case of MAID MD-SUMC. This task will require the efforts and collaboration of regulators, professional associations, institutional committees and all levels of government and these actors need to be engaged and supported in this important work.

Although some work is already underway to implement the recommendations of the Expert panel, there is concern that more remains to be done to ensure that all necessary steps have been taken to be ready by the March 2023 deadline when MAID provisions can be considered in the case of people suffering from a mental disorder as the sole underlying cause. We urge the federal government to work with the Provinces and Territories and others to ensure that the recommendations of the Expert Panel are implemented in a timely manner.

APPENDIX A: RECOMMENDATIONS OF THE EXPERT PANEL ON MAID AND MENTAL ILLNESS

MAID PRACTICE STANDARDS

Recommendation 1: Development of MAiD practice standards

The federal, provincial and territorial governments should facilitate the collaboration of physician and nurse regulatory bodies in the development of Standards of Practice for physicians and nurse practitioners for the assessment of MAiD requests in situations that raise questions about incurability, irreversibility, capacity, suicidality, and the impact of structural vulnerabilities. These standards should elaborate upon the subject matter of recommendations 2–13.

INTERPRETING GRIEVOUS AND IRREMEDIABLE MEDICAL CONDITION

Recommendation 2: Establishing incurability

MAiD assessors should establish incurability with reference to treatment attempts made up to that point, outcomes of those treatments, and severity and duration of illness, disease or disability.

It is not possible to provide fixed rules for how many treatment attempts, how many kinds of treatments, and over what period of time as this will vary according to the nature and severity of medical conditions the person has and their overall health status. This must be assessed on a case-by-case basis. The Panel is of the view that the requester and assessors must come to a shared understanding that the person has a serious and incurable illness, disease or disability. As with many chronic conditions, the incurability of a mental disorder cannot be established in the absence of multiple attempts at interventions with therapeutic aims.

Recommendation 3: Establishing irreversibility

MAiD assessors should establish irreversibility with reference to interventions tried that are designed to improve function, including: recognized rehabilitative and supportive measures that have been tried up to that point, outcomes of those interventions, and the duration of decline. It is not possible to provide fixed rules for how many attempts at

interventions, how many types of interventions, and over how much time, as this will vary according to a requester's baseline function as well as life goals. Therefore, this must be assessed on a case-by-case basis. The Panel is of the view that the requester and assessors must come to a shared understanding that the person is in an advanced state of irreversible decline in capability.

Recommendation 4: Understanding enduring and Intolerable suffering

MAiD assessors should come to an understanding with the requester that the illness, disease or disability or functional decline causes the requester enduring and intolerable physical or psychological suffering.

VULNERABILITIES

Recommendation 5: Comprehensive capacity assessments

MAiD assessors should undertake thorough and, where appropriate, serial assessments of a requester's decision-making capacity in accordance with clinical standards and legal criteria. These assessments should be consistent with approaches laid out in standardized capacity evaluation tools.

Recommendation 6: Means available to relieve suffering

To ensure all requesters have access to the fullest possible range of social supports which could potentially contribute to reducing suffering, the Panel recommends that 'community services' in Track 2 Safeguard 241.2(3.1)(g) should be interpreted as including housing and income supports as means available to relieve suffering and should be offered to MAiD requesters, where appropriate.

Recommendation 7: Interpretation of track 2 safeguard 241.2(3.1)(h) the person has given serious consideration to those means

Serious consideration should be interpreted to mean genuine openness to the means available to relieve suffering and how they could make a difference in the person's life.

Recommendation 8: Consistency, durability, and well-considered nature of a maid request

Assessors should ensure that the requester's wish for death is consistent with the person's values and beliefs, unambiguous and rationally considered during a period of stability, not during a period of crisis.

Recommendation 9: Situations of involuntariness

Persons in situations of involuntariness for periods shorter than six months should be assessed following this period to minimize the potential contribution of the involuntariness on the request for MAiD. For those who are repeatedly or continuously in situations of involuntariness, (e.g., six months or longer, or repeated periods of less than six months), the institutions responsible for the person should ensure that assessments for MAiD are performed by assessors who do not work within or are associated with the institution.

ASSESSMENT PROCESS

Recommendation 10: Independent assessor with expertise

The requester should be assessed by at least one assessor with expertise in the condition(s). In cases involving MAiD MD-SUMC, the assessor with expertise in the condition should be a psychiatrist independent from the treating team/provider. Assessors with expertise in the person's condition(s) should review the diagnosis, and ensure the requester is aware of all reasonable options for treatment and has given them serious consideration.

Recommendation 11: Involvement of other healthcare professionals

Assessors should involve medical subspecialists and other healthcare professionals for consultations and additional expertise where necessary.

Recommendation 12: Discussion with treating team and collateral information

- **If the requester's primary healthcare provider is not one of the assessors, assessors should obtain input from that person. When the requester's clinical care is shared by members of a multidisciplinary healthcare team, assessors should solicit their input as well.**

- **With a requester's consent, assessors and providers shall obtain collateral information relevant to eligibility and capacity assessment. This should include reviewing medical records, prior MAiD assessments, and discussions with family members or significant others. Care must be taken to determine that obtaining collateral information will not be harmful to the requester.**

Recommendation 13: Challenging interpersonal dynamics

Assessors and providers should be self-reflective and examine their reactions to those they assess. If their reactions compromise their ability to carry out the assessment in accordance with professional norms, they should seek supervision from mentors and colleagues, and/or discontinue involvement in the assessment process. The practitioner should adhere to any local policies concerning withdrawal from a MAiD assessment and onward referral.

IMPLEMENTATION

Recommendation 14: Consultations with first nations, inuit and métis peoples

Consultation between health regulatory bodies in each province and territory with First Nations, Métis, and Inuit peoples must aim to create practice standards with respect to MAiD MD-SUMC, and MAiD more generally, that incorporate Indigenous perspectives and are relevant to their communities.

Recommendation 15: Training of assessors and providers in specialized topics

To support consistent application of the law and to ensure high quality and culturally sensitive care, assessors and providers should participate in training opportunities that address topics of particular salience to MAiD MD-SUMC. These include, but are not limited to: capacity assessment, trauma-informed care and cultural safety.

Recommendation 16: Prospective oversight

Given its concurrent jurisdiction in relation to MAiD, the federal government should play an active role in supporting the development of a model of prospective oversight for all or some Track 2 cases that could be adapted by provinces and territories.

Recommendation 17: Case-based quality assurance and education

The federal government should play an active role in supporting the development of provincial/territorial systems of MAiD case review for educational and quality improvement purposes.

Recommendation 18: Modifications to data collection under the federal maid monitoring system

Data related to specific topics (eligibility, supported decision-making, means available to relieve suffering, refusal of means available, and residence and legal status) should be collected in the MAiD monitoring system in addition to data already collected under the 2018 Regulations. These data can be used to assess whether key areas of concern raised about MAiD MD-SUMC and complex Track 2 cases discussed in this report are being addressed by the clinical practices recommended.

Recommendation 19: Periodic, federally funded research

The federal government should fund both targeted and investigator-initiated periodic research on questions relating to the practice of MAiD (including but not only MAiD MD-SUMC).

APPENDIX B: SUMMARY OF RECOMMENDATIONS ON MENTAL ILLNESS AS A SOLE UNDERLYING MEDICAL CONDITION FOR ELIGIBILITY FOR MAID PRIOR TO THE EXPERT PANEL REPORT

Below is a table of the recommendations and conclusions of various panels and groups regarding MD-SUMC from 2015 to 2021. It does not include the Expert Panel recommendations found in Annex A.

Table 1—Recommendations and Conclusions Concerning the Legalization of Medical Assistance in Dying where Mental Illness is the Sole Underlying Medical Condition

Report	Recommendation
External Panel on Options for a Legislative Response to *Carter v. Canada*, "Consultations on Physician-Assisted Dying: Summary of Results and Key Findings," *Final Report*, 15 December 2015 * No recommendations made.	"The Panel heard widely diverging views on where mental illness might fit – or not fit – in a framework for physician-assisted death in Canada. At one end of the spectrum, Professor Eike-Henner Kluge [an expert in biomedical ethics from the University of Victoria] argued that, based on the principles of equality, even if a person's mental illness rendered them legally incompetent, that incompetence should not disentitle individuals who otherwise meet the *Carter* eligibility criteria from accessing physician-assisted dying. On the other hand, groups such as the Catholic Health Alliance of Canada argued that mental illnesses should not be included in the scope of the medical condition eligibility criterion." [p. 60]

Report	Recommendation
Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying, *Final Report*, 30 November 2015	Recommendation 18 "'Grievous and irremediable medical condition' should be defined as a very severe or serious illness, disease or disability that cannot be alleviated by any means acceptable to the patient. Specific medical conditions that qualify as 'grievous and irremediable' should not be delineated in legislation or regulation." [p. 7]
Parliament of Canada, Special Joint Committee on Physician-Assisted Dying, Medical Assistance in Dying: A Patient-Centred Approach, First report, February 2016	Recommendation 3 "That individuals not be excluded from eligibility for medical assistance in dying based on the fact that they have a psychiatric condition." [p. 15]
Canadian Council of Academies, *State of Knowledge on Medical Assistance in Dying for Mature Minors, Advance Requests, and Where a Mental Disorder Is the Sole Underlying Medical Condition*, Summary of reports [The State of Knowledge on Medical Assistance in Dying for Mature Minors, The State of Knowledge on Advance Requests for Medical Assistance in Dying, and The State of Knowledge on Medical Assistance in Dying Where a Mental Disorder is the Sole Underlying Medical Condition], 2018 * No recommendations made.	"Given this wide range of perspectives and the controversial nature of the topic, Working Group members do not agree on some fundamental issues [regarding mental illness as a sole underlying condition for eligibility for MAID]. … In some areas, the Working Group did not reach consensus on the interpretation and/or significance of the evidence, or about what constitutes relevant evidence." [p. 27]

Report	Recommendation
Quebec, Ministère de la Santé et des Services sociaux, Groupe d'experts sur la question de l'inaptitude et l'aide médicale à mourir, *L'aide médicale à mourir pour les personnes en situation d'inaptitude: le juste équilibre entre le droit à l'autodétermination, la compassion et la prudence* [Quebec, Ministry of Health and Social Services, Expert Group on the Question of Capacity and Medical Assistance in Dying, Medical assistance in dying for persons who are incapable: balancing the right to self-determination, compassion and prudence], 2019 [available in French only]	Recommendation 12 "That the equal human rights of persons with an intellectual disability or mental health disorder be upheld." [translation] [p. 130]
Government of Canada, *What We Heard Report: A Public Consultation on Medical Assistance in Dying (MAID)*, Consultations report, March 2020. * No recommendations made.	"Most of the comments were not in favour of expanding MAID to people who suffer from mental illness. They had concerns that people who had an illness such as depression may feel that MAID is their only option. But there may be effective treatments that could help them to feel better. … But others felt that people with mental illness should be eligible for MAID in certain situations. This would include where the mental illness is really affecting the person and where treatment does not work. Some noted that mental health conditions can cause as much suffering and pain as physical conditions. Mental health conditions may not respond to treatment. Sometimes this can make people attempt suicide in dangerous ways rather than ending their life in a safe way." [p. 3]

Report	Recommendation
The Halifax Group, *Faces of Aging – MAiD Legislation at a Crossroads: Persons with Mental Disorders as Their Sole Underlying Condition*, IRPP [Institute for Research on Public Policy], 30 January 2020	Recommendation 1 "The federal and Quebec governments should not amend their laws to exclude all persons with MD-SUMC [mental illness is the sole underlying condition] from accessing MAiD." * For other related recommendations, see the report.
Expert Advisory Group on Medical Assistance in Dying, *Canada at a Crossroads: Recommendations on Medical Assistance in Dying and Persons with a Mental Disorder*, Evidence-based critique of the Halifax Group IRPP report, 13 February 2020 Note: This is a response to the IRPP report by a group of mental health experts and individuals with lived experience of mental illness.	Core recommendation "MAID policy and legislation should explicitly acknowledge that determinations of irremediability and irreversible decline cannot be made for mental illnesses at this time, and therefore applications for MAID for the sole underlying medical condition of a mental disorder cannot fulfill MAID eligibility requirements." [p. 14] * For ancillary recommendations, see the report.
Association des médecins psychiatres du Québec [Association of Psychiatrists of Quebec], *Access to medical assistance in dying for people with mental disorders*, Discussion paper, November 2020	"[W]e think that it is a person's clinical circumstances and not his diagnosis that should determine MAID eligibility. Patients whose sole underlying medical condition is a mental disorder or mental illness should not be systematically excluded from accessing MAID." [p. 14] * While the paper focuses on this issue, the way it is structured does not allow for extractions of short quotes. See the report for further details.
Quebec, National Assembly, Select Committee on the Evolution of the Act respecting end-of-life care, *Report of the Select Committee on the Evolution of the Act respecting end-of-life care*, December 2021. * Scroll to the bottom of the webpage for the link to the report	Recommendation 11 "The Committee recommends that access to medical aid in dying not be extended to persons whose only medical condition is a mental disorder; that, to this end, section 26 of the *Act respecting end-of-life care be amended*." [p. 64]

APPENDIX C
LIST OF WITNESSES

The following table lists the witnesses who appeared before the committee at its meetings related to this report. Transcripts of all public meetings related to this report are available on the committee's webpage for this study.

Organizations and Individuals	Date	Meeting
Department of Health	2022/04/13	2
Abby Hoffman, Senior Executive Advisor to the Deputy Minister		
Department of Justice	2022/04/13	2
Jay Potter, Acting Senior Counsel		
As an individual	2022/04/25	3
Dr. K. Sonu Gaind, Professor		
Dr. Félix Pageau, Geriatrician, Ethicist and Researcher, Université Laval		
Diane Reva Gwartz, Nurse Practitioner, Primary Health Care		
Canadian Association of MAiD Assessors and Providers	2022/04/25	3
Dr. Stefanie Green, President, MAID Practitioner, Advisor to BC Ministry of Health		
As an individual	2022/04/28	4
Dr. Sandy Buchman, Chair and Medical Director, Freeman Centre for the Advancement of Palliative Care, North York General Hospital and Past President, Canadian Medical Association		
Dr. Harvey Max Chochinov, Distinguished Professor of Psychiatry, University of Manitoba		
Quebec Association for the Right to Die with Dignity	2022/05/05	5
Dr. Georges L'Espérance, President and Neurosurgeon		
As an individual	2022/05/09	6
Dr. Jocelyn Downie, University Research Professor, Faculties of Law and Medicine, Dalhousie University		

Organizations and Individuals	Date	Meeting
As an individual	2022/05/25	8
Valorie Masuda, Doctor		
Kwame McKenzie, Professor of Psychiatry		
Brian Mishara, Professor and Director, Centre for Research and Intervention on Suicide, Ethical Issues and End-of-Life Practices (CRISE), Université du Québec à Montréal		
Derryck Smith, Clinical Professor Emeritus, Department of Psychiatry, University of British Columbia		
Canadian Association for Suicide Prevention	2022/05/25	8
Sean Krausert, Executive Director		
The Canadian Bar Association	2022/05/25	8
David E. Roberge, Member, End of Life Working Group		
As an individual	2022/05/26	9
Tyler Black, Clinical Assistant Professor, University of British Columbia		
Mark Sinyor, Professor		
Georgia Vrakas, Psychologist and Professor		
Dr. Ellen Wiebe		
Canadian Psychiatric Association	2022/05/26	9
Alison Freeland, Chair of the Board of Directors, Co-Chair of MAiD Working Group		
Expert Panel on MAID and Mental Illness	2022/05/26	9
Mona Gupta, Associate Clinical Professor		
Ontario Association for ACT & FACT	2022/06/06	11
John Maher, President		
Myeengun Henry, Indigenous Knowledge Keeper, University of Waterloo		

REQUEST FOR GOVERNMENT RESPONSE

Pursuant to Standing Order 109, the committee requests that the government table a comprehensive response to this Report.

A copy of the relevant *Minutes of Proceedings* (Meetings Nos. 2 to 6, 8, 9 and 11 to 14) is tabled.

Respectfully submitted,

Hon. Marc Garneau and Hon. Yonah Martin
Joint Chairs

The Legal and Clinical Problems Respecting Medical Assistance in Dying in Cases Where a Mental Disorder Is the Sole Underlying Medical Condition

Special Joint Committee on Medical Assistance in Dying: Dissenting Interim Report

This Dissenting Interim Report reflects the views of the Conservative Members of Parliament who serve on the Special Joint Committee on Medical Assistance in Dying (the "Committee"): Michael Barrett (Co-Vice Chair of the Committee, Leeds – Grenville – Thousand Islands and Rideau Lakes), Michael Cooper (St. Albert – Edmonton), and Dominique Vien (Bellechasse—Les Etchemins—Lévis).

Introduction

We concede that the Interim Report presents the varying opinions that the Committee heard as evidence to a reasonable degree of satisfaction and to a reasonable degree of fairness and accuracy.

Nonetheless, we have written this Dissenting Interim Report primarily because of the concluding paragraph of the Interim Report. While not a formal enumerated recommendation, the conclusion states that: "[The Committee] urge[s] the federal government to work with the Provinces and Territories and others to ensure that the recommendations of the Expert Panel are implemented in a timely manner."

The Interim Report's effective recommendation that the federal government implement all 19 recommendations of the *Expert Panel on MAID and Mental Illness* (the "Expert Panel") is problematic. It presupposes that MAID should be expanded to include cases where a mental disorder is the sole underlying medical condition ("MAID MD-SUMC").

MAID MD-SUMC will likely take effect in March 2023, because of the Liberal government's irresponsible decision to accept a Senate amendment imposing a sunset clause on the legislative exclusion of MAID MD-SUMC, in a timeframe that does not allow for comprehensive study. However, the mandate of the Committee includes studying the issue of MAID MD-SUMC. Nothing precludes the Committee from evaluating whether MAID MD-SUMC should be permitted. Indeed, fundamental to a full evaluation of issues surrounding MAID MD-SUMC necessitates consideration of the appropriateness of such an expansion.

In endorsing the implementation of the Expert Panel's recommendations, the Interim Report fails to address this fundamental question. This is especially concerning considering evidence heard by the Committee regarding MAID MD-SUMC. For example, the Committee received ample evidence that it is not possible to predict irremediability, a key eligibility criterion, in cases where a mental disorder is the sole underlying medical condition. Clinical and ethical concerns were also raised. This Dissenting Interim Report further elaborates on these and other issues, including:

1. The lack of meaningful study and consultation regarding the expansion of MAID to include MAID MD-SUMC;
2. The difficulty in predicting irremediability in cases where a mental disorder is the sole underlying medical condition;
3. Clinical concerns and inherent risks of MAID MD-SUMC to vulnerable persons; and
4. General concerns with the Expert Panel and Expert Panel Report.

The Lack of Meaningful Study and Consultation

We are concerned by the rushed manner that the Liberal government is implementing MAID MD-SUMC absent meaningful study and consultation.

MAID MD-SUMC represents a significant expansion of MAID. Canada will be only the fourth jurisdiction in the world, after Belgium, Luxemburg, and the Netherlands, to permit MAID MD-SUMC.

Issues around mental illness in the context of MAID are incredibly complex and impacts some of the most vulnerable persons in Canadian society. The Honourable David Lametti, the Minister of Justice and Attorney General of Canada, acknowledged this, stating that there are "inherent complexities and risks with MAID on the basis of mental illness as the sole criterion, such as suicidality being a symptom of some mental illnesses."[1]

Notwithstanding this, the Liberal government abruptly accepted the Senate amendment to Bill C-7 to expand MAID to include MAID MD-SUMC. The Liberals did so absent further study and in the face of evidence from multiple expert witnesses who appeared at the Senate Standing Committee on Legal Constitutional Affairs and warned about serious risks associated with MAID MD-SUMC.[2]

The need for further study of the issues associated with MAID MD-SUMC is supported by the findings of the 2018 Canadian Council of Academies report: *The State of Knowledge on Medical Assistance in Dying Where a Mental Disorder Is the Sole Underlying Medical Condition* (the "2018 CCA Report"). That 2018 CCA Report found "many important knowledge gaps concerning mental disorders" and that "continued research and examination" is needed to "address some uncertainties and reduce or remove these knowledge gaps."[3]

Given the risks and uncertainties surrounding MAID MD-SUMC, it is noteworthy that the Quebec National Assembly Select Committee tasked with studying Quebec's MAID

[1] House of Commons, *Hansard,* (February 23, 2021)

[2] Evidence: Dr. Sonu Gaind (November 27, 2020) Mr. Andrew Galley (November 23, 2020); Mr. Mark Henick (November 24, 2020); Dr. Trevor A. Hurwitz (February 3, 2021); Dr. Trudo Lemmens (November 24, 2020); Dr. John Maher (February 23, 2021); Dr. Brian Mishara, (November 24, 2020); Dr. Francois Primeau (November 26, 2020); Dr. Tarek Rajji, (November 23, 2020); Dr. Mark Sinyor (February 3, 2021).

[3] Canadian Council of Academies, The State of Knowledge on Medical Assistance in Dying Where a Mental Disorder Is the Sole Underlying Medical Condition, p.189

regime recommended "that access to medical aid in dying not be extended to persons whose only medical condition is a mental disorder."[4] In light of the extent to which the Quebec National Assembly considered these matters, it is important to consider its recommendations.

Yet since adopting the Senate amendment and setting in motion MAID MD-SUMC effective March 2023, the Liberal government has not undertaken any further study to examine the many complex issues. Nor have the Liberals adequately considered the significant concerns that have been raised about the appropriateness of MAID MD-SUMC, and whether it can be safely implemented. Although the Liberal government appointed the Expert Panel, the mandate of the Panel was to bring forward recommendations on implementing MAID MD-SUMC, not to consider the question of whether such an expansion is appropriate.

In addition to a lack of study, there has been a lack of consultation. The Liberal government has failed to meaningfully engage with stakeholders, including persons with disabilities and their advocates, Indigenous peoples, mental health professionals and advocates, and other experts. This lack of consultation was condemned at the Committee by Sarah Jama, Executive Director of the Disability Justice Network of Ontario.[5] Notably, the mandate of the Expert Panel did not include consultation with affected stakeholders.[6]

Moreover, the Liberal government has ignored feedback from the limited consultation that occurred when Canadians were invited to provide feedback on issues surrounding MAID by completing a survey prepared by the Department of Justice. The Department of Justice's report on the results of the consultation concluded: "A majority of those who provided comments were not in favour of extending MAID to people who suffer from mental illness."[7]

The Difficulty in Predicting Irremediability

Based on evidence the Committee heard, there is significant doubt about whether it is possible to accurately predict the irremediability of a mental disorder that must be thoughtfully considered.

By law, to be eligible for MAID, a person must have a "grievous and irremediable medical condition" that is "incurable" and in "an advanced state of irreversible decline".[8] Another words, to qualify, a MAID assessor must be satisfied that the person's condition will not get better. The Committee heard from multiple witnesses who said that it is not

[4] National Assembly of Quebec, Select Committee on the Evolution of the Act respecting end-of-life care, Report of the Select Committee on the Evolution of the Act respecting end-of-life care, Recommendation 11 (December 2021)

[5] Evidence: Mrs. Sarah Jama, *Special Joint Committee on Medical Assistance in Dying* (May 16, 2022).

[6] Evidence: Dr. Mona Gupta, *Special Joint Committee on Medical Assistance in Dying* (May 26, 2022).

[7] Department of Justice, What We Heard Report: A Public Consultation on Medical Assistance in Dying (MAID), p.13

[8] *Criminal Code of* Canada (R.S.C. 1985, c. C-46), s. 241.2(2)

possible to predict whether a person suffering from a mental health disorder will get better, and therefore not possible to ascertain irremediability.[9]

For example, Dr. John Maher, a clinical psychiatrist, and medical ethicist, said:

> "Psychiatrists don't know and can't know who will get better and live decades of good life. Brain diseases are not liver diseases."[10]

Dr. Brian Mishara, also a clinical psychiatrist and professor at the Université du Québec à Montréal, said:

> "I'm a scientist. The latest Cochrane Review of research on the ability to find some indicator of the future course of a mental illness, either treated or untreated, concluded that we have no specific scientific ways of doing this. We are relying on the clinical hunch of someone who hasn't known the person for 20 or 30 years and who has no scientific data showing that they can determine this."[11]

Dr. Mishara further noted that "[e]ven the most severe mental illnesses, such as schizophrenia, are unpredictable."[12]

Dr. Valorie Masuda, a physician and MAID assessor, said:

> "When we look at what irremediable means in mental illness, I think it's very difficult to predict and to say that this person has tried a lot of things, but their depression they cannot recover from."[13]

Even the Expert Panel conceded the difficulty in determining the irremediability of a mental disorder, stating:

> "The evolution of many mental disorders, like some other chronic conditions, is difficult to predict for a given individual. There is limited knowledge about the long-term prognosis for many conditions, and it is difficult, if not impossible, for clinicians to make accurate predictions about the future for an individual patient."[14]

The degree of uncertainty in predicting irremediability is underscored by the Expert Panel's finding that "[i]t is not possible to provide fixed rules" and that determining

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[9] Evidence: Mr. Sean Krausert, *Special Joint Committee on Medical Assistance in Dying* (May 25, 2022); Evidence: Dr. John Maher *Special Joint Committee on Medical Assistance in Dying* (May 26, 2022); Evidence: Dr. Valorie Masuda, *Special Joint Committee on Medical Assistance in Dying* (May 25, 2022); Evidence: Dr. Brian Mishara, *Special Joint Committee on Medical Assistance in Dying* (May 25, 2022); Evidence: Dr. Mark Sinyor, *Special Joint Committee on Medical Assistance in Dying* (May 26, 2022).

[10] Evidence: Dr. John Maher *Special Joint Committee on Medical Assistance in Dying* (May 26, 2022).

[11] Evidence: Dr. Brian Mishara, *Special Joint Committee on Medical Assistance in Dying* (May 25, 2022).

[12] Ibid.

[13] Evidence: Dr. Valorie Masuda, *Special Joint Committee on Medical Assistance in Dying* (May 25, 2022).

[14] Health Canada, Final Report of the Expert Panel on MAiD and Mental Illness, p.9.

eligibility will be completely subjective and left up to MAID assessors to determine on a "case-by-case basis."[15]

As such, MAID decisions in the case of a mental disorder will be based on "hunches and guesswork that could be wildly inaccurate."[16] As Dr. Mark Sinyor, a professor of psychiatry at the University of Toronto and psychiatrist who specializes in the treatment of adults with complex mood and anxiety disorders, said:

> "They could be making an error 2% of the time or 95% of the time. That information should be at the forefront of this discussion, yet it is absent altogether."[17]

Likewise, Dr. Mishara stated with respect to persons suffering from a mental health disorder:

> "But any attempt at identifying who should have access to MAID will make large numbers of mistakes, and people who would have experienced improvements in their symptoms and no longer wish to die will die by MAID."[18]

Moreover, there is a paucity of scientific evidence to evaluate the safety of MAID MD-SUMC, and the possibility of predicting irremediability. According to Dr. Sinyor there "is absolutely no research on the reliability of physician predictions of the irremediability of illness or suffering in psychiatric conditions."[19] Consistent with this, Dr. Mona Gupta, the Chair of the Expert Panel, testified that she is unaware of any such studies.[20]

Having regard for the above and given the uncertainty around determining irremediability, it is irresponsible and appears to be legally incoherent to move forward with implementing MAID MD-SUMC at this time. It is first necessary for the Liberal government to thoroughly study whether irremediability in the context of a mental disorder is determinable so that, as noted by Dr. Mark Sinyor, "the necessary scientific information is in hand before making such a consequential decision."[21]

Clinical Problems Respecting MAID MD-SUMC

Several witnesses testified that MAID MD-SUMC blurs the line between suicide prevention and suicide assistance.[22] Dr. Mishara, and Dr. Georgia Vrakas, a psychologist, testified that 90% of those who commit suicide have a diagnosable mental

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[15] Ibid., p.55
[16] Evidence: Dr. Mark Sinyor, *Special Joint Committee on Medical Assistance in Dying* (May 26, 2022).
[17] Evidence: Dr. Mark Sinyor, *Special Joint Committee on Medical Assistance in Dying* (May 26, 2022).
[18] Evidence: Dr. Brian Mishara, *Special Joint Committee on Medical Assistance in Dying* (May 25, 2022).
[19] Evidence: Dr. Mark Sinyor, *Special Joint Committee on Medical Assistance in Dying* (May 26, 2022).
[20] Evidence: Dr. Mona Gupta, *Special Joint Committee on Medical Assistance in Dying* (May 26, 2022).
[21] Evidence: Dr. Mark Sinyor, *Special Joint Committee on Medical Assistance in Dying* (May 26, 2022).
[22] Evidence: Dr. John Maher, *Special Joint Committee on Medical Assistance in Dying* (May 26, 2022); Evidence: Dr. Brian Mishara, *Special Joint Committee on Medical Assistance in Dying* (May 25, 2022).

disorder.[23] Consistent with this testimony, the 2018 CCA Report cites studies finding, as determined by retrospective psychological autopsy, up to 90% of people who die by suicide may have had a diagnosable psychiatric disorder.[24] One cannot easily distinguish between a person with an underlying mental disorder motivated to request MAID due to suicidality and someone making a rational request.[25]

Moreover, MAID MD-SUMC may have the perverse effect of discouraging persons suffering from a mental disorder from seeking treatment and instead turning to MAID as a means of ending their suffering. Dr. Maher testified that some of his patients who suffer from a mental disorder are already refusing treatment, hoping instead to access MAID.[26]

Several witnesses told the Committee that if MAID MD-SUMC is permitted, it will result in the premature deaths of patients who would have otherwise gotten better[27]. Dr. Vrakas is of the opinion that no safeguards will make MAID MD-SUMC safe.[28]

There are further clinical concerns regarding structural vulnerability and social determinants of health. There are clear gaps across Canada respecting access to adequate care. Dr. Gupta told the Committee that there are already cases where patients are approved for MAID when suicidality and structural vulnerability may be at play.[29] This is unacceptable and must be addressed by seeing that vulnerable persons have access to adequate treatment and support. As Dr. Maher stated: "[d]eath is not an acceptable substitute for good treatment, food, housing, and compassion."

General Concerns with the Expert Panel and Expert Panel Report

The Expert Panel and the Expert Panel Report have multiple shortcomings, both substantive and process-related, including but not limited to:

1. There is an inherent contradiction baked into the Expert Panel Report. It contends that the current legal framework can be applied to MAID MD-SUMC while offering no guidelines to determine irremediability, nor any evidence that predicting the same is possible.
2. The Expert Panel Report fails to recommend safeguards for MAID MD-SUMC. Making recommendations around safeguards was the central mandate of the Expert Panel. Instead, the Expert Panel Report recommends that eligibility for

[23] Evidence: Dr. Brian Mishara, *Special Joint Committee on Medical Assistance in Dying* (May 25, 2022); Evidence: Dr. Georgia Vrakas *Special Joint Committee on Medical Assistance in Dying* (May 26, 2022).
[24] Canadian Council of Academies, The State of Knowledge on Medical Assistance in Dying Where a Mental Disorder Is the Sole Underlying Medical Condition, pp. 42 and 169.
[25] Dr. Georgia Vrakas *Special Joint Committee on Medical Assistance in Dying* (May 26, 2022).
[26] Evidence: Dr. John Maher, *Special Joint Committee on Medical Assistance in Dying* (May 26, 2022).
[27] Evidence: Mr. Sean Krausert, *Special Joint Committee on Medical Assistance in Dying* (May 25, 2022); Evidence: Dr. John Maher, *Special Joint Committee on Medical Assistance in Dying* (May 26, 2022); Evidence: Dr. Brian Mishara, *Special Joint Committee on Medical Assistance in Dying* (May 25, 2022).
[28] Dr. Georgia Vrakas *Special Joint Committee on Medical Assistance in Dying* (May 26, 2022).
[29] Evidence: Dr. Mona Gupta, *Special Joint Committee on Medical Assistance in Dying* (May 26, 2022).

MAID MD-SUMC be decided on a "case-by-case basis". The failure to recommend safeguards and practice standards supports our contention, based on the evidence that we heard, that MAID MD-SUMC cannot be implemented and carried out safely and objectively at this time.

3. The Expert Panel Report fails to adequately address issues of suicidality and structural vulnerability, even though Dr. Gupta at the Committee admitted that there are MAID cases where these factors are at play.
4. The Expert Panel did not engage in consultation with stakeholders, including notably with historically marginalized groups such as Indigenous peoples, and persons living with disabilities. This diminishes the weight that can be attached to the recommendations of the Expert Panel Report. It is further reason why we do not agree with the effective recommendation of the Interim Report for the federal government to implement the recommendations of the Expert Panel.
5. Two of the original members of the Expert Panel resigned before its Report was tabled. We have not yet offered them an opportunity to provide the Committee with their explanations. Dr. Jeff Kirby, one of the two members who resigned from the Expert Panel, is quoted in an article in *The Hill Times* that he "personally support[s] the implementation of MAID in MD-SUMC circumstances" but "was unable to sign-off on the final report's content in good conscience, including its recommendations."[30] It is important that the Committee hear from these former members as part of its deliberations regarding its response to the recommendations of the Expert Panel Report.

Conclusion

The Committee has heard considerable evidence that permitting MAID MD-SUMC presents considerable legal, clinical, and ethical challenges. Given the uncertainties around determining irremediability, there is not sufficient evidence that demonstrates how MAID MD-SUMC can satisfy the eligibility criteria. Further, it is difficult to see under what conditions it would be clinically acceptable.

There are far too many unanswered questions respecting MAID MD-SUMC. With the March 2023 deadline fast approaching, we urge the Liberal government postpone the expiration of the sunset clause respecting MAID MD-SUMC, allowing more time for these questions to be sufficiently studied, and for the legal, clinical, and ethical concerns to be rectified. It is unreasonable to expect the Committee to resolve these issues by the October 17, 2022, deadline it has to table its report.

Legislation of this nature needs to be guided by science, and not ideology. We have been warned by several experts that if MAID MD-SUMC is implemented as planned, it will facilitate the deaths of Canadians who could have gotten better, robbing them of the opportunity they may have had to live a fulfilling life. Such an outcome is completely

[30] Kirby, Jeff. "MAiD expert panel recommendations are inadequate contends panel member who resigned", *The Hill Times*, June 16, 2022.

unacceptable, and preventable, but only if the Liberal government halts and reconsiders the expansion of MAID MD-SUMC.

Respectfully submitted,

Michael Barrett, M.P.
Leeds – Grenville – Thousand Islands and Rideau Lakes

Michael Cooper, M.P.
St. Albert – Edmonton

Dominique Vien, M.P.
Bellechasse—Les Etchemins—Lévis