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# Special Joint Committee on Medical Assistance in Dying

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Co-Chairs:  
The Honourable Marc Garneau The Honourable Yonah Martin





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• (1400)

[English]

**The Joint Chair (Hon. Marc Garneau (Notre-Dame-de-Grâce—Westmount, Lib.)):** It being two o'clock, I'm going to call this meeting to order since we have quorum and the witnesses are ready.

Clerk, is there anybody in the room, either a witness or a member? I can't see the room.

**The Joint Clerk of the Committee (Ms. Andrea Mugny):** There is no one, Mr. Chair.

**The Joint Chair (Hon. Marc Garneau):** Very good. Thank you.  
[Translation]

Good afternoon, and welcome to the ninth meeting of the Special Joint Committee on Medical Assistance in Dying.

I would like to begin by welcoming members of the committee, witnesses and those watching this meeting on the web.

My name is Marc Garneau, and I am the House of Commons' Joint Chair of this committee. I am joined by the Honourable Yonah Martin, the Senate's Joint Chair.

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

[English]

The Board of Internal Economy requires the committee to adhere to health protocols. I'm not going to name them, because by now you're very familiar with them and they're in effect until the end of Parliament in late June.

Before beginning, here are a few pieces of administrative information. I'd like to remind the members and witnesses to keep their microphones muted unless recognized by name by the joint chairs. I would remind you that all comments should be addressed through the joint chairs. When speaking, please speak slowly and clearly. Interpretation of this video conference will work like an in-person committee meeting. You have the choice at the bottom of your screen of floor, English or French.

With that, I would like to welcome our first panel of witnesses today. Here on the first panel to discuss whether to permit medical assistance in dying for mental illness in Canada, we have Mr. John Maher of the Ontario Association for ACT & FACT. We also have two individuals, Dr. Georgia Vrakas and Dr. Ellen Wiebe.

Thank you for joining us here today. We'll begin in the usual fashion. You will each have five minutes for an opening statement. I would ask you to respect that five minutes, so that we can allow as many questions as possible.

We'll start with Mr. Maher. You have five minutes.

**Dr. John Maher (President, Ontario Association for ACT & FACT):** Thank you very much, and thank you for the invitation.

The Canadian Mental Health Association, CAMH, the Canadian Association for Suicide Prevention and my own organization, the OAAF, which is the largest professional association of community-based tertiary mental health care in Canada, to name but a few, have all denounced Bill C-7. Anyone who says there is an emerging consensus is grossly misinformed or worse.

The Quebec parliamentary commission listened to the facts. I am hoping that you will listen to the facts, because what is happening is tragic.

I am a psychiatrist, and I'm a medical ethicist. For 20 years I have worked only with adults who have the most severe and persistent forms of mental illness, in cockroach- and bedbug-infested rooming houses and on the streets, where our wealthy society forces them to live in poverty, our sons and daughters treated as social outcasts.

MAID activists say everyone must be able to access MAID regardless of crushing poverty, the shocking lack of treatment availability, protracted wait times of years or having brain diseases where it is impossible to predict irremediability. 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?

Death is not an acceptable substitute for good treatment, food, housing and compassion. You who voted for this law have not understood vulnerability and what it means for your doctor to offer you death over life. Do you seriously believe that you can prevent abuses by the 100,000 M.D.s and nurse practitioners in Canada who now have a licence to kill? Please read the news.

You know that Bill C-7 is not consistent with the Supreme Court's stated principle in Carter to preserve life. The ruling explicitly supported people getting help killing themselves only when they could no longer physically do it themselves. Please make a referral to the Supreme Court if you are so sure about how they will rule, because justice and the preservation of life demand it.

I am hearing shock and disbelief from psychiatrist colleagues. When the Ontario Medical Association in 2021 had a survey that asked Ontario psychiatrists clear questions after Bill C-7 became law, 91% objected to the law, 7% were uncertain and only 2% supported what this bill has done—only 2%.

Psychiatrists don't know and can't know who will get better and live decades of good life. Brain diseases are not liver diseases. If guesswork is good enough for you, it is not good enough for psychiatrists who understand the science and respect our duty to abide by a professional standard of care. You have been systematically misled by discriminatory ideology over clinical reality. Passing a law telling psychiatrists to make impossible predictions doesn't magically make it possible.

Some of my patients are now refusing effective treatment to make themselves eligible for MAID. They have been susceptible to the perverse lie that it is not suicide. Suicide is always clinically defined as taking the steps to arrange your own death. The Canadian Association for Suicide Prevention has stated that all MAID for mental illness is suicide. The frankly bizarre assertion that suicide is always an impulsive and unplanned act is not rooted in reality. Only 7% of people who attempt suicide in Canada actually die. I'm asking you, what will that percentage become? Likely number one in the world.

In the few European countries that at least require that standard treatments be tried before euthanasia, there have been steady and significant rises in the overall suicide rates in the last two decades, while the rates went down in all the countries around them. Women in particular have much higher suicide rates. The false claim that the Supreme Court accepted without evidence that suicide rates do not go up with MAID is absolutely contradicted by the data. Suicide contagion should scare you. Do you support suicide prevention or not?

Telling my patients that you will make it easier for them to die has enraged me. They will doctor shop to find the few psychiatrists who fancy themselves defenders of autonomy at all costs, as already happens in the Benelux countries, and they will die because death was offered over full and purposeful membership in the human community. They will die because of the social suffering that this law enshrines. They will die because of lack of services. They will die because psychiatrists will now have legal permission to give up. They will die because, whether you can see it or not, you have told them they don't matter.

• (1405)

You have killed hope in Canada in the places it is needed most.

**The Joint Chair (Hon. Marc Garneau):** Thank you very much, Mr. Maher.

I will now go to Dr. Georgia Vrakas.

Dr. Vrakas, you have five minutes.

**Dr. Georgia Vrakas (Psychologist and Professor, Department of Psychoeducation, Université du Québec à Trois-Rivières, As an Individual):** Okay, I will make sure to try to respect that. I will be speaking in French.

[*Translation*]

Good afternoon.

My name is Georgia Vrakas. I am a psychologist and professor, and I live with a mental illness.

To start, I would like to thank you for inviting me to testify before the Special Joint Committee on Medical Assistance in Dying.

I want to take a stand against including mental illness as the only medical condition to access medical assistance in dying. This issue is vital to me as a professional in the mental health field and as a person living with mental illness since the age of 23.

For more than 20 years, I thought I had a major depressive disorder. I had several episodes, which resulted in a lot of suffering and time off work. I also had suicidal thoughts.

In March 2021, I had my most recent relapse. I was discouraged and disillusioned, as I had gone through all the treatments recommended to me. The problem was that I hadn't received the correct diagnosis.

I was finally diagnosed on May 3, 2021, one year ago. I have type II bipolar disorder, a severe and persistent mental disorder. The months leading up to my diagnosis were very difficult and painful. I seriously considered suicide. I had a plan and I started to carry it out. Ultimately, I went to the emergency room.

I also talked to a worker at the Suicide Prevention Centre. She helped me hold on to life. I didn't want to die, but I wanted to stop suffering. The reason we have these types of services is to help us find hope. A promising drug treatment gave me back my confidence. Even after 20 years and several relapses, I am still standing. Not only am I alive, I plan to stay that way.

This is my personal story, but it is also the story of many others in Canada. As you know, approximately 20% of the population in Canada will experience a mental illness in their lifetime, and 90% of people who die by suicide have a mental disorder. Mental illness and suicide are public health problems that require a public health response.

Including mental illness as the sole reason for the Canadian Medical Assistance in Dying Act is a political response to a public health problem. This law reduces a societal problem to the individual level: “I’m sick, I want to stop suffering.” Mental illness is still taboo, access to mental health services is very difficult, psychiatric research is underfunded, and funding for promotion and prevention programs continues to decline.

Our governments have chosen not to invest in what we need to improve our mental health upstream or what we need to recover when we are already ill. Now they want to include people like me with mental illnesses in medical assistance in dying. This will supposedly help us die better. But we don’t even have access to the minimum services that would help us live better. I’m talking about living, not surviving.

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.

Yet we invest in suicide prevention. We know that it is not death that people are looking for, but the end of suffering. We say it over and over again, suicide is not a solution. So how can we reconcile medical assistance in dying with this, knowing that 90% of people who die by suicide have a mental illness? How do we differentiate between the desire to die by medical assistance and the desire to commit suicide?

We are told that we cannot exclude mental illness as the sole reason for MAID to avoid discriminating against people living with mental illness. Yet in life we face discrimination daily, whether it is access to housing, work, a decent income or disability insurance. In my view, the argument of discrimination in the face of death cannot be considered legitimate when there is discrimination in the face of life.

MAID on the grounds of mental illness alone, in the current context, is an easy and cheaper solution to a complex problem. The solution lies in increasing promotion and prevention programs, increasing mental health services, investing in psychiatric research, investing in mental health education programs, and fighting stigma.

The last 20 years have not been easy for me in terms of mental health. The last year has been very difficult, but I am still alive.

• (1410)

I know that the road to recovery will be fraught with challenges, but I am slowly learning to rebuild myself.

Recovery does not mean the elimination of all symptoms or a return to life before diagnosis. It is a process of rebuilding oneself that includes, but is not limited to, mental illness.

Many of us go down this bumpy road. Rather than stopping us halfway along our journey, give us a chance and help us move forward in our recovery process and live with dignity.

The Quebec government has obviously heard us by excluding mental illness from medical assistance in dying. Will you hear us?

Thank you.

**The Joint Chair (Hon. Marc Garneau):** Thank you, professor Vrakas.

[English]

We will now go to Dr. Ellen Wiebe.

Dr. Wiebe, you have five minutes.

**Dr. Ellen Wiebe (As an Individual):** Thank you very much.

I want to tell you a bit about my experience. I have 30 years’ experience as a full-service family doctor, during which I treated a lot of mental health, because we did not have good access to psychiatry. I have had a lot of experience with treating people with mental illness. I’m also a MAID provider and, for the last six and a half years, have assessed about 750 people for MAID, and I’ve provided about 430.

One of these was the one and only person who had MAID for mental illness as the sole underlying medical condition. That was E.F., who, as I’m sure all of you know, was approved by the superior court of Alberta to have MAID before I was allowed to provide it. I also have a lot of experience with our new group of patients, who we call “track two”. These are the patients whose natural death is not reasonably foreseeable and who we’ve been providing for since March of 2021. My own experience is about 40 assessments and 18 provisions.

In addition, I work with the Canadian Association of MAID Assessors and Providers and was the lead author for the clinical practice guidelines on assessing patients with dementia and with chronic complex conditions. I am also a MAID researcher and have published a number of articles on MAID in Canada.

One of those, for example, was on suicide versus MAID. We spoke with providers and the general public and people who we knew had a great deal of experience with suicide—namely, a very vulnerable population, the kind that Dr. Maher was talking about. They all were very clear that suicide and MAID were completely different. The differences they talked about—and again, this is a wide variety of people—were that MAID meant that people could be with their family and that having assistance wasn’t illegal. They didn’t have to be secretive. They could be open and with family. For example, E.F. arrived in Vancouver with 10 family members surrounding her to support her through her last minutes.

I want to tell you a bit more about track two patients, because my research team did a research project on the first six months of track two patients and the experience that MAID assessors and providers had. We got detailed information about 53 track two patient assessments. In 67.3% of these, the main challenge was the concurrent mental illness, and this is my personal experience as well. What I'm saying is that we have already had a lot of experience now at assessing and providing or not providing medical assistance in dying for people who have concurrent mental illness, not sole mental illness.

I want to tell you that when I assess somebody who has unbearable suffering from a grievous and irremediable condition that includes mental illness and I tell them that they are eligible under our law, you should see the smile that comes across their faces: They've been listened to and their suffering has been acknowledged in a way that often nobody else has really acknowledged, which is that their suffering is unbearable, it's unrelenting and they envision the rest of their lives with more of it.

How do I, as an assessor, say that it's irremediable?

• (1415)

They have had one treatment after another, after another, by different psychiatrists, different psych hospitals, and again, I'm extrapolating my patients who have both physical and mental illnesses, but that's my experience, of course, except for that one, who was E.F.

**The Joint Chair (Hon. Marc Garneau):** Dr. Wiebe, I will have to ask you to wrap up, please.

**Dr. Ellen Wiebe:** I am done, except to say that I agree with the "Final Report of the Expert Panel on MAID and Mental Illness" that there should be no new law, that track two provisions are working and will work for mental illness as a sole underlying condition.

• (1420)

**The Joint Chair (Hon. Marc Garneau):** Thank you very much, Dr. Wiebe.

We'll now go to questions and I'll turn it over to my co-chair, Dr. Martin.

It's over to you, Dr. Martin

**The Joint Chair (Hon. Yonah Martin (Senator, British Columbia, C)):** Thank you, Mr. Garneau.

We'll begin with Michael Cooper and each of the members will have five minutes.

Mr. Cooper.

**Mr. Michael Cooper (St. Albert—Edmonton, CPC):** Thank you, Madam Joint Chair.

Dr. Maher, you stated in the case of mental illness it's impossible to determine irremediability. What can you add to the definition of "irremediable medical condition" in the Criminal Code? That includes serious and incurable illnesses in which the patient is in an irreversible state of decline.

Would you say, in light of that statutory requirement, that this could not be satisfied in any case involving mental illness from the standpoint of a MAID assessor?

**Dr. John Maher (President, Ontario Association for ACT and FACT):** Certainly, the Quebec legislation that was just tabled got it right when they said that you can't determine whether psychiatric disease is irremediable. You can't, and the paradox here is that I'm representing 80 psychiatrists in Ontario who do subspecialist work. We see only the sickest people who are people who have been treated for the longest time, suffering terribly, and we're part of a group of 200 subspecialists in Canada.

We do a different type of work. We see only the sickest, and the paradox here that a lot of people just don't seem to get, and it's incredibly frustrating for me, is that the longer someone has been sick, the easier it becomes to treat them because with psychiatric disorders we have, as treatment options, literally hundreds of medication combinations. 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.

It's the work of time. I'm going to use an analogy here. I worked in pediatric oncology for many years. When a child was diagnosed with leukemia and had to start a two-year chemotherapy protocol where they were vomiting and ill for that two years, come the one-year mark, we had kids who didn't want to keep going.

What this law is offering people is an opportunity to stop because the healing is hard and long, but recovery is always possible. I've surveyed my colleagues on this. We've talked about this. We have yet to find a case where treatment and recovery were not possible. The challenge is that 70% of all people with mental illness in Canada stop taking their medication or they don't want to continue treatment because of suffering. What you are saying is to give up before the remedy is provided, give up before the healing is possible, and it's done under this guise that we have to relieve their immediate and horrible suffering—poor them.

If you did that with dying children, where would you be? Right now you're offering to do it with dying adults and these are neurodegenerative diseases. The longer you wait, the harder it becomes to treat, but it doesn't mean they are not treatable.

Let me give you numbers. My teams in Ontario treat the 7,000 sickest. We have 6,000 on our wait-list waiting up to five years. I would like to know, have any of you had a serious illness where you've had to wait five years for treatment? This is stigmatization entrenched in our system.

**Mr. Michael Cooper:** Thank you, Dr. Maher. What you're saying essentially is that the expert panel got it backwards in saying that, in terms of assessing irremediability, somehow this could be determined on the basis of treatments that had been provided over the patient's medical history.

**Dr. John Maher:** Right. 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 Canada, where you're trying to gauge the clinical reality of whether treatment will work, they say it's an "ethical choice". It's in there as well.

This is astonishing to me. This report is astonishing in terms of its abrogation of responsibility for us, as psychiatrists and clinicians, to treat the sickest and most vulnerable. I literally defy anyone...and Dr. Kutcher, I'm going to single you out.

You said that all psychiatrists in Canada who object to MAID for mental illness are selfish and paternalistic. I'm not sure what purpose that comment served, but I defy literally any psychiatrist to say that this particular patient has an irremediable illness, because you can't. I have patients who get better after five years, after 10 years and after 15 years. You cannot do it. It's guesswork. If you're okay with guesswork, if you're okay with playing the odds, or if your position is let's respect autonomy at all costs—if someone wants to die, they can die—call it what it is. It's facilitated suicide.

• (1425)

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

As a reminder to our witnesses, please address the chair in your response. Thank you.

We now have Dr. Fry.

You have five minutes, Dr. Fry.

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

I had a bit of a glitch with all my technical stuff, and I wasn't able to hear fully the ACT group. However, I was listening to Dr. Maher answer this particular question.

You make the point, Dr. Maher, that what the expert panel said was that they were looking at what treatment has been done, but not what is possible in the future. You then equate that to [*Technical difficulty—Editor*], if we look at it from the patient's perspective, that what for the patient is intolerable and irremediable and what they refuse to continue to put up with, is not important. It is always about what the physician treating them desires.

I don't believe that this is what this is about. I think we heard from Dr. Wiebe about the chronicity of people who have had it and don't want to try anymore. We see that in physical decisions as well, with physical ailments, where people say, "I don't want the chemotherapy anymore. I don't want to do this anymore."

I'd like to ask what makes it different for a patient who has a mental problem. That is a real problem. We shouldn't put it into a category that says, because a patient has a mental problem, they do not have the ability to decide for themselves in many instances.

Can you answer me whether it is about what the doctor should be doing, or is it about what the patient requires?

**Dr. John Maher:** Thank you for the question.

I never said that it's about what the doctor wants. I'm answering the legal question.

The legal criterion is irremediability, so let's start with that. If you have a law that says doctors are asked to offer an opinion on irremediability, we can't.

**Hon. Hedy Fry:** Dr. Maher, I only have five minutes to get questions and answers, so I just need you to answer some simple questions.

From what I heard, and I may have misunderstood—

**Dr. John Maher:** I think you did misunderstand me.

**Hon. Hedy Fry:** —you're saying that it's what is possible in the future. However, if the patient says they have gone through enough and don't want to go through any more, you think that is helping somebody to commit suicide. Obviously the patient has no say in the matter, from what I heard you say.

Do you think the patient has a say?

**Dr. John Maher:** My daily work involves trying to sustain hope in people who are suffering terribly.

**Hon. Hedy Fry:** Please, I need a quick answer. Is that what you're—

**Dr. John Maher:** I am answering your question.

**Hon. Hedy Fry:** But you're taking a long time. I only have five minutes.

**Dr. John Maher:** Do you want an honest answer?

**Hon. Hedy Fry:** I just want a quick and simple answer, so I can move on to Dr. Wiebe.

**Dr. John Maher:** The simple answer is, of course, all psychiatrists are passionately committed to the relief of suffering. We listen to the suffering and are doing our best to relieve it. How do I serve my patients—

**Hon. Hedy Fry:** Thank you very much, sir.

Dr. Wiebe—

**Dr. John Maher:** —if they die instead of heal?

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

**Dr. John Maher:** I'm wondering why you didn't want an answer to my question.

**Hon. Hedy Fry:** Because I have only five minutes, Dr. Maher, and you should not be questioning me about what I need to hear from witnesses today.

Dr. Wiebe, you were saying that you agree with the results of the expert panel.

I think you have dealt with many cases, and you have been an assessor for a long time. Who do you think, at the end of the day, should be the one who decides what is intolerable, even if it means not accepting any further treatment because that treatment for them is intolerable?

**Dr. Ellen Wiebe:** There's only one person and that's the patient themselves. They are the ones who are suffering and have suffered, and they are the ones who can choose. We can't have anybody else making that decision. They are the ones who decide that it is unbearable and that they want a peaceful and dignified death.

**Hon. Hedy Fry:** Help me here. Walk me through what you do when you're assessing someone. Do you have to give them every single option that is available to them, and then do you make the decision? How do you go through this?

Tell me. Give me a step-by-step.

• (1430)

**Dr. Ellen Wiebe:** With cancer, it's relatively easy. There are standard protocols. They have to have been offered the treatment, but they don't need to have taken it. For mental illness, it is not so standard because psychotherapy is different from one person to another. As we heard, there are many different psychiatric medications and other treatments, like electroconvulsive therapy.

We need to make sure that the patient has been offered a number of different treatments, that they are reasonable treatments and that they have tried or seriously considered—the law says “seriously considered”—and we—

**The Joint Chair (Hon. Yonah Martin):** Thank you, Dr. Wiebe. Please briefly finish up.

**Hon. Hedy Fry:** Thank you, Chair.

Dr. Wiebe, finish your sentence, please.

**The Joint Chair (Hon. Yonah Martin):** Dr. Wiebe, complete your sentence and then we'll go to the next questioner. Thank you.

**Dr. Ellen Wiebe:** It's just that the patient has to have seriously considered the treatment options.

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

**Hon. Hedy Fry:** Thank you, Dr. Wiebe.

**The Joint Chair (Hon. Yonah Martin):** Next we have Monsieur Thériault for five minutes.

[*Translation*]

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

I thank all the witnesses for their enlightening testimony.

I will address Professor Vrakas first.

I am glad that people can advocate for better living conditions and better investment in mental health, as everyone recognizes that major investments must be made to improve accessibility to care.

This has been established by the Council of Canadian Academies and by the expert panel report.

I have heard your argument and I think it needs to be taken into account, and the same goes for Professor Maher's heartfelt plea. We have heard you loud and clear.

For my part, I am not a psychiatrist. I am an MP, and I certainly don't pretend to be an ethicist. Having said that, I question what is in the expert report. This report has already been quoted and I will quote it again:

In considering MAID requests for persons who have mental disorders, it must be recognized that thoughts, plans and actions to bring about one's death may also be a symptom of the very condition which is the basis for a request for MAID.

The expert report does not deny this. It states that mental disorders induce a desire to die and that the assessor must pay close attention. The report states:

In any situation where suicidality is a concern, the clinician must adopt three complementary perspectives: consider a person's capacity to give informed consent or refusal of care, determine whether suicide prevention interventions—including involuntary ones—should be activated, and offer other types of interventions which may be helpful to the person.

Does it reassure you that the report specifies we need to be careful of this aspect? It seems that this is limited to mental disorders. Suicidal tendencies do not manifest in all cases of mental illness. Later in the report, it says that when someone is in crisis, their MAID application will not be granted.

Don't you think this report indicates that precautions should be taken?

**Dr. Georgia Vrakas:** No, I don't agree. When I assess someone's condition, I cannot make that distinction. There is no tool at the moment that would allow me to distinguish a suicidal person from someone who is requesting assisted suicide, meaning medical assistance to die. How can I distinguish between the two?

When you are affected by mental disorders and cognitive distortions, you see things in a darker light and you want to stop suffering. Believe me, I know what it's like, having been there myself. If medical assistance in dying had been available five years ago, I might have asked for it, but the diagnosis was wrong. I was given time to get where I am today.

• (1435)

**Mr. Luc Thériault:** Perhaps the question is this: Would you have been eligible?

What I read in the report is that the assessors—I'm not one of them—seem to say that they, themselves, are able to distinguish a suicidal state, which by the way is quite reversible, everyone agrees on that, from chronic and persistent suffering over several decades.

[*English*]

**The Joint Chair (Hon. Yonah Martin):** Be very brief, please.

[Translation]

**Dr. Georgia Vrakas:** We have tools to assess suicidality. Suicide prevention is my field of expertise. However, when it comes to differentiating this suffering from that of a person with a mental disorder who wants help to die, there is a fine line. We will definitely overlook some cases, scientifically speaking.

**The Joint Chair (Hon. Yonah Martin):** Thank you, professor Vrakas.

[English]

Next we have Mr. MacGregor for five minutes.

[Translation]

**Mr. Alexandre Boulerice (Rosemont—La Petite-Patrie, NDP):** Good afternoon, Madam Chair.

Mr. MacGregor's name is Mr. Boulerice today!

[English]

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

[Translation]

You have the floor for five minutes.

**Mr. Alexandre Boulerice:** Thank you very much, Madam Chair.

I thank all three witnesses for being here.

Professor Vrakas, thank you very much for your honesty, sincerity and candour. It's very moving.

I will ask a question, which I invite all three witnesses to answer in the five or six minutes that I have. I have a question that is troubling me. I came here with no preconceptions. I'm listening and trying to learn.

Ms. Vrakas, you said in your testimony that you did not want to die, but to stop suffering. I am under the impression that this is the case for many people who have physical illnesses and are suffering. They don't necessarily want to die, they want to stop suffering. How can I, as a legislator, differentiate between the right of someone who is suffering physically and the right of someone who is suffering from a mental health problem? I want them both to have equal rights.

Mr. Maher, you said there was no discriminating between the two, but why would I give a right to someone who has irremediable physical suffering and not give the same right to someone who has mental suffering? I know that the issue of irremediability is very sensitive.

Ms. Vrakas, you could go first, and Mr. Maher and Ms. Wiebe can respond afterwards.

**Dr. Georgia Vrakas:** First of all, the aspect of irremediability is essential. It can't be ignored. When I say I wanted to stop suffering, that was exactly what I wanted. So I went to the emergency room to get help. I called the Suicide Prevention Centre. Do you know what? My suffering decreased. I'm here today in front of you, alive, and I'm fine. You could have said: it's fixable, but while we're at it, let's go for it. That is not reality. It's not the same for someone with cancer whose death is predictable.

**Mr. Alexandre Boulerice:** Mr. Maher, I'm listening.

[English]

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

Go ahead, Dr. Maher and then Dr. Wiebe.

**Dr. John Maher:** A very short answer to the question is that the main difference is that we're talking about treatable brain diseases, so if it's treatable, why are you offering death?

To the second point about suffering, when Dr. Fry asked the question, she was setting me up to sound like I'm paternalistic or that my wishes would supersede the patient's. In fact, the patient comes to me because of suffering. They come to me because they believe I have expertise and knowledge and the ability, with my team, to relieve that suffering. Why would I offer death instead of doing exactly what they're asking from me in the first place? They have crossed my doorstep seeking help, seeking relief from suffering, and I'm telling you I can offer it. I'm telling you that teams can offer it. I'm telling you that we only have one in three Canadians who have accessed mental health care in Canada and you're offering death instead of treatment.

Treat everybody and then let's have this discussion, but to offer them death and say, "Oh, these people have had all kinds of treatments", I have patients referred to me all the time from psychiatrists who have said that they're never going to get better, and they get better because of subspecialist care. It's subspecialist care. If you have a particular type of tumour, you're not having your family doctor treating it. You're going to a specialist in that type of cancer. It's true in psychiatry as well. You have this false narrative going on here about how it's all equal and all psychiatrists are equal and all diseases are equal.

Talk about the treatment of resistant diseases. Talk about the people whose suffering has lasted for a long time and answer this question: What do they want? They want relief from suffering. I would tell you honestly—

● (1440)

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

**Dr. John Maher:** —if I couldn't do it.

[Translation]

**Mr. Alexandre Boulerice:** I would like Ms. Wiebe to have a chance to speak.

[English]

**The Joint Chair (Hon. Yonah Martin):** Dr. Wiebe.

**Dr. Ellen Wiebe:** I see physical and mental illness and suffering very similarly. People come to me sometimes and say exactly what you said, Dr. Vrakas, that they don't want to die but they want to stop suffering.

The question is this: Have they been offered the treatments that might relieve their suffering, and did it work enough for them? For example, if I had a subspecialist like you, Dr. Maher, and I told my patient there was a five-year waiting list for the specialist in their area and asked them whether they were willing to continue suffering for the five years, and they said they weren't, then I would say that was irremediable.

The issue with relieving suffering is so similar in many kinds of situations. 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, so I don't see a big difference. Have they been offered the right treatment? Can they be offered it? We talked about—

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

We've now completed round one, so I will turn the floor back to the joint chair, Monsieur Garneau.

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

We'll now have a round of questions from the senators, and we'll begin with Senator Mégie. These will be three-minute rounds.

[*Translation*]

Senator Mégie, you have the floor for three minutes.

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

My question is for Dr. Maher, but Ms. Vrakas could answer it as well.

Dr. Maher, I don't know if you fully answered Dr. Fry's question. I feel like there were bits and pieces missing.

In the case of a physical illness, if specialists are trying to come up with all sorts of drugs and treatments, complex or not, to bring a person relief, it's called overtreatment. In the case of mental illness, does this concept also exist?

Do we sometimes not offer MAID, hoping that the individual will one day get better if we put them on several treatments, experimental or not?

[*English*]

**Dr. John Maher:** If you're asking me whether we try things without purpose, or let's see if it works because we have nothing to lose, the answer is no. I never get to that point. I have standard treatments that work, and it takes a long time to get there. The process of healing is slow. If you are asking me whether I think people should try experimental treatments, to me that's a matter of subjective choice. I'm not pressuring anyone to do anything. I'm offering standard treatments, and the standard treatments work.

It's an astonishing thing to me that if the treatment isn't available, and Dr. Wiebe is saying you can't get to see someone.... I'm wondering whether any of you would say "I'm going to die because I can't get the right care", or are we people in a position of privilege, where we say, "I'm going to go to the States, or I'm going to pay for it somewhere else"? It's actually been said out loud, we'll let people die. We've seen in the news: Let people die because they can't get an apartment. Irremediability, on my understanding of the Supreme

Court ruling and subsequent legislation, had nothing to do with psychosocial resources. We were talking about diseases. These were medical diseases—brain diseases we're talking about now—where we couldn't medically treat them.

Boy, has the barn door been opened wide here if that counts as irremediable. I'm going to cite this as a specific example of my great fear of the abuses that are going to follow with this legislation, because there's no oversight. There's no requirement that there be prospective judgment of what the doctors and nurse practitioners are doing. If Dr. Wiebe is going to let someone die because they can't get a treatment that will help them, then I'm frankly just shocked. That is not what this law is about, nor should it be. If we as a Canadian society are willing to let people die over apartments, I'm frankly just disgusted. Forgive my passion here, but you're parliamentarians with a duty to preserve life.

• (1445)

**The Joint Chair (Hon. Marc Garneau):** Thank you, Dr. Maher.

We're now going to go to Senator Kutcher.

**Hon. Stan Kutcher (Senator, Nova Scotia, ISG):** Dr. Wiebe, I just want to let you know that I'm sure all committee members appreciate the humility of your testimony.

Dr. Smith said in previous testimony that he felt that the Government of Canada should accept all—

[*Translation*]

**Mr. Luc Thériault:** Excuse me, but...

**The Joint Chair (Hon. Marc Garneau):** I'm having a hard time hearing the senator as well.

[*English*]

Senator Kutcher, we can't hear you very well. Do you have your microphone boom down at the right place?

**Hon. Stan Kutcher:** I've moved it. Thank you so much.

Dr. Smith in his previous testimony said that he felt that the Government of Canada should accept all of the recommendations of the expert panel report. Would you agree with that?

**Dr. Ellen Wiebe:** No. I accept a lot of them, almost all of them. My concern was with the issues of the provinces and the colleges being responsible for the standards guidelines. There's a huge problem with that. There are 26 different colleges that are handling the professionals involved, the nurse practitioners and doctors, and their mandate is that we provide professional and competent care. That isn't interpreting criminal law.

These 26 colleges are not what we need to do this, and the idea that the provinces and territories, the 13 jurisdictions—

**Hon. Stan Kutcher:** Excuse me, Dr. Wiebe. Would you be able to write that concern down and send it to us so that we will have that concern?

**Dr. Ellen Wiebe:** Okay.

**Hon. Stan Kutcher:** There are couple of things in that report that address some of the concerns that other witnesses have had, one being the idea of having a national framework up for case review for educational and quality assurance purposes, a national framework for protective oversight, and improving the federal MAID monitoring system.

Would you agree with those components of the report, and if you do, how quickly should those be put into place?

**Dr. Ellen Wiebe:** Absolutely, and do so immediately.

**Hon. Stan Kutcher:** That would have to be done as soon as possible.

**Dr. Ellen Wiebe:** That's right.

**Hon. Stan Kutcher:** There is training of assessors and providers, item 15. Would you agree with that as well, and do you have anything to tell our committee about any training programs that are currently being developed?

**Dr. Ellen Wiebe:** Thank you.

Yes, Health Canada has partnered with the Canadian Association of MAID Assessors and Providers to set up a national program of education. We have already been doing this, but this will be far more extensive and well done.

**Hon. Stan Kutcher:** My understanding, and correct me if I'm wrong, was that this was going to be credentialed by the Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada. Is that correct?

**Dr. Ellen Wiebe:** That's right.

**Hon. Stan Kutcher:** It includes indigenous physicians, indigenous nurses and the Canadian Nurses Association, and multiple other stakeholders in the medical and health-providing fields?

**Dr. Ellen Wiebe:** Yes.

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

We'll now go to Senator Dalphond.

• (1450)

[*Translation*]

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

Thank you, Mr. Chair.

I thank all the witnesses for their testimony, but I only have three minutes.

My question is for professor Vrakas.

Professor Vrakas, you talked about a crisis, someone going to the emergency room. Obviously, the intervention has to be quick. In other words, there is no time to lose. However, when we talk about accessibility of medical assistance in dying, is there not room for nuance?

Protective measures are already in the Act, including the period of at least 90 days, which is still quite long. Then there are steps. Assessments need to be done by two people, not just one. According to the working group's recommendations, this second person

should specialize in mental illness. There is also a need for those doing the assessment to have specialized training in this field and to work in conjunction with the treatment team.

Don't you think this system is very different from the reaction to a crisis?

During an assessment, it takes several months to come to the conclusion that the patient is eligible for medical assistance in dying. In your case, you said you wanted to die, but that does not mean you would have been allowed to access medical assistance to die.

**Dr. Georgia Vrakas:** There's a good chance I would have been eligible since treatment had been only somewhat effective for 20 years and I was still experiencing bouts of depression.

They are two different things. A crisis is fleeting. You have a crisis and you get help. When you have a mental illness, you live with the suffering and problems over a long period of time. During that time, you can seek help and you can find out whether you are eligible for MAID. The real problem is access to treatment.

I am a psychologist, and I can't choose to turn away clients. I just received an email from the government asking me to make my services available to the public. Services are desperately needed, and those who are suffering don't have access to the services they need.

No matter how it is structured and no matter what protocols are in place to regulate MAID, it doesn't change the situation. People like me and others are being told that they can access MAID, that they can die, that they can have help to die, and that death is an option. We are told that suicide is not a solution, but that assisted dying is. That sends the message that our situation is hopeless.

When that is presented as an option, the person may choose it because, morally and socially, it is seen as an acceptable solution. Whatever protocols are put in place, it won't change things. That thinking will become mainstream.

**Hon. Pierre Dalphond:** Thank you.

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

We now go to Senator Wallin.

[*English*]

Senator Wallin.

**Hon. Pamela Wallin (Senator, Saskatchewan, CSG):** Thank you, Chair.

My question is for Dr. Wiebe.

You mentioned that we make this huge distinction between physical illness pain and suffering, and mental illness pain and suffering. Can you really speak to the issue, that when it comes to mental illness it seems that we see it as endlessly fixable and that treatment must be relentless and go on and on and on. We've kind of come to terms with the physical side. We're saying that if you're in intolerable pain, you should be able to have access to MAID. Why do we have that distinction?

**Dr. Ellen Wiebe:** Why do we have that distinction? That's not mine to answer, but I can tell you my position here is that chronic conditions are similar whether they're mental or physical. Pancreatic cancer has a very strict trajectory, but the chronic conditions that people are suffering with and for which the treatments are not adequate to make their lives worth living are similar whether they're physical or mental. The suffering's unbearable. The treatments are either inadequate or unacceptable, and they are people who are rationally able to say, "My life is not worth living with this chronic condition," whether it's mental or physical, because it ruins their lives and it's just not good enough for them. I'm so glad that Canadians have these choices.

• (1455)

**Hon. Pamela Wallin:** If someone had stage 4 cancer, we wouldn't argue with them or say please take one more round of chemo, please do this or please do that, if they had made this choice, but we seem to want to impose that on people with a mental illness.

**Dr. Ellen Wiebe:** Yes, and what I'd say is that it's more like the court case *A.B. v. Canada*, in which the patient had unbearable disability and pain from her inflammatory arthritis, and she said that it was not good enough. We have treatments. You can certainly say that arthritis is treatable—it is—but it was unbearable for A.B., and the treatments were not good enough for her. That is exactly what happens with mental illness. There are people for whom the treatments aren't good enough. They're still suffering.

**Hon. Pamela Wallin:** Thank you.

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

Senator Martin, you have three minutes.

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

Dr. Maher, later, we're going to be hearing from Dr. Gupta from the expert panel on MAID and mental illness to discuss the report. Do you have anything you wish to say about the report or any cautions for our committee?

**Dr. John Maher:** Thank you.

I've known Mona for many years. We're colleagues. She's a smart, wise psychiatrist, but I will say she has information but not knowledge, and she is the first to say out loud that she doesn't work with the sickest people. She has also publicly said that she believes that people should have to have at least 10 years of treatment before you can even start to think about whether someone has irremediable illness.

Apropos the myth that Senator Wallin just threw out there that we're trying to force treatment on anybody, I'm sure that Dr. Gupta would agree we're not forcing treatment on any capable patient. They keep coming because they want help and relief from their suffering. At the risk of sounding insensitive, no one is keeping them from killing themselves. I say this with literally a broken heart because of the number of my patients who have carefully and thoughtfully planned their own deaths. As for this myth that it's tragic and horrible, people keep saying... It is tragic and horrible in mental illness. We have one study from Switzerland in which 40%

of the families report having PTSD or depression after supporting a loved one who's dying.

Dr. Gupta's report brings together plausible evidence but in the same breath says that we can't identify who's irremediable, the key legal criterion we're talking about here. It talks about your duty to review and also says that this is an ethical decision, not a clinical decision. I'm frankly stunned that Dr. Gupta has gone there. I'm also wondering why two people resigned from that panel. I would like to know that story. What you have is a number of very sensitive thoughtful statements but not a single safeguard. In the Benelux countries, you at least have to have tried standard treatment before you get euthanasia. In Canada—

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

**Dr. John Maher:** —we won't even require standard treatments. It's astonishing.

Thank you.

**The Joint Chair (Hon. Yonah Martin):** I was going to ask this to Dr. Vrakas. Are there any safeguards that could make MAID for mental illness safe?

[*Translation*]

**The Joint Chair (Hon. Marc Garneau):** Please keep your answer brief, Ms. Vrakas.

[*English*]

**Dr. Georgia Vrakas:** In my opinion, right now based on evidence, studies and research, there is no acceptable safeguard that will make MAID for mental illness safe.

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

**The Joint Chair (Hon. Marc Garneau):** That concludes our first panel.

On behalf of the committee, I would like to thank Dr. Maher, Dr. Georgia Vrakas and Dr. Ellen Wiebe.

[*Translation*]

Thank you for appearing before the committee today and answering our questions on an extremely complicated and emotionally charged issue. It is greatly appreciated.

We are now going to suspend momentarily to bring in the next panel.

Thank you everyone.

• (1455)

(Pause)

• (1500)

[*English*]

**The Joint Chair (Hon. Yonah Martin):** I have just a few comments for the benefit of our new witnesses.

Before speaking, please wait until I recognize you by name. As a reminder, all comments should be addressed through the joint chairs. When speaking, please speak slowly and clearly. Interpretation in this video conference will work as it does for in-person committee meetings. You have the choice at the bottom of your screen of floor, English or French. When you are not speaking, please keep your microphone on mute.

With that, I would like to welcome our witnesses for this panel, who are here to discuss whether to permit medical assistance in dying for mental illnesses or disorders in Canada. First, there's Dr. Alison Freeland, chair of the board of directors and co-chair of the MAID working group at the Canadian Psychiatric Association. As individuals, we have Mr. Mark Sinyor and Dr. Tyler Black. Thank you for joining us today for the second panel.

We'll begin with opening remarks by Mr. Sinyor, followed by Dr. Freeland and Dr. Black.

Mr. Sinyor, you have the floor for five minutes.

**Dr. Mark Sinyor (Professor, As an Individual):** Thank you very much.

Good afternoon, committee members. It's an honour to be with you today. My name is Mark Sinyor. I'm an associate professor of psychiatry at the University of Toronto and a psychiatrist at Sunnybrook Health Sciences Centre who specializes in the treatment of adults with complex mood and anxiety disorders.

My research is focused on suicide prevention. I'm a former vice-president of the board of the Canadian Association for Suicide Prevention, lead author on the Canadian guidelines for responsible media reporting about suicide, a steering group member of the International COVID-19 Suicide Prevention Research Collaboration and I was recently asked to coordinate the International Association for Suicide Prevention's efforts to create a regional suicide prevention network across the 35 countries in the Americas.

I should note that I am not involved in MAID assessment or provision. I am also not a conscientious objector to MAID. To be transparent, my professional agendas, both in general and in these deliberations, are to do my best to help contribute to a Canadian society with fewer suicides and to protect psychiatry as an evidence-based science.

Given that I only have a few minutes, I will focus my remarks on what ought to be the overriding issue in your deliberations. As highlighted in the expert panel report, I and some of my colleagues have argued that, like any other medical procedure, physician-assisted death for sole mental illness should be permitted only if there is evidence that the benefits outweigh the harms. In their recently tabled report, the expert panel noted that they "considered this possibility but did not arrive at this conclusion."

The imperative to do no harm has been a foundational principle of medicine for thousands of years and underpins the modern principles of evidence-based medicine, which call for us to undertake scientific evaluation of the benefits and harms of our treatments to determine whether delivering them is ethical. If, as a country, we're going to reject these ideas, first, we should be aware that we're doing so and, second, we ought to have a compelling reason.

In short, we are essentially missing all of the necessary scientific evidence to evaluate the safety of physician-assisted death for mental illness. If I had more time, I could list many examples, but let me focus on the fact that there is absolutely no research on the reliability of physician predictions of the irremediability of illness or suffering in psychiatric conditions. To my knowledge, there is not a single study.

Advocates for the practice are suggesting that we have safeguards, because the practice carries many inherent dangers. This is the entire reason for safeguards. We do not propose safeguards for practices that are already safe, but the degree to which any proposed safeguards actually fix that problem is entirely unquantified. No one has provided you with those numbers because there has been absolutely no research and they don't exist. As a result, if this goes forward, MAID assessors will have no idea how often they are wrong when they make a determination of eligibility in the context of physician-assisted death for sole mental illness. 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.

There are many other examples of evidence about serious harms that are simply missing, such as rigorous study of the impact on suicide and its prevention. 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 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.

What is so disconcerting here is that we could conduct the necessary studies. We demand evidence on benefits and harms before legalizing natural health products, new medicines and vaccines. Why skip that step in such a profound deliberation as the one you are engaged in now? I would argue that we owe it to our fellow Canadians with mental illness to have the necessary scientific information in hand before making such a consequential decision.

Thank you. I wish health and well-being to all during the pandemic.

• (1505)

**The Joint Chair (Hon. Yonah Martin):** Thank you very much, Mr. Sinyor.

Next we will have Dr. Freeland for five minutes.

**Dr. Alison Freeland (Chair of the Board of Directors , Co-Chair of MAiD Working Group, Canadian Psychiatric Association):** Thank you for the opportunity to be here today. My name is Alison Freeland. I am a psychiatrist, and I'm here in my capacity as chair of the board of directors of the Canadian Psychiatric Association and co-chair of the CPA's MAiD working group.

Today I will focus my remarks on medical assistance in dying as it pertains to requests on the sole basis of a mental disorder to supplement the CPA's brief that was submitted to this committee a few weeks ago.

The CPA has not taken a position on whether MAiD should be available where mental illness is the sole underlying medical condition. However, we do believe that any new legislation must protect the rights and choices of all vulnerable Canadians without unduly stigmatizing and discriminating against those with mental disorders where eligibility requirements are determined to be met.

In considering safeguards, the CPA discussion paper looked at the issue of capacity. A mental disorder does not in and of itself imply incapacity in any domain of decision-making, but when active, various forms of mental illness can impair decision-making and capacity. Psychiatrists have specialized training and expertise in the assessment, diagnosis and treatment of mental illnesses, including the assessment of decisional capacity as well as the durability, stability and coherence of a person's expressed will and preferences. Psychiatrists are well versed in taking into consideration any external constraints or internal psychopathology that may impact these issues.

Inequities of service provision and funding are an issue for all types of conditions. This is an area that is particularly problematic for people living with mental illness. Such inequities are further exacerbated for people who live in rural or remote areas. Whether the illness is physical or mental, or a combination of both, equitable and timely access to evidence-based, culturally appropriate clinical services is a first and essential safeguard to ensure that people do not request MAiD due to lack of available treatments, supports or services.

In the context of mental disorders, there is no generally agreed definition of incurability. Within the field of psychiatry, there are some who do not accept that any mental disorder isn't curable and will argue that there is always another treatment to be attempted.

Resolution of this issue requires a pragmatic approach that balances clinical expertise and assessment of incurability with the patient's perspective and experience of their illness.

Socio-economic determinants of health, which play a key role in each person's experience of suffering and adaptability to mental illness, are important to consider. If a patient refuses recommended treatment for their disorder without good reason, weighing both the potential benefits and burdens, they are unlikely to have met the eligibility criterion for incurable.

Vulnerability is not limited to those with mental illnesses. Many people with non-psychiatric illnesses are also vulnerable because of such psychosocial circumstances as isolation or poverty, cognitive distortions and demoralization due to failed treatment attempts or difficulty in adjusting to life with their illness. The trajectory of physical illness can be as unpredictable as that of mental illness. Loss of hope can occur, as can spontaneous remission. Predicting treatment outcomes is as much a challenge for psychiatry as it is for the rest of medicine.

Both acute and chronic suicidal ideation must be considered and evaluated to make a best determination as to whether the patient's wish to end their suffering represents a realistic appraisal of the situation, rather than a potentially treatable symptom of their mental illness. A request for MAiD should be considered and sustained, and not be the result of a transient or impulsive wish. This is particularly important for persons with non-terminal conditions, such as a mental disorder where illness maybe more episodic in nature.

Therefore, separate from any MAiD eligibility assessment, it is essential that at least one independent psychiatrist completes a comprehensive clinical assessment to validate whether the patient has received an accurate diagnosis and access to evidence-based mental health assessment, treatment and supports for an adequate period of time based on generally accepted standards of care.

Thank you very much. I'd be happy to try to answer your questions.

• (1510)

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

I don't see Dr. Black. Am I correct?

**Dr. Tyler Black (Clinical Assistant Professor, University of British Columbia, As an Individual):** I am here.

**The Joint Clerk (Ms. Andrea Mugny):** He's there, Senator. He's on the screen now.

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

Dr. Black, you have five minutes.

**Dr. Tyler Black:** Thank you for the opportunity to provide my perspective.

I'm a physician with 14 years of tertiary experience in emergency psychiatry involving suicidality, and I'm a researcher, teacher and expert in suicide and suicidology.

It's really important to note that what most people think of as suicide is far different from most experiences of MAID. I've submitted a brief regarding many of the myths comparing suicide to MAID, and I trust that it's been helpful to the committee. I'd like to draw special attention to three of the points that I made.

First, motivations in MAID and suicide are rarely the same. 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.

Second, the wish to die is not indicative of a mental illness. While depression does include suicidality as one of its nine criteria, the presence of a serious mental health diagnosis is absent in 40% to 50% of all who die by suicide. Many who experience suicidal thinking do not have a diagnosable mental illness, and the vast majority do not die by suicide.

Third, capacity assessments are a core part of psychiatric training. This is probably the most achievable and least controversial aspect of these discussions and not an area of significant controversy in psychiatry.

To the larger complex question regarding psychiatric MAID, I'm comforted by an approach that helps me in my clinical life. You see, most of my patients are sent to me as a tertiary psychiatrist when other psychiatrists and doctors are seeking care and expertise for a complicated case. Where other physicians who deal with primary presentations follow guidelines or algorithms, I rarely have an algorithm to follow. In fact, the book of algorithms for my line of work would be minuscule.

Rarely do I ever have a perfect answer. For this, I both teach and practise science-based medicine and principle-guided medicine. For science-based medicine, we use the best evidence we have at the time. We apply plausibility in expertise and recognize the importance of updating our information as new, excellent information comes to light.

In this regard, there are decades of experience of MAID in some countries and some with psychiatric MAID, and it suggests that it's well practised, well accepted and represents only a small fraction of all MAID deaths, 1% to 2%. Given the number of people with suicidal thinking, there is simply no credible foundation for the fear that allowing MAID for psychiatric conditions would create a flood of deaths in Canada.

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.

Adding the procedures that should be in place for MAID, the plausibility of a hasty, poorly thought out conclusion regarding MAID is drastically reduced. I've also submitted evidence regarding a review of studies of psychiatric MAID in various countries to the committee.

For principle-guided medicine, one uses a set of principles to dictate decision-making. There are many principles that I consider when it comes to psychiatric MAID. First, we must respect the autonomy of our patients, especially when we have determined that they have the capacity to make decisions for themselves.

Second, we must be cognizant of systemic racism, systemic ableism and lack of access to mental health care in Canada. It should never be that someone chooses MAID due to a system that inflicts racism or ableism on that person or limits their ability to access quality mental health care.

Third, we must not discriminate against people with mental illnesses nor discriminate against those with psychological suffering.

Fourth, not all conditions respond to treatment. No treatment in psychiatry has a 100% cure rate, and psychiatry has been loathsome slow compared with other specialties to the medical notion that some people do not, for a variety of reasons known and unknown, respond positively to treatment. For some, treatment is a miserable experience with no benefits.

Fifth, psychiatry has a long legacy of paternalism, and decisions must be centred in a place where the expertise of physicians and those with lived experience overlap. Finally, only a physician's professional opinions, not their personal beliefs, should exert influence on a patient in their health care decision-making.

I can imagine a system in Canada that honours the best science and principles we have regarding this issue and, for that reason, I'm cautiously but generally supportive.

● (1515)

Thank you.

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

Thank you to all of our witnesses for your testimony today. That will be very helpful to our committee.

We'll begin our first round with Mr. Cooper.

You have the floor for five minutes.

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

Dr. Sinyor, in your testimony you said that what is lacking is literally all necessary scientific evidence to establish that MAID can be carried out safely in the case of sole mental illness. You focused in specifically on the lack of study around predicting irremediability. You did go on to say that you could cite other examples of evidence that is missing, so I'd invite you to take this time to do so.

**Dr. Mark Sinyor:** Thank you very much.

I think there are a few key things. The first is that the legislation doesn't only talk about incurable illness, but also incurable and intolerable suffering. The idea of incurable and intolerable suffering doesn't actually have a scientific definition. There was an article in the Canadian Medical Association Journal just a month ago in which there were calls for a scientific definition for that, which would really be a precursor of being able to study it. It's important to alert the committee that the concept we're trying to treat doesn't even have a scientific definition. That's part of the reason there have been no studies of it.

I think there's a whole host of other things that we need to look into beyond.... There's not only the irremediability of psychiatric disorders but also the irremediability of psychiatric suffering. While I agree with the other witnesses that there are psychiatric illnesses for which we know we can't cure the underlying illness, that's actually somewhat different from the idea of whether we can provide a treatment that may be able to alleviate the suffering that corresponds to that illness. To my knowledge, that has never been the focus of a single psychiatric study or any kind of study.

The large rest of studies that would be necessary are those related to suicide and suicide prevention. We just heard correctly, for example, that there's this question about whether MAID is suicide or not. Some people say it's exactly the same thing. Some people say it's totally different. The reality is probably that it's something in between. Obviously, in the case of mental illness, we have to be concerned that there may be substantial overlap. Trying to quantify the degree to which that overlap exists and the degree to which messaging....

I'll just say that my research mainly focuses these days on public messaging. We find that when you message across society that when you're having difficulty and struggling with mental illness, you can go seek treatment and get help, we see fewer suicides across the population. When you see media reporting about the idea that people will take their own lives when they're in difficulty in life, we see an increase in suicides. The degree to which that media reporting and this sort of cultural change that we have may have an influence is something worth studying, as is the impact on the physician-patient relationship and how people view psychiatry.

I would say the last thing that probably would be worth studying is an economic analysis of whether there are perverse disincentives. Of course, if this goes forward you would want any money that's saved through MAID to then be funnelled back into the mental health system. There is the possibility, of course, that there's a perverse disincentive to invest because if you don't invest, the more people have what appears to be irremediable illness and they die through MAID. Then our health care system just gets worse, which I think we can all agree would be a complete disaster.

All of that research would be helpful to know before going forward.

• (1520)

**Mr. Michael Cooper:** Thank you very much.

I presume that, absent being able to establish irremediability, talking about safeguards is really putting the cart before the horse. If you can't establish irremediability, you really can't go forward—certainly from the standpoint of the legislation, but even putting aside the statutory requirement, from a safety standpoint.

**Dr. Mark Sinyor:** I think that's correct. If you think about it logically, if someone asks if this plane can fly.... We have a dangerous plane. We know that it crashes. Can we get it safely from point A to point B? You could get a group of people to say that we should put a whole bunch of safeguards into place, but without actually testing those safeguards, I wouldn't want to get on the plane.

**Mr. Michael Cooper:** That's right.

Could you perhaps just explain what full disclosure for informed consent for MAID in the case of sole mental illness would look like?

**Dr. Mark Sinyor:** I think here's the difficulty. One could construct a study where you take all of those people who might be eligible for MAID for mental illness and provide them with really excellent care, provide them with whatever they might need—psychotherapy, adequate pharmacotherapy, a nutritional program, exercise, access to neurostimulation, other psychosocial interventions that might help—and you could look and see what proportion of those patients actually change from appearing irremediable to remediable. I think many of us are concerned that it's probably a very large proportion of them.

The concern there is that psychiatrists don't know that because we don't have the research. There's no evidence for it, so you could have a patient and a psychiatrist sit together and earnestly decide there's nothing that can be done, that this case is irremediable, and both have that entirely wrong, and then have that person end their life. As a practitioner or clinician or psychiatrist, the idea that we might go forward with that without informing patients that this is a possibility is a problem. At the moment—

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

**Dr. Mark Sinyor:** Sure.

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

Next we'll have Mr. Maloney.

You have five minutes.

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

Thanks to all three witnesses. Your presentations were excellent and levelly presented, based on some previous panels we've had, most recently an hour ago.

Dr. Sinyor, I'd like to start with you if you don't mind. At one point you said you're trying to protect psychiatry as evidence-based science, which I respect and I thank you for. Have you ever rendered an expert opinion in a legal matter before?

• (1525)

**Dr. Mark Sinyor:** Yes, in the Truchon hearings.

**Mr. James Maloney:** Okay. It seems to me that, regardless of what side of this issue you're on, one of the biggest problems or areas of conflict is this issue of whether it's irremediable or not and whether it's permanent or not. That's what that means. Is that right?

**Dr. Mark Sinyor:** Correct.

**Mr. James Maloney:** Okay. In your view, no psychiatrist can ever render an opinion that says a mental disorder is permanent and be accurate. Is that fair to say based on what you told us?

**Dr. Mark Sinyor:** I think anybody could offer an opinion, but whether that opinion would be solidly grounded in science I think is a very dubious claim.

**Mr. James Maloney:** Okay. I have to assume then that, in your opinion, any doctor who does say that is overreaching and not using evidence-based science to inform their psychiatric opinion. Would that be fair?

**Dr. Mark Sinyor:** I would say so. I just would wish that my colleagues would have better data to act on if we're going to go forward with this.

**Mr. James Maloney:** Thank you, Dr. Sinyor.

I was a lawyer for 20 years before I went into this profession and I can tell you with absolute certainty that every single day in the province of Ontario you have colleagues in court testifying in psychiatric cases that persons have permanent irremediable medical disorders. Are you here today telling me that those people are all giving opinions that aren't valid?

**Dr. Mark Sinyor:** I think they're dubious. If you look at the Canadian Mental Health Association, the American Psychiatric Association, the expert advisory group, numerous organizations have clearly said that in fact we can't make such determinations. I'll let Dr. Freeland obviously comment on her end, but the CPA has essentially taken no position on that. The consensus is certainly that there isn't very good evidence for that at all.

**Mr. James Maloney:** Okay. You agree then that there's a whole group of doctors out there giving opinions that aren't valid, and that's your view.

**Dr. Mark Sinyor:** Here's the issue. If someone asks.... You can ask my opinion. Courts can ask people's opinions. If we're asked, we have to provide the best opinion possible, but to make such a consequential decision, I would want better evidence and usually medicine demands that.

**Mr. James Maloney:** Okay, so you're not comfortable with it, but I don't think it's fair for you to sit here and say the entire profession is incapable of doing that. I'm going to pose that question to the other two panellists and see what their views are on that, because it seems to me anybody who says that a psychiatrist or somebody in that aspect of the medical profession can't do it is not necessarily giving the profession its due respect.

Dr. Freeland, what do you think of that?

**Dr. Alison Freeland:** Speaking from a CPA perspective, I think the perspective from the CPA is that we are trained in a certain way, we are committed to our profession and we follow through on doing assessments and treatment with patients absolutely to the best of our professional ability. I think we all recognize that from an evidence-based perspective there are clinical guidelines and there are practices and standards that we follow, but for many illnesses, when those things haven't worked, there is an unknown that we all operate within. The real importance of working in this area is about finding the balance between a psychiatrist's commitment to provide treatment, care and hope for recovery but really listening to the person's own experience of suffering and the right to make a personal choice in their health care decisions.

When we talk about science, there is a scientific part of that, but we also talk about the importance of the art of working with patients and reflecting that as well. I think that's what we try to do from a CPA perspective.

**Mr. James Maloney:** Thank you. I appreciate that.

Dr. Black, I don't have much time, so I'll go over to you.

The last thing you said was that no personal opinion should form part of a doctor's view when making an assessment—a view I share. I assume you said that because, in your opinion, there are doctors out there who do have a strong opinion on either side of this thing and it does form part of their opinion. Is that accurate?

**Dr. Tyler Black:** Absolutely. I think it's a big problem. When we test the limits of psychiatric science, we have to do that on the positive and negative. 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.

**Mr. James Maloney:** That's ultimately what this is about.

Thank you, Dr. Black.

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

Next we'll have Monsieur Thériault for five minutes.

[*Translation*]

**Mr. Luc Thériault:** Thank you, Madam Chair.

My first question is for all three witnesses.

Is it your view that there is no such thing as an incurable mental illness ever?

Dr. Sinyor, would you like to answer first?

• (1530)

[*English*]

**Dr. Mark Sinyor:** I'm not sure I fully understood. Maybe I could just clarify. I think the issue is that our ability—

[*Translation*]

**Mr. Luc Thériault:** Do you think that no mental illness is ever incurable?

[English]

**Dr. Mark Sinyor:** No, I don't think that's what I'm saying. There's a consensus that some mental disorders are incurable, and certainly that the suffering that exists as part of mental disorders might be incurable in certain instances, but we have absolutely no data to identify what those instances are and how often they occur.

[Translation]

**Mr. Luc Thériault:** I'd like to hear from Dr. Black and, then, Dr. Freeland.

**The Joint Chair (Hon. Yonah Martin):** All right.

[English]

Let's have Dr. Black first, followed by Dr. Freeland.

Go ahead, Dr. Black.

**Dr. Tyler Black:** In a previous meeting, Dr. Derryck Smith emphasized the importance of not focusing so much on a diagnosis but on the patient. The patient's experience could very much be untreatable and incurable, and many of the treatments we offer them may or may not work. Our ability to cure everybody is not 100%. Psychiatry has some good outcomes and some poor outcomes, and based off of different trajectories, we see various results. I think it's very safe to say there are many psychiatric disorders that are not curable with the present science.

**The Joint Chair (Hon. Yonah Martin):** Go ahead, Dr. Freeland.

**Dr. Alison Freeland:** I would underscore Dr. Black's comments and add that a common verbiage used in psychiatry is the concept of "serious and persistent mental illness", which in and of itself speaks to the fact that we try to treat people, but many people are left with residual symptoms and experience those symptoms with varying degrees of suffering.

[Translation]

**Mr. Luc Thériault:** Dr. Freeland, would you say psychiatrists are, to some extent, focused on heroic measures?

[English]

**Dr. Alison Freeland:** Again, speaking for the Canadian Psychiatric Association, we're founded on following evidence-based practice. We look at clinical practice guidelines.

If I think about clinical practice guidelines, the concept of a heroic measure is probably not well articulated there. I believe practitioners go above and beyond for patients and really think about what might be helpful for them. Despite that, there are people, as you've heard, that have outcomes that do not respond to a full complement of evidence-based interventions in addition to maybe some other unique innovative interventions.

[Translation]

**Mr. Luc Thériault:** Dr. Sinyor, could you answer that question as well?

[English]

**Dr. Mark Sinyor:** I know there has been some focus on heroic measures in this discussion, but I also think it's important to say, as someone who is a practitioner in the tertiary care centre, that I've

seen many people who have been judged to have irremediable illness in the community, who are referred to our service and who receive higher-level psychiatric treatments, such as neurostimulation, and some of the older medications we have, such as monoamine oxidase inhibitors. Without great difficulty, we're able to essentially change their situation from being irremediable to remediable.

The concern here is that people will be inappropriately considered irremediable, when in fact you don't need heroic measures. You just need really solid care to alleviate suffering.

[Translation]

**Mr. Luc Thériault:** Dr. Black, you can answer, if you like.

[English]

**Dr. Tyler Black:** Just to follow up on that point, I think neurostimulation and older medications are all things that.... I've practised ECT and I've seen some pretty incredible responses.

That being said, ECT is a daunting prospect for a patient. It has a number of benefits and side effects. So do monoamine oxidase inhibitors. Again, it always comes down to the fact that the treatment may or may not be available and the question of whether it is the right treatment for that patient. Patients have different reasons for saying yes or no to those treatments.

I've also seen many people receive ECT, monoamine oxidase inhibitors and many psychiatric medication combinations and experience only side effects with no benefit.

● (1535)

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

We now have, to end off this first round, Monsieur Boulерice for five minutes.

[Translation]

**Mr. Alexandre Boulерice:** Thank you, Madam Chair.

My first question is for Ms. Freeland.

You talked about socio-economic determinants that could push people to experience mental illness. There does indeed seem to be a strong correlation between poverty and social inequality and an increased risk of mental illness.

How much could addressing those socio-economic factors—the possible causes of mental illness—help avoid a situation where people are requesting MAID because of mental health issues?

[English]

**Dr. Alison Freeland:** Thank you for the question.

As I understand it, the question is whether, if we spend more time focused on addressing socio-economic determinants and their impact on people's experience of their health issues, we would avoid having to take on MAID as a solution.

You know, I think as part of thinking about treatment, and certainly again from a CPA perspective, the idea of biopsychosocial interventions to treat mental illness is really important and part of evidence-based care. We think about assessing and treating the biological symptoms of illness using a variety of measures and treatments, but in addition think about psychological measures and consider the social circumstances in which somebody lives.

When somebody has appropriate access to a treatment team that's able to provide biopsychosocial interventions, that should go a long way to trying to ensure that we are providing people with the best kind of care, which is what we would all want to do in a situation with somebody who has either physical or mental health issues and who is thinking about ending their life because of the nature of their experiences.

As I said, one of the first and primary safeguards is to ensure that people have the right access to treatment. That being said, there may still be circumstances in which somebody has experienced something in their life or they're in a unique circumstance where, regardless of what a treatment team can do, it doesn't specifically meet that patient's individual needs. If that is considered to be the only way to try to mitigate MAID, I don't believe that's something that will happen. I think that's why we have to think about those things in a very fulsome way and understand them as part of the safeguards and do the best we can to help steer people in a direction of hope and recovery, and then think about what safeguards we need to have in place to ensure people are not going too quickly to explore MAID as an option.

[Translation]

**Mr. Alexandre Boulerice:** Thank you very much, Dr. Freeland.

Now, I'm going to ask a simple question, and if there's enough time, I'd like all three witnesses to answer.

Something that has come up a number of times in our discussion is whether the experts and science are able to make a clear distinction between someone who is suicidal and someone whose suffering would exclude them from eligibility for MAID. That strikes me as a basic question.

Ms. Freeland, are you able to say to a patient, a person, that they are suicidal or that they are living with suffering that excludes them from MAID? Is it possible to make that determination reasonably but, above all, scientifically?

[English]

**Dr. Alison Freeland:** I think those are issues that we want to continue to understand and explore. As trained psychiatrists we do get experience in how to tease those things apart—to understand socio-economic suffering versus the experience of having suicidal ideation as a symptom of illness. Very careful assessment using a fulsome team, seeking a second opinion where needed, is important for us to try to understand and tease out those things. Where that's applicable to the issue of medical assistance in dying, thinking about the appropriateness of new curricula that help train psychiatrists to think very specifically in this area and appropriately assess and be able to sort those things through will be important going forward.

[Translation]

**Mr. Alexandre Boulerice:** What do you think, Mr. Sinyor?

[English]

**Dr. Mark Sinyor:** I would answer that we can all try. We are all experts. We can do our best. However, it's never been the subject of rigorous scientific study, no.

**Dr. Tyler Black:** I'd simply answer yes, and unequivocally yes. This is the core part of psychiatric training. I understand the need for good scientific analysis, but there are many reasons why the science in this area is difficult to conduct. All the best science we have points towards a very clear difference between the type of suffering that happens in MAID requests and the general suicidal patient who presents to a hospital or to a psychiatric clinic.

• (1540)

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

Thank you to all of our witnesses.

We're going to the round with senators, and I will turn this over to Monsieur Garneau.

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

We'll start with Senator Mégie.

Given that one of the senators will not be in this round, I'll give the first three senators four minutes each.

[Translation]

Senator Mégie, you may go ahead. You have four minutes.

[English]

**The Joint Chair (Hon. Yonah Martin):** Mr. Joint Chair, Senator Dalphond is present, so there are five of us here.

**Hon. Pamela Wallin:** He was referring to me. I am going to forfeit my time.

**The Joint Chair (Hon. Yonah Martin):** I see. Okay. I'm sorry about that.

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

[Translation]

Senator Mégie, you may go ahead. You have four minutes.

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

My question is for all three witnesses or whoever wishes to answer.

A witness in the first panel said that suicide rates had gone up in countries where MAID was available to people whose sole diagnosis was mental illness.

How do you explain that? Is it possible that the so-called suicide figures also take into account assisted suicide deaths?

[English]

**The Joint Chair (Hon. Marc Garneau):** To get the ball rolling, I'm going to suggest Dr. Freeland, followed by Mr. Sinyor, followed by Dr. Black, if you wish to respond.

**Dr. Alison Freeland:** Thank you very much.

I will skip this question, because from a CPA perspective, we haven't specifically studied that, and I don't feel I can give a representative response. You have my apologies.

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

Dr. Sinyor.

**Dr. Mark Sinyor:** I would say that I've seen both argued and, frankly, it's another area where people are often just looking at curves without actual statistical analysis accounting for other factors that may affect suicide rates. However, certainly I think you have to be concerned about an increase in suicide rates in the context of MAID.

As I said, my major expertise and research are around public messaging, and when you share with the public the idea that death is an appropriate response to mental suffering, you see more suicides. That's one of the things that the Government of Canada certainly needs to grapple with, if that's the message that is being sent.

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

Dr. Black, do you wish to comment?

**Dr. Tyler Black:** Yes. I have done these analyses. I've actually submitted the evidence to the committee. There is no evidence to support the notion that suicide rates have increased in countries that have adopted MAID, nor in states that have adopted MAID. I have submitted that evidence to the committee.

It's a positive claim, and it would require some pretty significant evidence. It's absolutely true that it's fraught to compare countries in the best of times. When you're looking at curves and things, what I would say is that the rates are generally parallel to those in neighbouring states and countries that didn't.

There is no notion to support that whatsoever that I'm aware of.

[Translation]

**Hon. Marie-Françoise Mégie:** Thank you.

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

[English]

We'll now go to Senator Kutcher.

You have four minutes.

**Hon. Stan Kutcher:** Thank you very much, Mr. Chair.

I have a question for Dr. Black and then for Dr. Freeland.

Let's follow the suicide rate discussion.

Since Bill C-14 came into Canadian play, there has been lots and lots of public discussion about MAID in the media—all over the place in Canada. What has happened to suicide rates in Canada since MAID was introduced, generally and specifically to the popu-

lation of those over 50 or so, who would more generally seek MAID?

**Dr. Tyler Black:** Thank you for the question.

I provided that evidence in my brief to the committee. There has been no significant change to suicide rates since the implementation of MAID, despite many proclamations that it would increase, by supposed experts, prior to the passing of MAID. It reminds me a lot of what happened during the initial phases of COVID, when a number of experts stepped forward and said that suicide rates would increase then as well. In fact, we saw a significant decrease in suicide rates in 2020.

There has been no impact in a negative way on suicides since the introduction of MAID.

**Hon. Stan Kutcher:** Would it be safe to say then that all this public messaging around MAID has not led to increased suicides?

• (1545)

**Dr. Tyler Black:** There are so many factors that go into a nation's global rate. Whenever we look at a large population rate like the Canadian average, we're including a number of people with a number of different experiences. I'm always careful to not make a positive claim where one doesn't exist.

I would say that evidence that an increase has occurred because of MAID messaging is not substantiated.

**Hon. Stan Kutcher:** Thank you.

Dr. Freeland, thank you very much for tackling this issue of who decides whether the suffering is intolerable.

If I understand correctly, your perspective is that a competent person's own experience of suffering dictates what they choose to do. A psychiatrist needs to offer all options to the patient, but it's the person, not the psychiatrist, who decides what will happen, if the person is competent.

There have been concerns raised that some psychiatrists will never accept that a patient's suffering is not remediable. In such a situation, where the psychiatrist feels that the patient's suffering is not irremediable and wants the patient to keep going and trying but the patient says that enough is enough, what happens in that relationship? How should they proceed together?

**Dr. Alison Freeland:** I think in those kinds of challenging situations....

Maybe I would just preface this by saying that, ideally, these are shared decisions because the patient is listening to the psychiatrist's perspective and input, and we are there to think about hope and recovery. At the same time, we have to listen to a competent patient's perspective and what they want to come up with a decision that forges a path forward for the patient that they find appropriate for them.

Where a patient feels that they perhaps are not getting what they feel they might need from a practitioner, I think the solution would be similar to what patients do when they experience that in many different medical predicaments. There are opportunities to reach out, request a second opinion, ask for a re-evaluation or maybe come to a shared decision around what next steps should be taken, and then maybe have a second opinion.

I think there are different alternatives, but ideally these are transparent, informed conversations between two people who care about somebody's outcome, treatment and care.

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

[*Translation*]

We now go to Senator Dalphond for four minutes.

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

Thank you to the witnesses for their illuminating insights. You're giving us a lot of food for thought.

Since I have only three and a half minutes left, my questions will be for Dr. Freeland.

[*English*]

Dr. Freeland, I understand your association has been quite interested in the issue of access to MAID for mental disorders and you co-chair a committee—a working group—on this.

Can you tell us how many members are on that committee? Did your subgroup study the report from the task force?

**Dr. Alison Freeland:** I'm just quickly counting them to give you the right number. We have 12 people on our working group. We went through a pretty rigorous process to request that people apply. A number of our members applied to be on this working group. That process happened a few years ago.

We have people with many differing perspectives on medical assistance in dying, which I think is truly representative of our membership at the CPA. That's why we have focused our work on what the safeguards are if this is coming to fruition and on how we truly educate our membership around understanding what the issues are.

Our group has an upcoming meeting. We have not had a chance yet to review the expert report. I've had a quick look at it, so I won't be able to provide comments formally from the CPA about that, but I would be happy to share those once we've had our meeting.

**Hon. Pierre Dalphond:** Yes, please send us a copy once your subgroup has met.

In the meantime, can you tell us, based on your previous discussions and your understanding of the report, if that report is missing something on some issues. Are there issues that need further study?

**Dr. Alison Freeland:** Overall, the expert committee report, from my cursory reading, reflects some of the important considerations for safeguards. Some of the things that were mentioned in the report were also things which, from our CPA discussion paper and input from our membership, were areas of concern for psychiatry. Those things seem to have been captured. In fact, one of the appendices reflects some of the areas from CPA in a table that includes

the Canadian Bar Association and the CMA. I think that would be there in terms of feedback from the CPA from that perspective.

One of the things to really home in on is the importance of a national, standardized approach to this. As we all know, for all things health care, when things get to a provincial level, there are so many differences in how stuff happens. This is going to be a challenging and important area to demonstrate that, from a safeguard perspective, we've established a very clear set of oversight rules, managing and making sure that the steps we've taken are the right steps to be taken.

Perhaps that would be one area in the report to really home in on from that perspective.

• (1550)

**Hon. Pierre Dalphond:** Do you think it's possible to have these national standards before the contemplated date of these provisions of MAID coming into effect?

**Dr. Alison Freeland:** The expert committee did very good, fast work. From my perspective, that was important and promising. We're going into the summer. I think it will depend on people staying focused and wanting to get that work done by next February.

**Hon. Pierre Dalphond:** Thank you.

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

We'll now go to Senator Martin for three minutes.

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

Thank you to all of the witnesses.

I'm going to continue from where Senator Dalphond left off with Dr. Freeland and ask Dr. Sinyor and Dr. Black for their comments regarding the expert panel report.

I'll ask Dr. Sinyor first.

**Dr. Mark Sinyor:** Ultimately, with respect, it appears that the expert panel has done their best to provide you with what they think is correct, and they're entitled to their opinion. My response is that, at the outset of their report, they rejected the idea that we need to ensure that the harms don't outweigh the benefits before going forward, and that deeply concerns me. That's not what we do in medicine. We didn't do that, for example, with vaccines. We waited pretty much a whole year after the vaccine was available before administering it to make sure it was safe, because it could have been a disaster if it had been unsafe.

Why not do that in this instance? In that sense, I disagree with them.

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

Go ahead, Dr. Black.

**Dr. Tyler Black:** I think the report was excellent. I read it and I find that I agreed with most of it. I found it was a pretty good summary of the expertise we currently have on the issue.

**The Joint Chair (Hon. Yonah Martin):** Thank you to all of you once again for your comments and expertise.

It's back to you, Mr. Joint Chair.

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

Thank you to all of the witnesses. We will be getting ready for our next session, but I wanted to thank you on behalf of all of the committee members for your expert testimony today, for being very candid with us, for your opening comments and for answering our questions on what is a challenging file that we take very seriously.

Your input as experts is very highly valued. Thank you very much for taking the time in your busy schedules to be with us today.

With that, we'll suspend this panel. As you know, members, we have to provide a break at this point for our interpreters and others, so we will resume with testimony from Dr. Gupta at 4:30 this afternoon.

Thank you all. This meeting is temporarily suspended.

• (1550) \_\_\_\_\_ (Pause) \_\_\_\_\_

• (1630)

**The Joint Chair (Hon. Yonah Martin):** Welcome back, colleagues.

We now have a very special panel for one and a half hours. We have the chair of the expert panel on MAID and mental illness, Dr. Mona Gupta. I'm not sure if there are others accompanying her, but I see her online.

This panel will be one and a half hours in length. Therefore, the format will be slightly different from our usual format. Following Dr. Gupta's opening statement of five minutes.... Actually, I misspoke. We will be going back to our original round of questions. We have never been able to get to round two, as you know. We'll be doing round one with MPs and senators, and then the second round with three minutes for both Conservatives and Liberals and two minutes for Bloc Québécois and NDP. We have never gotten to the second round, but because we have one and a half hours, we'll be able to do the full order.

Dr. Gupta, we welcome you and the expertise that you bring to the table. You have five minutes to address our committee. The floor is yours.

[*Translation*]

**Dr. Mona Gupta (Associate Clinical Professor, Expert Panel on MAID and Mental Illness):** Thank you, Madam Chair.

I am pleased to appear before you to represent the Expert Panel for MAID and Mental Illness, which was created under Bill C-7 and whose final report was tabled in Parliament on May 13, 2022.

I am a psychiatrist and regular researcher in philosophy and ethics of psychiatry at the Centre Hospitalier de l'Université de Montréal. In my clinical practice, I work in the area of consultation-liaison psychiatry, the subspecialty devoted to the psychiatric care of the medically ill. I have also been involved in cases of persons requesting MAID, primarily as a psychiatric consultant and sometimes as an assessor.

In these opening remarks, I will provide a brief overview of the reasoning behind the panel's recommendations. I can elaborate up-

on this reasoning in more detail during the discussion period as needed.

Just a quick note about terms: although our mandate used the expression "mental illness", we chose to use the term "mental disorder" since this is standard terminology in medicine. Hereafter, I will use the expression "mental disorder".

Our mandate was to make recommendations for safeguards, protocols and guidance for MAID requests made by persons with mental disorders, not to debate whether such persons should be permitted to have access. Nevertheless, we took the concerns raised by those who are opposed to this practice very seriously. By these concerns, which are addressed in the report, I mean incurability of a medical condition, irreversibility of decline, capacity, suicidality and vulnerability.

[*English*]

As we undertook our work, our first observation was that people with mental disorders are requesting and accessing MAID now. This group includes a range of requesters, from people whose mental disorder is stable, to those whose psychiatric and physical problems are active and together motivate the request for MAID, all the way to those whose requests are largely motivated by their mental disorder but who happen to have another qualifying condition. These requesters may have long histories of suicidality. There may be questions about their decision-making capacity. They may also be in situations of structural vulnerability.

A second and related observation the panel made is that there are people requesting and accessing MAID now whose medical conditions are difficult to assess with respect to incurability and irreversibility in decline—for example, some requesters with chronic pain.

Based on these observations, the panel concluded that there is no single characteristic 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. That is why the panel's approach is to try to address these problems head-on.

When we looked carefully at the concerns raised about MAID for mental disorders, we found that they were clinical in nature, meaning that the difficulties arise when clinicians have to apply legal terms to MAID assessments—for example, interpreting the word “incurability” for a particular medical condition or assessing chronic suicidality.

• (1635)

What seems to be required to address these concerns is greater elaboration about the applicability of the eligibility criteria and the best approaches to adopt in assessing specific challenging issues in clinical practice. The panel has tried to provide this elaboration and specification in our recommendations.

This process of elaborating and specifying has also allowed the panel to clarify that, in order for a mental disorder to be a grievous and irremediable medical condition in the sense of the Criminal Code, it must be of long standing and the person must have had an extensive history of treatment and social supports. MAID is not intended for people in crisis or those who have not had access to health and social resources.

With that, I will stop. I would be very glad to continue on in discussion with you.

**The Joint Chair (Hon. Yonah Martin):** Thank you very much, Dr. Gupta.

We will begin round one with Mr. Cooper.

Mr. Cooper, you have five minutes.

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

Thank you, Dr. Gupta, for being here.

I note that on page 21 of your report, it says that a “consensus-seeking approach was adopted” during the panel's deliberations and that the authors had reached “unanimity” in the recommendations. I would note that's not entirely true, as two members of your panel resigned. Isn't that correct?

**Dr. Mona Gupta:** It's true in the sense that they were no longer members. The authors of the report supported the report unanimously.

**Mr. Michael Cooper:** Can you elaborate on why those two members resigned or left the expert panel?

**Dr. Mona Gupta:** Sure. My understanding is that the panel was selected and appointed by both ministers. They sought to ensure that there was a range of views represented amongst the panel membership, including members who had publicly stated that they were opposed to the practice of MAID for mental disorders. As we started working on the report and the recommendations, one member, despite her initial willingness to participate, realized that, given her public opposition, she could not reconcile her personal position with the work of the panel, given its mandate. That was one resignation that occurred in December.

The second resignation occurred at the end of the panel process, at the end of April. Actually, I don't have information about the specifics of why the person chose to resign, but they sent a letter saying that they were resigning their membership.

**Mr. Michael Cooper:** Thank you for that. Also page 21 of the report confirms that there was no stakeholder or expert consultation. I recognize that the report elaborates that there was some very limited consultation. That is correct; is it not?

**Dr. Mona Gupta:** Our mandate was not to do consultation, but what we did have to do was to try to go out and get some information that was not available otherwise in the public domain. Yes, we elaborated on that in the report. You're correct.

• (1640)

**Mr. Michael Cooper:** And that—

**The Joint Chair (Hon. Yonah Martin):** I'm sorry, but may I just interject? There's a note for Dr. Gupta.

Would you raise your microphone a little bit higher, please? It's for the interpreters.

[*Translation*]

**Dr. Mona Gupta:** All right.

[*English*]

**The Joint Chair (Hon. Yonah Martin):** I've paused your time, Mr. Cooper. You may continue.

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

There was no stakeholder or expert consultation and no consultation with indigenous communities. Is that correct?

**Dr. Mona Gupta:** Again, our mandate was not to do consultations through an expert panel, and the panel was appointed with the requisite expertise on the panel to do the work. That said, three members of the panel do identify as indigenous and, therefore, were able to guide us and had sensibilities that we were able to happily take advantage of in reflecting on those issues.

**Mr. Michael Cooper:** Would you concede that the absence of stakeholder and expert consultations, which I recognize was not part of the mandate, diminishes the weight that should be attached to the findings of the report? Surely you would concede that it would be important in terms of coming up with recommendations.

**Dr. Mona Gupta:** I don't know if “concede” is the right word. I think we were given a task to do as an expert panel and, as I said, I believe the panel was constituted with the requisite expertise amongst the membership when we did that task. Stakeholder consultation, I think, provides a different kind of information that is also valuable, and if the government wishes to pursue that and obtain that, I'm sure that will contribute valuable information as well.

**Mr. Michael Cooper:** Changing gears, are you aware of any study on the reliability of physicians predicting irremediability?

**Dr. Mona Gupta:** By reliability do you mean that, if a number of physicians assess the same patient, they will come to the same decision?

**Mr. Michael Cooper:** Yes, or are you aware, more broadly, of any studies on predicting irremediability?

**Dr. Mona Gupta:** You mean studies about reliability of assessments and then studies about prediction.

**Mr. Michael Cooper:** Exactly.

**Dr. Mona Gupta:** I am not aware of studies about predicting irremediability. Irremediability isn't a clinical term; it's a legal term. One of the things the panel tried to do was to give it some clinical flesh, if you will, and put it in terms that clinicians can understand.

I'm going to just modify your question slightly, if you'll let me, and say there are studies about predicting, for example, treatment resistance. That's a term that would be more familiar in psychiatry, for example, amongst people with a certain condition who have had certain kinds of treatments. For example, when we do research on treatment resistance, we certainly identify subjects to enrol in those studies, so you could say, yes, the researchers—clinicians often—who recruit patients for those studies come to agreement on who are treatment-resistant patients and who are not.

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

Next we will have Monsieur Arseneault for five minutes.

[*Translation*]

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

Welcome, Ms. Gupta.

Thank you for providing all that information, as chair of the Expert Panel on MAID and Mental Illness.

The people before you today are members and senators. At the end of the day, we are lawmakers who don't have all of your psychiatric expertise.

Our focus is whether to permit medical assistance in dying when mental illness is the sole underlying condition. I don't know what the split among psychiatrists is on the issue, but we have heard arguments at both ends of the spectrum from members of the profession.

That said, there seems to be a consensus within the profession that it is indeed possible to distinguish between a person who has suicidal tendencies and a person who does not, even if that person is suffering solely from mental illness. Do I have that right?

**Dr. Mona Gupta:** That is interesting. As you have already heard from the other witnesses, there is debate in the scientific documentation as to whether the desire for MAID is the same thing as being suicidal. Some say it is, others say it is not. In the report, we noted this difference of opinion in the scientific documentation. Setting aside my role as panel chair, I would like to talk about my own work as a researcher in our research group. I will not analyze the question that way, that is, by trying to determine whether one can make a distinction between these two states of mind. I will ask instead if we know how to respond when we deem someone at risk for suicide and when that is not the case.

To answer your question, I will draw on other areas of medicine. For instance, some patients make choices that will certainly lead to the end of their lives, such as stopping treatment. Should all those

patients be considered suicidal, hospitalized against their wishes, and forced to continue their treatment? In some cases yes, in others no. On which principles and practices should we rely in making those decisions?

Returning to my role as panel chair, we use these same principles and practices to evaluate a person requesting MAID. Should we take action, even if it is against the patient's wishes, or rather should we assess their ability to make that decision?

• (1645)

**Mr. René Arseneault:** Okay.

**Dr. Mona Gupta:** That is how we approach it.

**Mr. René Arseneault:** That is interesting because it leads me to the issue of what is irremediable. Among psychiatrists, those opposed to MAID often say that we cannot define irremediable in the case of mental disorders. It seems that is not possible in psychiatry. In your presentation, however, you said that someone suffering from long-standing mental disorders who has received all the necessary help would be eligible for MAID.

I would point out that this is related to the Supreme Court decision in Carter, which launched MAID in Canada. The Supreme Court noted that “the term ‘irremediable’ does not mean that the patient must undergo treatments that he considers unacceptable”.

As a lawyer, I wonder how we can reconcile this recommendation from the Supreme Court with the field of psychiatry.

**Dr. Mona Gupta:** Okay.

Your question touches on various aspects. I will try to answer it as best I can.

First of all, the panel's position is that the term “irremediable” is not a clinical term. It is a term found in the Criminal Code that is based on three sub-criteria: the incurability of the condition, advanced and irreversible decline in capability, and suffering. All of these terms have a clinical meaning. So we can try to understand these terms and define them in a way that is meaningful to clinicians and that is consistent with what we do in our practice and the treatments patients receive.

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. That is why, in the report, the panel tried to offer a definition of an “incurable illness” for mental disorders that would be meaningful in a clinical context.

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. This relates to your comment about the decision in Carter.

As Dr. Maher said earlier, we will certainly not force people who are fully competent to do things that are unacceptable to them. Equally, if I note that someone has an incurable illness, how do I proceed if the patient has not tried any treatments? How many treatments do we have to try? It depends on what the clinician and the patient have negotiated.

**Mr. René Arseneault:** Thank you.

[English]

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

We will now go for five minutes to Mr. Thériault.

[Translation]

**Mr. Luc Thériault:** Thank you, Madam Chair.

Thank you for being here, Dr. Gupta.

I read your report with interest a number of times, and I would like to share my chief concern.

I thought your mandate would include the broadening or banning of MAID in cases where a mental disorder is the only medical problem involved. Why was that not part of your mandate? I understand that you worked from the assumption that this broadening was necessary, and that you sought to determine how to proceed.

If you could answer briefly, please, because I have several more questions for you. Why was that not part of your mandate? Were you surprised by that?

• (1650)

**Dr. Mona Gupta:** I will answer fairly quickly to save on your speaking time. I think this should be a question for the government, because that is where our mandate came from.

I assume that is because that access is already included in bill C-7, effective March 2023.

**Mr. Luc Thériault:** In the review of the act, however, we had to determine whether to apply the sunset clause or whether that option should be entirely removed. I think it would have been helpful for the expert panel on mental illness to have that discussion. As a result, Quebec cannot proceed. If it did proceed, it would probably have application problems on the ground. We shall see what happens.

According to the Canadian Psychiatric Association, and based on your report, to determine that a person with a mental disorder meets the incurability criterion, three criteria must be considered: the chronic nature of the condition, the scope of previous treatment attempts and thus the effectiveness of treatments, and the person's refusal of treatment. I assume you have to evaluate whether there

have been repeated refusals or refusals that have affected the required assessment.

Some people say there are no incurable mental disorders, under any circumstances. Clearly, that is not what you are saying. Nonetheless, all patients have the right to refuse treatment. What role does that right play in your assessment of whether a person meets the incurability criterion? In the case of a patient who has refused or refuses treatment, can one conclude that the person has not done what is necessary to be cared for? In that case, would the patient not be eligible?

In some instances, it is said that a mental disorder is incurable. That also entails some suffering.

**Dr. Mona Gupta:** Thank you very much for your question.

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.

**Mr. Luc Thériault:** Thank you.

I have a fear related to the reliability of the assessment process. I do not think there are a lot of psychiatrists who are assessors or MAID providers in Quebec. There are family medicine providers who are trained to do the assessment, but I know full well that some are very opposed to expanding MAID to persons suffering from a mental disorder alone. You said it takes at least one assessor with expertise in the "condition". Can you tell me what "the condition" means?

As well, the assessor with expertise in "the condition" has to be a psychiatrist who is independent from the treatment team and provider—and we already have problems with access to psychiatrists. Could you please explain.

Are all the criteria set out in recommendations 10, 11 and 12 realistic?

[English]

**The Joint Chair (Hon. Yonah Martin):** Be very brief, Dr. Gupta.

[Translation]

**Mr. Luc Thériault:** Will we be ready on March 17, 2023?

• (1655)

**Dr. Mona Gupta:** I will answer briefly, but we can come back to this.

I think it is feasible. Right now, when a person with a complex illness requests MAID, we seek the opinion of specialists.

Let me give another example, to which we can draw a parallel.

In the case of evaluations for institutional commitment, the law requires the opinion of two psychiatrists, not just one psychiatrist, regardless of whether it is during the day, during the week, or on the weekend, and we make sure that is done. Those patients are ill and are the most vulnerable. In my opinion, we can create a structure that will properly accommodate their request.

[English]

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

Next we will have Mr. MacGregor to finish off this first round.

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

Dr. Gupta, thank you so very much for joining our committee today and helping guide us through some very difficult issues. I appreciate the report that we now have to refer to as we commence our study.

I've been a member of Parliament since 2015 now. I was there for the Bill C-14 and Bill C-7 debates. For me, the problem with this whole process is that it seems, with the amendments that were made by the Senate to C-7, which effectively are going to allow for mental illness as an underlying condition by March of next year, it's also a situation where we've put the cart before the horse. We're involved in this very in-depth study, but we're working with an impending deadline that is now less than a year away. You've talked a lot about the fact that we need to make sure every option is available.

Before I get to supplementary questions, though, my first question to you is this: What was it like for the expert review panel working under the knowledge that you had this deadline? Did you feel a sense of pressure? How did that inform your work, knowing that in March of next year this is now going to be a part of the Criminal Code and allowed?

**Dr. Mona Gupta:** Thanks so much for the question. I appreciate the opportunity to have a chance to discuss these issues with you.

I think it was Dr. Wiebe earlier today who talked about the commonality between chronic physical conditions and chronic psychiatric conditions, so I think I would start my answer there by saying that it was not so much the March 2023 legislative deadline that put pressure, because I think that we see a lot more commonality between psychiatric disorders and physical disorders, as I said in my opening remarks, which are already being structured under the track two safeguards. Our task was really to say, let's take a look at these safeguards. Are they doing the work that we want them to do in situations of mental disorder as a sole underlying medical condition?

I think the pressure is about wanting to respond in good faith to the concerns that have been raised, which we also shared and took seriously, and to produce something that would work for patients, for families and for practitioners and not just specialists in cities but people who are living in rural or remote areas, where access may be very different from in cities, and for people living in all kinds of circumstances. I think it was inherent to the exercise. That was the pressure.

**Mr. Alistair MacGregor:** Thank you for that.

In your interventions with some of my other colleagues on this committee, you were talking about our really having to make sure we have resources in there so that patients can avail themselves of every option for treatment. Certainly in previous testimony, we've heard of "groundbreaking research" that's going on with psilocybin as a potential therapeutic intervention to help guide people through mental health problems. I know it's still in its infancy.

I realize that, for future patients who are accessing MAID, there will be the safeguards in place. They will have to have an extensive history. I guess my concern is that I look around in my own community and I see so many people who are living on the street in obvious mental distress. I keep wondering—if they had had early interventions, could that have prevented them from getting to a state where it became so bad that they didn't see a way of pulling out?

I know the Government of Canada has made some commitments to a big mental health strategy, but can you maybe just talk a little bit about how much more is needed to really fill in the gaps? The last two years, especially, have really highlighted this issue in many communities like mine.

• (1700)

**Dr. Mona Gupta:** That's a really good and big question. I want to start by saying that I'm by no means an expert in the administration of mental health services or financing of mental health services.

To connect your question to the topic that we're addressing today, I think we want to be thoughtful of the fact that mental disorders are not a homogeneous group of people. There are subgroups. Quite often in the public and policy debate about MAID, we conflate people with severe conditions who have been ill for decades, who have had a lot of treatment and a lot of follow-up with people who can't get access to first-line resources during times of distress, times of personal difficulty or perhaps at the beginning of a condition when they're not that severely unwell.

I don't think that responds fully to what you're saying, but thinking about what's needed to fill the gaps has to think about these difference subgroups because I think their service needs are quite different. I know it's not popular to say, but I'm going to say it anyway. There are patients in Canada who get excellent care. I'm sure that Dr. Sinyor's patients at a tertiary-level centre in Toronto and Dr. Maher's patients get excellent care.

Part of the problem is homing in on where the deficiencies are and recognizing that it's probably not just a big mental health strategy with a big spend that's needed, but really targeted funding for very different kinds of services for different subgroups.

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

I'll now pass this over to our joint chair, Mr. Garneau.

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

We're now going to do a senator round, each for three minutes.

Just before that, Dr. Gupta, your microphone has sloped down a bit. It causes popping, so to minimize that—I know it's hard to keep it in the same place—if you could lift it up a couple of inches, that would be great.

We'll start off with Senator Mégie.

[*Translation*]

Senator Mégie, you have the floor for three minutes.

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

Ms. Gupta, thank you for being with us today.

I have reviewed the recommendations from the expert panel. Recommendation 16 pertains to prospective oversight, recommendation 18 to data collection, and recommendation 19 to periodic research.

In your opinion, how could the federal government go about this?

Should there be committees responsible for prospective oversight and data collection? The research would be done periodically. What would those periods be?

How could it all be coordinated?

**Dr. Mona Gupta:** Thank you very much for your question.

I think there are various ways of going about it. Research could be centralized at the three offices of the National Research Council of Canada. Calls for proposals could be issued for projects that are open or on specific topics.

That research could be linked to the data collected by Health Canada. In the report, we proposed that the new variables be incorporated into the current oversight system. In the Netherlands, the research is already linked with data collection. To date, the system in Canada has focused more on calls for proposals for projects that are open or on specific topics. So I think there are various ways of going about it.

We say prospective oversight, but oversight falls under provincial jurisdiction. That is how it stands for the time being. I think the

federal government could play a coordination role to ensure that the provinces and territories can develop prospective oversight systems. In the report, we noted that this was a request from psychiatrists. That kind of oversight system would allow them to do their jobs well and have a broader view. It would ensure that they have done their assessments correctly, given the complexities.

**Hon. Marie-Françoise Mégie:** Thank you.

Mr. Chair, do I have time for a quick question?

**The Joint Chair (Hon. Marc Garneau):** You have 45 seconds left, Ms. Mégie.

**Hon. Marie-Françoise Mégie:** Dr. Gupta, do you have any final advice for the committee? Do you have any comment to make after all this work?

**Dr. Mona Gupta:** I would like to be able to call a friend. That is what participants on a television show do.

If I may, I will think about your question and provide an answer later on.

• (1705)

**Hon. Marie-Françoise Mégie:** Okay.

**Dr. Mona Gupta:** Thank you.

**The Joint Chair (Hon. Marc Garneau):** Very well.

[*English*]

We'll now go to Senator Kutcher for three minutes.

**Hon. Stan Kutcher:** Thank you very much, Chair.

Thank you, Dr. Gupta, for your thoughtful and well-considered testimony.

I noticed in the report that you made suggestions that will not only provide solid safeguards for individuals seeking MAID for solely a mental illness, but also for all people seeking MAID.

Do you think your report would make a substantive contribution to the practice of MAID in general in Canada?

**Dr. Mona Gupta:** Thank you for the question.

We were mindful of the fact that it wasn't our place to take on many different new mandates. At the same time, and as I tried to present in my opening remarks, our analysis took us there, because the things that people are worried about in the practice of MAID are not unique to mental disorders. We were a bit stuck and said that these things are really important but they are not just important for people with mental disorders. These recommendations are important any time you're concerned about the incurability of a condition.

This is an approach. Any time you're concerned about suicidality, here's an approach and a way to think about it. I hope that our recommendations will be considered to be useful in track two, and even in track one. Suicidality exists in track one, and questions about capacity exist in track one as well.

Thank you for the question, and, yes, that was our hope as a panel.

**Hon. Stan Kutcher:** Thank you for that.

Specifically, it's fascinating that Senator Mégie, who is also a physician, homed in on the same three things that I'm going to ask you about right now: the national framework for protective oversight, the framework for case review, and the importance of the ministry of health adding the additional research components that you put into your report.

Would you agree that the Minister of Health could actually start putting those in right now?

Then second, for the other two, protective oversight and the case review, do you think it would be feasible for the federal government to convene provincial and territorial governments and the other appropriate stakeholders to start moving that ahead immediately?

**Dr. Mona Gupta:** I think data collection and research are things that fall squarely within the competence of the federal government. Other governments, as well, can do those things, but the federal government is doing them now and can take on those recommendations if it wishes.

As for case review and perspective, we recognize this is something that has to be done in collaboration between the federal government and the provincial and territorial governments. We'd like to see the federal government take a leadership role, exactly as you said, in convening the relevant parties to work on that, and it might be that there are different ways of approaching case review and perspective oversight in different provinces.

I don't think the panel has a view on whether they need to be exactly the same. But that the principles we have articulated be put in place.

**Hon. Stan Kutcher:** Thank you very much.

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

[*Translation*]

Senator Dalphond, you have the floor.

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

Dr. Gupta, thank you for your participation, and in particular for having chaired a group that issued such an important report.

The chair of Canadian Psychiatric Association appeared just before you. You may have listened to her. In order to improve your report, she said that national standards would have to be established that would apply to all psychiatrists and other assessors taking part in the process. Psychiatrists will be taking part in the process because at least one of the two assessors has to be an expert.

Do you think it is possible to create national standards or suggestions, national parameters, that would apply, by March 2023?

**Dr. Mona Gupta:** That is a big question.

As you know, health care falls under provincial jurisdiction. I do not think the federal government can decide for the provinces how they should approach MAID or tell clinicians across the country how they should go about it.

That said, I think there is already a national organization, the Canadian association of MAID assessors and providers, or CAM-PAP, that plays a leading role by publishing various background documents, clinical guidelines, and so forth. The association is currently conducting a project on practice standards, guidelines, and best practices for MAID.

In practice, clinicians will turn to this kind of training and documentation to be familiar with the details of what they have to do every day. Even if it were possible for the federal government to work with the provinces and magically create a national system, I do not think this is the area in which clinicians need help and directives. Rather, I think they need to know what to do, and how to assess a given thing. That is in the hands of national organizations in any case.

Yes, I think it is possible. I think the national training program will be offered this fall. Work on this is already well advanced.

• (1710)

**Hon. Pierre Dalphond:** Do you think support from the professional bodies would make it possible to standardize all of this?

There are already various national medical standards.

**Dr. Mona Gupta:** Yes, indeed.

I do not share the opinion of my colleague, Dr. Wiebe. I think the regulatory bodies have a special and important role to play.

Quebec's college of physicians has really become a leader in this regard. The beauty of a regulatory body is that all clinicians have to be members and the advice provided is mandatory.

I understand that their role is somewhat different in other provinces, but I think that if they approve training, that gives the members an important signal that they have to follow the training created and that they cannot do it informally on their own.

**Hon. Pierre Dalphond:** Thank you.

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

[*English*]

We'll now go to Senator Wallin.

**The Joint Chair (Hon. Yonah Martin):** Was it for me?

**The Joint Chair (Hon. Marc Garneau):** The order doesn't matter that much, but it was for Senator Wallin. Perhaps I didn't say it clearly enough.

I'm assuming Senator Wallin is still with us. I'm not hearing anything.

Why don't you go ahead, Senator Martin?

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

Dr. Gupta, I'm also quite concerned about the consistent policies and standards for our country. At the same time, I'm mindful of the differences between rural and urban Canada and specifically the indigenous peoples, Métis and Inuit. There are cultural differences.

I'm trying to understand how, with a March 23 deadline, we can prepare for all of these different groups based on this consistent standard and policy. Would you speak a bit more about how we will achieve this?

**Dr. Mona Gupta:** Thank you. That's an excellent question.

In recommending what we did with respect to consultation, we really took to heart the advice provided to us by our three members of indigenous identity. While they believe that there are many members of indigenous communities who are supportive of MAID and who, as individuals, may wish in the future to either access MAID or support their family members in accessing MAID, they also recognize that it is important that these consultations occur. This is something they've been expecting, in fact, since MAID was first permitted, and it ought to be made good on.

What are the best mechanisms to achieve that? Where we landed was that this ought to happen at a provincial level, perhaps with the collaboration and leadership of the federal government. Because the communities are very different, having a single kind of indigenous, pan-Canadian consultation wouldn't necessarily work or reflect the important differences and nuances between the many indigenous communities that are out there.

Whether it can be done in a way that would respect the March deadline, I think it's for those communities to express themselves on that.

**The Joint Chair (Hon. Yonah Martin):** The question is, how do we do that? How do these communities find the resources to be able to do that?

In your report at page 35, it says, "As a result of the creation of laws that provide access to MAiD, concerns have been raised by Indigenous leaders and communities that it is easier for people in their communities to access a way to die than to access the resources they need to live".

Change and improvements on many of the reserves and in the first nations communities are very challenging at best and very slow. I'm really concerned about this deadline. What would you say in response to this specific quote?

• (1715)

**Dr. Mona Gupta:** I think that's something that we need to ask indigenous leaders and indigenous communities. How exactly do they want to move forward with this? I do believe that the Government of Canada is increasingly working in partnership with these

communities, recognizing on a variety of different subjects their leadership and their ability to make decisions for their own communities.

I think it's a very good question that ought to be discussed and those communities ought to be engaged on it.

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

We'll now proceed with round two, which is a shorter round. This is with the MPs, and we'll start with Mr. Stephen Ellis.

You have three minutes.

**Mr. Stephen Ellis (Cumberland—Colchester, CPC):** Excuse me, Mr. Joint Chair, but Senator Wallin didn't have her turn. I don't know if we want to return to her or not, sir.

**Hon. Pamela Wallin:** No, it's fine. I'm having a lot of technical problems so please go ahead.

**The Joint Chair (Hon. Marc Garneau):** Senator Wallin, I'm happy to have you. I looked across all of the screens and I didn't see you so I assumed you were gone.

Would you like your three minutes?

**Hon. Pamela Wallin:** No. Go ahead, please.

**The Joint Chair (Hon. Marc Garneau):** Okay, we'll catch you on the next one.

MP Ellis, you have the microphone for three minutes.

**Mr. Stephen Ellis:** Thank you, Mr. Joint Chair.

Thank you, Dr. Gupta, for being here.

I have a couple of things. Just to paraphrase, I heard you say that patients need to be assured of appropriate treatment and social supports. Certainly we know that we're at a time in Canada when there's a realistic inability to access.... We've heard that from multiple witnesses and certainly I've been a family physician for 26 years, so I've heard that over and over.

How would you characterize in your mind the access to treatment and appropriate social supports for mental disorders in Canada at the current time?

**Dr. Mona Gupta:** Just to make sure that I understand your question, are you asking me if I think people with mental disorders have appropriate access?

**Mr. Stephen Ellis:** To treatment and social supports...that's correct.

**Dr. Mona Gupta:** I'm going to again preface my question by saying my area of expertise is not administration and service provision in mental health. I'm going a bit from my clinical experience and my work on this report and on this topic.

I think it's highly variable. I think there are groups that do not have quick and appropriate access. I see that every day in my practice. Particularly in first-line care, people are waiting a long time for pretty simple things. I see people who have great access to mid-level care, but when they need something subspecialty, it's difficult to get—and the opposite. It depends on where you live in the country, unfortunately.

You see people who actually are quite severely affected and they actually have—that's a good thing, right, the system actually works sometimes—appropriate services that are at a level of intensity that is needed for the care of those folks. I do think it's highly variable. Obviously, like all health care services, it's worse, I think, and access is poorer the farther away you are from urban centres. In urban centres you have lots of providers, but there's a discontinuity there that maybe is less obvious than in rural areas. That's something I experienced when I did locums up north, where there was less provision but it was actually more coherent.

I think there's a lot of variability.

**Mr. Stephen Ellis:** Dr. Gupta, you did talk about the indigenous communities having a variety of ideas around MAID, etc., and that they should be taken individually. Does that also mean then, going along with this line of reasoning, that rural communities that have different access perhaps should have different inputs on how MAID is performed or safeguarded in their communities as well?

**Dr. Mona Gupta:** Yes, I have to assume that in each province, each province with its different geography, east, west, north, south, right, and some are very long, and some are this way, and with different regional characteristics, that there needs to be thought, as there is for all health care services, I would say, about the best way to deploy a service or a practice.

I'm hesitating about the idea that all rural communities will have the same vision about how it should be done. I'm thinking that at the level of provincial planning, working with different rural areas is going to be necessary in order to ensure that service provision is what they want it to be.

For example, I can imagine in some areas, growing on what we were doing during the pandemic, the idea of doing video consultations will be quite welcome. In other rural areas where actually getting there in person might not be so difficult, people might say they actually want to have what I did up north—have locums where people come in and they can see them in person.

I think it's going to be, again, quite variable depending on the region.

• (1720)

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

We'll go to Dr. Fry now.

Dr. Fry, you have three minutes.

**Hon. Hedy Fry:** Thank you very much, Chair.

There are two questions I wanted to ask Dr. Gupta. Thank you for coming and taking this yeoman's duty today to spend all of this time answering our questions.

There are two things. During the course of hearing our witnesses, we have heard something that kept recurring. People said you shouldn't look at establishing incurability based on looking backward at what people's treatments were, what their access was, etc. You should be looking forward at what is the next big cure or what the next thing is, and giving them that kind of hope before you offer MAID. It's saying, "No, let's keep going and look forward to what we have to offer." That's the first question that I'd like to hear a comment on.

The second one is about a point you made in the report. Basically, a lot of people can't.... Witnesses in the hearings tended to take suicide and mental health and conflate them. You clearly said in your report that people do not have suicidal ideation purely because they have a mental health problem. In fact, the majority of people with mental health problems don't express suicidal ideation.

The second piece is that a lot of people with suicidal ideation do not have a mental health problem. Should we conflate those two? Should we see them as separate issues? You are making the point that they are separate issues.

**Dr. Mona Gupta:** Thank you very much for those questions.

I'll start with the second one first. I think that's absolutely right. There's obviously an overlap between mental disorder and suicidality. It can be a symptom of a certain number of psychiatric diagnoses. It is associated with completed suicide, but it is also the case that there are people who are suicidal who do not have a psychiatric diagnosis, so they need to be understood as two separate things.

As I mentioned earlier, there was suicidality in track one. I remember a case in which a man attempted to kill himself because of the severity of his chronic pain. He did not complete suicide and he came back and asked for MAID. I think that case raised very similar questions. Are we basically helping him kill himself? This was not a man with any kind of psychiatric history.

You're absolutely right that they should not be conflated, and suicidality should be treated as its own phenomenon independent of mental disorder. It may be the case that the person has a mental disorder, but we should be just as concerned about suicide in the person who does not have a psychiatric diagnosis as we are in the case of the person who does.

With respect to incurability, I'm going to come back to the technical clinical point that I made earlier, which is that with certain diagnoses, because of what we know about the trajectory of those conditions, the moment the person receives the diagnosis, we have a pretty good idea of how things are going to evolve and we have a greater degree of certainty. With others, particularly what we call chronic medical conditions, at the time the person is diagnosed it's very difficult to know what's going to happen, so they have to try a bunch of things and see what impact that has on their condition.

When we translate that to the MAID situation, if somebody has a chronic condition, the only way we can say something about the severity of their illness is to look back and say, “What has this person done?” It is the case that some people try lots and lots of things and don't get a significant degree of relief or an improvement in their quality of life? Happily, many do.

[*Translation*]

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

[*English*]

**Hon. Hedy Fry:** Thank you.

[*Translation*]

**The Joint Chair (Hon. Marc Garneau):** We will move on to Mr. Thériault now.

Mr. Thériault, you have the floor for two minutes.

**Mr. Luc Thériault:** Thank you, Mr. Chair.

In reading the report, in which each of the recommendations includes precautions, I got the impression that very few people whose only medical problem is a mental disorder would have access to medical assistance in dying.

The Quebec commission that discussed eligibility and non-eligibility for MAID did not reach this conclusion and the bill tabled yesterday excludes this situation entirely.

Given the lack of social consensus or social acceptability related to mental illness, Dr. Gupta, don't you think the March 17, 2023 date is premature?

• (1725)

**Dr. Mona Gupta:** I'd like to say two things about that.

First, it's true that very few people are going to have access to it if we follow our recommendations. At the same time, these are similar recommendations to those of countries where this practice is allowed and where very few people have access to medical assistance in dying. If they have little access to it, it is precisely because there are many treatment options.

We should ensure that people have access to care and services. A minority of people will find themselves at the end of a long and dark journey caused by mental illness, but this could happen if "incurable" were defined that way.

Secondly, with regard to exclusion and the notion of social consensus or acceptability, I hesitate. Sometimes, what is socially acceptable is not the right thing to do. Not long ago, homosexuality was not socially acceptable, whereas driving while intoxicated was socially acceptable.

**Mr. Luc Thériault:** Wait a minute—

**Dr. Mona Gupta:** I think we can challenge the consensus.

**Mr. Luc Thériault:** Wait a second, Dr. Gupta.

There is a commission—

**The Joint Chair (Hon. Marc Garneau):** Mr. Thériault, your time is up.

You will have the opportunity to ask other questions during the next round.

[*English*]

Mr. MacGregor, you have two minutes.

**Mr. Alistair MacGregor:** Thank you.

Dr. Gupta, the conclusion of your report stated, “This report is the beginning of a process, not the end.” You very clearly outlined that the expert panel played a very specific role. It was defined clearly by your terms of reference. As we, as a parliamentary committee, take the baton, so to speak, and carry on with this study, we're grappling with a major role because we're ultimately going to make recommendations to the government as well. We, as legislators, may ultimately play a role in debating a future bill on this.

I don't have much time, so my question to you would be this: Do you have any advice for us on the things that we should be keeping in mind as we continue this study based on the experiences that you had, being so deep in these issues before us?

**Dr. Mona Gupta:** Thanks a lot for the question.

I'm going to take advantage of the question to also answer Senator Mégie's question from earlier about last advice.

I think that I would be really critical about exceptionalizing mental disorders and treating mental disorder as a sole underlying medical condition as some entirely distinct reality from people with comorbid mental and physical disorders or people with other kinds of physical disorders. That would be my advice. The clinical reality does not support that idea.

It's worth noting that, in the small number of countries where this practice is permitted, there are no legislated safeguards that are specific to people with mental disorders as a sole underlying medical condition. The reflection I think has pretty much landed where we've landed in terms of the greater commonality versus difference, particularly when it comes to eligibility.

As for Senator Mégie's question—

**The Joint Chair (Hon. Marc Garneau):** We're at the end of that. Perhaps catch that up later.

**Dr. Mona Gupta:** Okay. I'll catch it up later. I've made a note.

**The Joint Chair (Hon. Marc Garneau):** Just for everybody's information, we'll now go to another round just like the one we've completed—three, three, two and two—and then we'll go to the senators.

We'll begin round number three. I believe it's Mr. Cooper.

You have three minutes.

• (1730)

**Mr. Michael Cooper:** Thank you very much, Mr. Joint Chair.

Dr. Gupta, do you believe that it is an acceptable—

[Translation]

**Mr. Luc Thériault:** Sorry to interrupt, Mr. Cooper.

Mr. Chair, there is no interpretation.

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

[English]

We'll pause for a second here. I'll stop the clock. We appear to have a translation problem.

We will just pause until that's resolved.

[Translation]

**Mr. Luc Thériault:** It's back on, Mr. Chair.

**The Joint Chair (Hon. Marc Garneau):** Very well.

[English]

Mr. Cooper, I had stopped your clock, but you can resume now.

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

Dr. Gupta, do you believe that it is an acceptable risk that persons suffering from mental health issues, who could get better, could prematurely end their lives? Is that an acceptable risk?

**Dr. Mona Gupta:** 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.

That's what we tried to say in the report. Look, we understand there are benefits and risks, but that is what this practice is all about. It's giving the individual that opportunity, given a bunch of conditions and conditions of the law and so on.

**Mr. Michael Cooper:** In short, the answer to my question is, yes, you believe that it is acceptable that people could prematurely end their lives?

**Dr. Mona Gupta:** I think it's acceptable for the individual to make that decision, yes.

**Mr. Michael Cooper:** In your report on page 40, it is stated that "it is difficult, if not impossible, for clinicians to make accurate predictions about the future of an individual patient." How do you square that with the statutory requirement? It seems to be logically inconsistent to say, on the one hand, that it may be impossible to predict and, as you know, in order to satisfy "irremediable", it must be established that the person is suffering from an incurable illness, is in an irreversible state of decline and, of course, is enduring intolerable suffering.

I'm having a real tough time squaring this.

**Dr. Mona Gupta:** Thanks for bringing that up. I think now we're getting into the really interesting details of clinical practice, because you're going to have folks to whom you can't say anything. Maybe the person hasn't had adequate treatment, what they've had you can't figure out from the file or whether their treatment was optimized, etc., or they haven't had proper social supports. You say, look, there's too much uncertainty here. I can't say anything useful here about what's going to happen in this person's course of illness. I'm not going to find this person eligible.

Then there will be other cases where, in fact, the person has had a very long course of treatment, decades of care, high-quality care, and has reached an informed and capable choice that they want to access MAID. I think those two kinds of clinical situations and everything in between complicate things.

We spoke to that in the report.

**Mr. Michael Cooper:** I'm sorry to interrupt—

**Mr. Michael Cooper:** —but based upon what criteria would a MAID assessor make such a determination? Your report doesn't provide any criteria, any specific safeguards. It barely speaks of "on a case-by-case basis" that the physician and the patient—

**Dr. Mona Gupta:** Go ahead.

**The Joint Chair (Hon. Marc Garneau):** Be very quick.

**Mr. Michael Cooper:** —come to a determination on that question of irremediability.

**Dr. Mona Gupta:** The criteria are the criteria that we would use to assess the severity of any chronic condition. They're based on what the person has already had. That's what we do all the time when we have to make determinations, as we mentioned in the report, about long-term disability, for example, or in any other context where psychiatrists and other physicians, in fact, are asked to say something about the person's, say, access to benefits on the basis of being ill, etc. It's based on that same kind of approach.

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

Mr. Maloney, you have three minutes.

**Mr. James Maloney:** Thank you, Mr. Joint Chair.

Just quickly, Dr. Gupta, first of all, let me add my thanks to the long list of those who are grateful for everything that you've done, including being here today.

I just want to pick up on something that Mr. Cooper asked you. He did what lawyers sometimes do. He loaded the question with the answer, and he used the word "prematurely" when he was asking you if you thought it was an acceptable risk for people to prematurely end their lives.

I just want to give you an opportunity to answer that question again, because your answer suggested to me that you were saying it's up to the individual, which is the point you were trying to emphasize, not the premature aspect of his question. Is that fair?

● (1735)

**Dr. Mona Gupta:** Yes, that's fair. I understood the question to mean before they died of whatever they're going to die of if they lived their whole life, so in that sense, it's premature. Yes, it's up to the individual to make a decision, on the basis of the totality of their medical circumstances, whether they have reached that point.

**Mr. James Maloney:** Thank you. That's what I thought.

By that definition of “premature”, you could apply it to many circumstances. I get that. Thank you.

One of your recommendations, of course, was the training of assessors and providers. Do you think this should be a mandatory component of the medical school curriculum?

**Dr. Mona Gupta:** That is a very good question. Let me think about that.

I think probably that learning about assisted dying and end-of-life care more generally should be mandatory, because I think it's something that practically every clinician is going to encounter.

It's still a minority of people who are providing and assessing patients for MAID, so I don't know if medical school is the place where it ought to be mandatory, but perhaps later on in training, when people are developing what their future practice is going to look like, I think that's where something mandatory ought to happen. I do think the idea of training that's very focused on MAID assessment and provision is a worthwhile idea. I don't think it's just enough to learn about the law and then hope that practitioners can figure it out.

**Mr. James Maloney:** Yes, learning about the law is not going to help doctors in practical application, in my view.

I'll take the answer as a partial yes, but maybe the focus should be on continuing education and residency programs, perhaps. Is that a better place to do it?

**Dr. Mona Gupta:** Yes, I think so. There's such a competition in medical school curricula to cram everything into the heads of these poor students in a very short period of time that I think you want to gear training to when people are making career choices.

**Mr. James Maloney:** Thank you.

I think I'm virtually out of time, so I'll stop there.

Thank you, Mr. Joint Chair.

**The Joint Chair (Hon. Marc Garneau):** Thank you, Mr. Maloney.

[Translation]

Mr. Thériault, you have the floor for two minutes.

**Dr. Mona Gupta:** I think we'll continue.

**Mr. Luc Thériault:** I interrupted you because my main argument was not about social acceptability. My main point is that we have a deadline of March 17, 2023. We're proposing something new, while there are still people to be trained. A full legislature says it has asked the preliminary question that our committee did not ask. As a legislator, I have to take that into account. This assembly asked the preliminary question and decided not to go ahead, because it found that the experts were divided and that there was not a broad enough consensus, as is the case for other aspects—Quebec has always been a pioneer.

How can we ensure that this is put into practice on the ground? It's difficult to implement a measure in the absence of a clear legal framework. The entire National Assembly of Quebec has spoken out against this. That is my main argument.

I am not saying that I am opposed to everything you say. Your report is excellent, in that it aims to present all the precautions to be taken if this were to happen, but we are not in that situation. Sometimes it's better to take the time to do things correctly.

**Dr. Mona Gupta:** As I said at the beginning, it's important not to make an exception for mental illness and mental disorders. In fact, mental disorders are already being considered as an important component driving the request. Assessors and health care providers already do this. I don't think there's a big lack of training among people already involved in this practice, since these are cases they see.

As for your comment about social acceptability, it's only if you say that everyone has to agree that the deadline will be too difficult to meet. If we say that consensus may not be the right objective to aim for, the deadline could become more realistic.

• (1740)

**Mr. Luc Thériault:** However, the Legislative Assembly unanimously rejects this. That is what will be problematic. That's the discussion I wanted to have with you. Sometimes it's better to have a discussion beforehand—which you haven't done—and take the time to make sure that when it's put into practice, there's consistency on the ground.

**Dr. Mona Gupta:** I understand. As a federal legislator, you're in a difficult position as a result of the Quebec decision. I wish you well.

A lot of study and thought had already gone into this. Our report addresses what appears to be contradictions by offering definitions and ways to unravel some of the problems for which the Quebec commission had no solution in December.

Will it be enough? I don't know.

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

**Dr. Mona Gupta:** I would like to add that the professional orders in Quebec are all in favour of this expansion. So I was a little surprised by Quebec's decision, but I understand that because of the differences, the legislators didn't have much choice.

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

[English]

Mr. MacGregor, it's over to you for two minutes.

**Mr. Alistair MacGregor:** Thank you, Mr. Joint Chair.

Dr. Gupta, I think you were in the process, during my last intervention, of providing an answer to Senator Mégie's previous question. If you'd like to take some time to get that on the record, you can go ahead.

**Dr. Mona Gupta:** Thank you so much.

My answer is actually not that long or complicated. The question she asked was what my final reflection was after having done all of this work.

I recognize that it's difficult and that these issues are complicated, so we sort of have two choices. One is to say this is too complicated, and we're going to avoid it. The other is to say this is complicated, and let's bring our best resources to bear on it and let's try to come to ground. That's what we did as a panel. There were plenty of divergent views on our panel, but let's try to come to ground on something that makes sense for patients and families.

I am confident that this group will continue to do its good work. I hope, and my advice to you is, that you not avoid the hard issues because they're hard.

**Mr. Alistair MacGregor:** It's safe to say that, with the subject matter before us, that is impossible. It seems that at every meeting we're right into it.

I'll close off with the time I have to thank you again for joining us. We do appreciate your testimony today. Thank you.

**Dr. Mona Gupta:** Thank you.

**The Joint Chair (Hon. Marc Garneau):** Thank you, Mr MacGregor.

We'll now go to a round with the senators of three minutes each. We'll begin with Senator Mégie.

[*Translation*]

Senator Mégie, you have three minutes.

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

I'd like to discuss the concept of patient autonomy with Dr. Gupta.

Respect for the patient's autonomy is the basis of the decisions to be made when requesting medical assistance in dying. If this autonomy is limited by several types of factors, such as the lack of family or professional support, for example, are there tools available to health professionals—in this case psychiatrists—that would make it possible to accurately and objectively assess the degree of autonomy of the patient when that person decides to request medical assistance in dying?

**Dr. Mona Gupta:** Does your question concern situations where autonomy is diminished or compromised?

**Hon. Marie-Françoise Mégie:** I'm talking about situations that may impede or limit the patient's ability to make a choice.

**Dr. Mona Gupta:** Okay.

The main tool is the fitness criteria that we use in clinical practice in Quebec and in Nova Scotia. We also use the Applebaum criteria, which are complementary.

As you probably know, there's also a movement coming out of the United Nations to respect people's wishes, even when they have a mental disability. We talk about supported decision-making in the report. We didn't want to go too far because this is an issue that requires a lot more thought.

There is legislative reform in Quebec. There is already legislation in British Columbia, and I believe in Alberta as well, where they are putting in place structures for supported decision-making for patients with limited autonomy. This is somewhat the current trend.

It's part of the broader trend of no longer telling people that because they're not capable of making decisions, you force them to do things or you give someone else the right to decide for them.

At this stage, we haven't gone too far. We see that legislative initiatives have already been taken across the country. That being said, that's why we've recommended that data be collected on this.

● (1745)

**Hon. Marie-Françoise Mégie:** Thank you.

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

Senator Kutcher has the floor now.

[*English*]

**Hon. Stan Kutcher:** Thank you very much, Mr. Chair.

Dr. Gupta, earlier today we heard some inflammatory testimony that said MAID is actually a licence to kill. In your report you said that, if there's uncertainty in either capacity assessment or suicidality, the answer is no, you don't proceed with MAID. It seems that your standards have actually been created to ensure that MAID is done in a thoughtful, comprehensive and methodological way that puts the safety of the person at its core.

Am I reading your report correctly?

**Dr. Mona Gupta:** I'm delighted that you read that because, yes, it is exactly what we were aiming for. The folks that you heard from were all clinicians, all colleagues, and we share those concerns. None of us wants to see a situation.... No clinician takes pleasure in the idea that a patient would ever get to that stage, and no clinician wants to encourage a patient to give up hope in the possibility of being well or living better.

Absolutely, we have those worries front of mind the entire time. How could we ensure that the only people to have access would be those who have really had a very significant history of disease and treatment and have really been very thoughtful about this wish at this point in their lives? That was our priority.

**Hon. Stan Kutcher:** Thank you for that.

We've also heard testimony that may have created confusion in our minds. I've written this down because it's complicated. The testimony suggested that people who have been accepted for MAID for a mental illness—including those who are comorbid, who have a mental illness and a physical illness at the same time, and who are currently acceptable—have not received substantial amounts of treatment and, therefore, MAID should never be provided to those individuals.

Can you help us through this conundrum? Maybe talk about what kinds of treatment processes, what duration of illness and what kinds of things a MAID assessor would have to look at, not just for mental illness but also for comorbid mental illness—a mental illness and a physical illness at the same time.

**Dr. Mona Gupta:** It's highly variable. It's going to depend on the condition and the treatment options available and so on. Generally speaking in psychiatry, for mental disorders, whether there's a co-morbid physical condition or not is almost irrelevant really, but there are treatments that require a lot of time and patience and follow-up care and a lot of changes. Even with regard to the very first medication you prescribe someone, strictly speaking, according to the research, you wouldn't say there's been a treatment failure until three months have gone by—and that's the first one, not to mention the second, third, fourth and fifth ones that people try, and then all of the combinations that people try and then all of the neurostimulatory treatments that are accessible.

When we talk about standard treatment, we're really talking about years—years of trials of different things. That's the kind of treatment history that I think MAID assessors are looking for, whether it's a chronic mental disorder or a chronic physical disorder. Quite frankly, in Crohn's disease, epilepsy and rheumatoid arthritis, you're looking at exactly the same kinds of things: What kinds of care has the person had? What kind of follow-up? What subspecialty opinions have they had? Have they had novel treatments, etc.? It's a very similar kind of thinking.

• (1750)

**Hon. Stan Kutcher:** Thank you.

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

[Translation]

Senator Dalphond [*Technical difficulty—Editor*].

**Dr. Mona Gupta:** Mr. Chair, I can't hear the senator.

**The Joint Chair (Hon. Marc Garneau):** Senator Dalphond, we can't hear you.

[English]

Perhaps Senator Dalphond has had to step out for a minute.

**The Joint Clerk (Ms. Andrea Mugny):** I see that Senator Dalphond is in the Zoom meeting. However, his microphone does not seem to be working at this time.

[Translation]

Senator Dalphond, I suggest—

**Hon. Pierre Dalphond:** Can you hear me?

**The Joint Chair (Hon. Marc Garneau):** Yes, we can hear you now.

**Hon. Pierre Dalphond:** I unplugged and plugged my headphones back in. It seems to be working.

**The Joint Chair (Hon. Marc Garneau):** The floor is yours, Senator.

Senator Dalphond, we can't hear you once again.

[English]

**The Joint Chair (Hon. Yonah Martin):** He seems to be frozen, Mr. Chair.

**The Joint Chair (Hon. Marc Garneau):** We'll just temporarily go to the next senator and come back to Senator Dalphond later.

Senator Wallin, if you're ready, you have three minutes.

**Hon. Pamela Wallin:** Thank you very much, Chair.

My questions or comments are for Ms. Gupta. I would just like to hear you express your views on these.

First, do you believe there is any real threat to a minority or a disabled community, a religious community or those with social constraints from the access to MAID legislation that exists?

My second question is this, and then you can judge your time. You have challenged all of us to do the hard work. I think that if we did not take up the complicated issues as legislators, we know that in this country we would not have medicare or railways or a constitution or energy or food. I know we need clarity for doctors and for citizens and patients. What is the most important thing that we must do as this committee?

**Dr. Mona Gupta:** Can I just clarify? Do you mean with respect to MAID for mental disorders?

**Hon. Pamela Wallin:** Yes, and I mean in the broader context, if you wish, please.

**Dr. Mona Gupta:** With respect to the question of threat, I don't know. I don't know what's going to happen. I can't promise you that there isn't going to be some impact on some of the other groups because that remains to be seen. That is not what we have learned from the countries that permit this practice, so to the extent that we can base ourselves on that, it seems like it's not very likely.

Actually, it's a credit to communities that have raised these worries. The disability community in particular, I think, has sensitized everyone in this debate to be mindful of the threats to well-being and to quality of life, and that MAID assessors and providers need to remember that, be sensitized to that and to take that into consideration.

Actually, they need to keep going in their efforts to sensitize us to their lived reality. I think that work has actually been invaluable. You will notice in the development of the CAMAP curriculum that this actually has led to the incorporation of people with lived experience, people with disabilities, etc., so that MAID assessors and providers are going to learn from their experiences. That would be my answer to that.

With respect to your second point, it's generous of you to ask for my opinion on that. The thing that has troubled me throughout the debate as I've been following it along is the strands of illogic or incoherence that we can allow MAID for mental disorders when the person has a comorbid physical condition, like somehow that erases their vulnerability or erases their history of suicidality. Now they have a physical condition, so it's okay and they can have access, but if that same person doesn't have the medical condition, they must never have access under any circumstances. There's an inherent illogic there that I have never understood. When somebody has a condition where it's really difficult to predict what's going to happen, they can have access as long as it's not a mental disorder. This illogic is concerning to me, and I would encourage you to find a solution to this illogic. I think there are different ways of doing that.

It worries me because it suggests that as a society we don't believe that people with mental disorders can really ever be capable of making their own decisions for themselves. I think we've really fought hard against that for a long time, so I am surprised.

I absolutely understand the arguments about lack of resources. To me, it's not a choice that we have MAID or we have better resources. We need to have better resources—period—but that's not a reason not to have MAID.

• (1755)

**The Joint Chair (Hon. Marc Garneau):** Thank you, Dr. Gupta.

[*Translation*]

I see that Senator Dalphond is back.

You have the floor for three minutes, Senator Dalphond.

[*English*]

**Hon. Pierre Dalphond:** Thank you.

Dr. Gupta, you said that there are some uncertainties with some of the concepts and that's why your group has come up with a list of recommendations. You said these recommendations are based on the experience in Belgium and the Netherlands. Based on that, you also refer to the fact that very few cases are accepted. Most of them are turned down.

Is it right to reassure people who are listening here that your recommendations are aimed to lead to a denial of the request in cases of uncertainty and, therefore, are designed to protect and, in cases of doubt, not to give access to MAID but rather to deny when there's a doubt?

**Dr. Mona Gupta:** Mr. Chair, you'll be very happy. My answer is very short.

Yes, that is exactly what we're trying to say. Like in all aspects of clinical practice, if you have doubt about the indication of what you're about to do, you do not go forward.

**Hon. Pierre Dalphond:** There's uncertainty with any words in the world, but you're trying to guide the practitioners to remove that uncertainty. If they still have uncertainty, they should say no.

**Dr. Mona Gupta:** Yes. We're not going to remove all uncertainty. Medicine is largely a probabilistic discipline, and we're always making decisions under conditions of uncertainty. There will always be some uncertainty.

The question is, how much is too much? The line shifts with respect to that with time, but when there's too much uncertainty and the practitioners cannot come to ground on whether this condition should be considered incurable along the lines of what we've laid out or the person does not have capacity, then they should not go forward.

**Hon. Pierre Dalphond:** The intent of the report is to err on the safe side, rather than otherwise.

**Dr. Mona Gupta:** Yes, absolutely.

**Hon. Pierre Dalphond:** Thank you.

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

We'll finish off now with Senator Martin. You have three minutes.

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

With what my colleague Senator Dalphond just said, "to err on the safe side," I'm going back to what you and Mr. Thériault were discussing in your exchange and the fact that March 23 is less than a year away. There are a lot of questions. In fact, Ms. Abby Hoffman, when she appeared before our committee, said there haven't been consultations with first nations, Métis and aboriginal peoples.

If the provinces are not ready, will it fall upon individual practitioners to make decisions? I'm really quite concerned about the readiness of our country, province by province and territory by territory.

Would you comment on anything to reassure me, others listening and members of this committee? It is less than a year away and we seem to not have the consistency and the standards across our country.

**Dr. Mona Gupta:** I'll say, slightly tongue-in-cheek, that compared to the time frame of C-14 and C-7, this is loads of time, whereas those changes happened very quickly.

I want to come back to my opening remark, which is that we're already doing it. We're already evaluating requesters who have histories of suicide attempts. We're already evaluating requesters who have serious histories of mental disorder. I'm not so concerned about the preparedness of the assessor and provider community. I think the training that's being developed is excellent. I think practitioners should pursue it, but I'm not so worried about that.

Your question about consultation with indigenous peoples is a good one. As I said, I really think it's for indigenous communities to say how they think we should move forward and not have a unified vision that gets imposed upon them.

• (1800)

**The Joint Chair (Hon. Yonah Martin):** With that, who would lead those consultations? The federal government has not done that, so I don't see how individual nations or groups would lead their own and be able to understand what's happening federally, because it involves the federal government.

**Dr. Mona Gupta:** That's right.

What our panel membership came to ground on was the idea that this could happen at a regional level. You're absolutely right that this isn't something for individual indigenous communities to organize, lead and finance themselves. It's something that needs to be done in partnership between indigenous communities and the provincial and federal governments.

My understanding is that there are structures in place at the federal government level for consultation and engagement with indigenous communities. Similarly, we encourage provincial authorities to do the same, particularly because we imagine that there are going to be differences in the indigenous communities across provinces, just as there are in non-indigenous communities.

**The Joint Chair (Hon. Yonah Martin):** We haven't heard about what models there are for such consultation. Would you be able to provide our committee with the examples that you are citing?

**Dr. Mona Gupta:** Yes. I believe that Crown-Indigenous Relations has a framework for consultation and engagement. I believe that exists at the federal government level.

At the provincial level, it was our hope that the regulators would take a leadership role in engaging with indigenous communities within their provinces. I don't think there's a specific model for that, but I can certainly forward you those documents that exist at the federal government level.

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

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

Before I thank you, Dr. Gupta, you have recommendation 14, which makes the recommendation of consultation with first nations, so I think you've covered that, as well, in the report.

Thank you very much for offering up your time this afternoon to face a barrage of questions. It speaks to the fact that we are very engaged on this very important topic. We very much appreciate that you took the time to come and speak to us so eloquently about the work that you and your committee did. Thank you. It will help us as we move forward.

As you saw, we still have some questions. That comes with our job.

With that, committee members, we will suspend. We will now attend to committee business. As you know, it's a different link and password. I will suspend for the moment and ask you to reconnect with the different link in a minute or two.

Thank you very much. This meeting is suspended.

*[The meeting was adjourned at 6:53 p.m. See Minutes of Proceedings]*

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