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The Honourable Marc Garneau The Honourable Yonah Martin



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• (1835)

[English]

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

Good evening, everyone. Welcome to this meeting of the Special Joint Committee on Medical Assistance in Dying.

I'm Yonah Martin, and I am the Senate's joint chair of this committee. I'm joined by the Honourable Marc Garneau, the House of Commons' joint chair—

[Translation]

Mr. Luc Thériault (Montcalm, BQ): Excuse me, Mr. Chair, but I can hardly hear the interpretation. There was none at all at the start.

I'd also like the sound in the room to be adjusted.

Lastly, I'd like to know if the sound tests were successfully completed for all the witnesses.

[English]

The Joint Chair (Hon. Yonah Martin): We're not getting the English translation at the moment. We have tested the sound quality for each of our witnesses, and I'm told that we're ready to begin. However, I didn't hear the English translation of Mr. Thériault, so I'm assuming that everything is okay. We'll continue. Let's see how this goes.

We're continuing our examination of the statutory review of the provisions of the Criminal Code relating to medical assistance in dying.

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

This evening, we'd like to welcome our witnesses. Thank you very much for joining us. Your testimony will be very important to our study.

We will have our witnesses in the order of Dr. Chantal Perrot by video conference, followed by Professor Peter Reiner, professor of neuroethics in the department of psychiatry at the University of British Columbia, and Dr. Jennifer Gibson, associate professor and

director of the joint centre for bioethics at the University of Toronto.

Again, thank you to our witnesses.

We will begin with opening remarks. Each of you will have five minutes. I hope to give you a four-minute warning. When there's one minute remaining, I'll say, "one minute". If you can keep your remarks to five minutes, it will be very helpful for us to keep our time.

Let's begin with Dr. Chantal Perrot.

Dr. Chantal Perrot (Doctor, As an Individual): Thank you, joint chairs and committee members, for the opportunity to speak with you today.

I live in midtown Toronto, on what was the shore of the old Lake Iroquois. This is the traditional territory of the Mississaugas of the Credit, the Haudenosaunee, the Huron-Wendat, the Anishinabe and the Chippewa, and it is still home to many diverse indigenous peoples.

I'm a community-based MAID assessor and provider—since July 2016—and chair of the board of MAIDHouse, a director of Dying with Dignity Canada, co-chair of the Dying with Dignity Canada clinicians advisory council, and a member of the CAMAP complex cases working group, developing the new national MAID curriculum. However, I am speaking today as an individual not representing any of these organizations.

I appreciate the work of the Canadian government in considering so thoroughly and carefully the issues related to and raised by MAID. I have learned from listening to the many hours of testimony presented to the various iterations of MAID-related committees over the years. Hearing all these different points of view and being challenged by others' opinions and beliefs have contributed to improving my MAID practice. I have something to say about all of the aspects of this committee's deliberations but will limit my comments today to advance requests.

While I would much prefer to provide MAID to a person who is conscious and capable of providing consent at the time they receive MAID, there are conditions and events that occur which lead to the loss of capacity or even loss of consciousness. A number one fear expressed by most people I know and virtually all the patients I assess for MAID is that they will lose the capacity to request or consent to MAID and thus have to die a natural death in circumstances they find abhorrent and intolerable. The addition of "Audrey's amendment" in Bill C-7 went some way to alleviate the fears of some, but it did not go far enough for most people.

Most of my patients are not interested in staying alive until the very end of a natural death. They actively choose MAID. However, they also want to live as well as possible for as long as possible. There is much uncertainty when it comes to dying, and thus much anxiety. Many people fear losing their physical capacities and thus their autonomy, or developing dementia and losing their cognitive capacities or losing the ability to direct their own care.

I am frequently contacted by people who want to be assessed for MAID because they think they could then have it at a later time of their choosing or in the event that they become incapable in the meantime. Some, like the two patients I assessed yesterday, are shattered on learning that this is not possible. They don't want to die now even if they are eligible. They certainly don't want to set a date for MAID, but they know what is likely coming their way within a few months or years. They know what they want to try to avoid, and being able to write an advance request for MAID would alleviate a tremendous amount of their current suffering and anxiety about end of life.

To date, I have cared for people like this by starting an assessment, gathering the background clinical information I need to know and then keeping in touch with them on a regular basis. The assessment is completed if and when they want MAID and are prepared to set a date—sometimes months in the future and sometimes years. This gives them comfort and me ongoing work, but it does not replace the benefit an advance directive or advance request would confer.

My mother died in 2009. She had fallen and hit her head and, in part because she was taking anti-coagulants for one of her medical conditions, she had a brain bleed. She had surgery, which was successful, but she did not wake up, and the scans and examinations did not suggest a positive outcome was likely. Because I had talked with my parents over many years about their end-of-life wishes, and because they had answered my many questions and completed and regularly updated forms I gave them to create their statements of end-of-life wishes, I knew what to do. It was difficult, but I was reassured by the certainty that I knew what my mother had wanted in the event something like this happened. She died never regaining consciousness, but with her family around her for the last days of her life.

I've just come back from visiting my 96-year-old French-born father, who lives in Texas. He would much prefer to live in Canada—what he considers the most civilized country on the planet—but he and my mother waited too long to start the immigration process, so he had to content himself with lengthy visits while he was still able to travel. He is now frail and weak of body, but sound of mind. He still carries a torch for my mother, whose pictures surround him in his apartment. While he looks like he should be suffering, he really isn't. He would be content if he went to sleep and did not wake up, dying peacefully, but he has no interest in or desire to hasten death in his current condition. I have provided MAID for many patients who were not as physically debilitated as he is. Were he living in Canada, suffering intolerably and asking for MAID, he would be eligible. He would also want an advance request.

All this is to say that advance requests and advance directives are important and actionable. Speaking with a designated attorney or future substitute decision-maker about one's wishes in the event of

incapacity is important. Clearly outlining the care one would want to receive and the care one would not want to receive is crucial. This is the information that will guide those tasked with one's care. The more detailed this information is, the better, particularly when it comes to advance requests for MAID.

• (1840)

Ideally there would be a national database to store advance requests. The onus would be on health care providers to inquire about the existence of an advance request and then to access it. This would allow patients, no matter where they fall ill in Canada, to have their wishes available to those who need to know in order to provide care.

It's a big responsibility to take on the role of attorney for personal care or SDM. It requires a lot of time, thought and education. I think most people have no idea how much is involved or how much will be asked of them. It will be even more complicated and complex when it comes to advance directives or requests that include MAID, but I believe it can be done and done well with careful planning and guidance.

I've seen well-drafted advance directives at work—

The Joint Chair (Hon. Yonah Martin): Thank you, Dr. Perrot. Will you kindly wrap up. It is a bit over time.

Dr. Chantal Perrot: Yes.

Over time and with experience, templates for MAID advance directives can be drafted, refined and improved. I would be pleased to provide you with my thoughts on what should be included in an advance request for MAID. I have provided some in the written piece I submitted.

Thank you.

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

Next, we'll have Professor Reiner for five minutes.

Professor, go ahead.

Professor Peter Reiner (Professor of Neuroethics, Department of Psychiatry, University of British Columbia, As an Individual): Thank you very much for inviting me to speak before this committee.

I am a professor of neuroethics at the University of British Columbia. Today I'm going to outline for you a problem and then share some solutions.

If advance requests for MAID become legal, one might think that all that is required is to properly fill out a form and that, when the time comes, a MAID provider will take care of the rest. Unfortunately, that might not be what happens. Evidence from the Netherlands, where advance requests have been legal since 2002, reveals that physicians do not always comply with dementia patients' wishes. Indeed, very few advance requests have resulted in dementia patients' receiving MAID.

In order to anticipate what might happen in Canada if advance requests for MAID in dementia were legal, my colleagues Adrian Byram, Ellen Wiebe, Sabrina Tremblay-Huet and I asked 103 MAID providers working in all provinces whether they would provide MAID under the aegis of an advance request that listed the sorts of specific circumstances that have been discussed often in these proceedings. The vast majority agreed that they would provide MAID if the patient was able to provide full consent. However, as we changed the description of the situation to include circumstances that would likely apply as dementia takes hold—nodding yes instead of providing consent, unresponsive patients but agreement by the family, or reliance upon the written advance request without anyone else to agree that “it’s time”—as we moved along that spectrum, the percentage of providers who would offer MAID to dementia patients decreased to the point where substantially less than half would agree.

These data suggest that advance requests for MAID in the case of dementia do not represent a slippery slope. Rather, their implementation represents an uphill battle. This is a pragmatic problem that threatens to undo all the hard work that many of you have put into establishing a route for advance requests in the case of dementia.

Then this question arises: How can we design those requests so that MAID providers will follow the wishes of individuals?

Fortunately, we asked these very same MAID providers to propose concrete policy suggestions that might alleviate the situation. Their recommendations were exceedingly thoughtful, and I want to take this opportunity to publicly thank them for their insights, which are distilled in our 2021 paper, which has been made available to the committee.

I’d like to end my testimony by highlighting five points that stand out as what I would consider minimal solutions to our common dilemma.

First, the advance request should include a list of specific circumstances for the provision of MAID, with extra emphasis on the term “specific”.

Periodic reaffirmation of the advance request would be the second suggestion, because continuity of one’s wishes seems to hold particular sway with MAID providers.

Third is enumeration of why each specific circumstance constitutes intolerable suffering for the requester. MAID providers were generally receptive to the idea that individuals could determine for themselves what constituted suffering, but regularly commented that explicit discussion of the issue in the advance request would reinforce the idea that they were doing the right thing at the right time.

Fourth is discussion of the advance request with family and relevant designated decision-makers. Surprises at the time of provision puts MAID providers in an extremely awkward situation.

Fifth is a question asking requesters to be explicit about what they would want to happen if, at the time of provision, things don’t go as expected—for example, if family members or the patients themselves object to the procedure.

As you prepare your report, I urge you to consider implementing these recommendations. Our data suggest that, in order to have advance requests do what they are intended to do, we need to carefully consider the reality that confronts the MAID providers. They already have the morally weighty job of providing MAID, and if this legislation becomes law, they will be asked to take on the additional challenge of providing MAID based on an advance request. The success of the entire program depends upon our designing the advance request so that everyone—patients, families and MAID providers alike—obtains the results we all want.

Thank you for your attention.

• (1845)

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

Lastly, we’ll hear from Dr. Jennifer Gibson.

You have the floor for five minutes.

Dr. Jennifer Gibson (Associate Professor, Director of Joint Centre for Bioethics, University of Toronto, As an Individual): Thank you so much, and thank you for the invitation to meet with you in this important study.

I am director of the University of Toronto’s joint centre for bioethics and an associate professor in the Dalla Lana school of public health. However, this evening, I am speaking as an individual, drawing upon my disciplinary background in bioethics and health policy, and my experience as co-chair of the provincial-territorial expert advisory group on physician-assisted dying in 2015, and as chair of the advance request working group of the Council of Canadian Academies’ expert panel on medical assistance in dying in 2018-19.

I’ve had the opportunity to listen to several testimonies by previous witnesses over the last week. In the next few minutes, I hope to build on this testimony and indeed that of my colleagues on the panel today, and offer the committee some points to consider in its deliberation about the potential role, application and conditions of advance requests for MAID.

A first point to consider is that, while advance requests for MAID may be relevant to persons with dementia, they’re not relevant only to such persons. Discussions of advance requests for MAID often focus on dementia as the root cause and reason for a person’s advance request. It is important, however, to distinguish between the grievous and irremediable medical condition that may lead someone to seek an advance request for MAID and the clinical circumstances that may result in the loss of their decision-making capacity. For some patients, dementia may be both a grievous and irremediable medical condition and the basis of their loss of capacity; however, this is not necessarily the case.

For example, consider an advance request for MAID from a person who is in active treatment for cancer or heart disease, with an uncertain prognosis, who is also at risk of a potentially life-limiting event, such as a stroke. Consider a person who has inherited the dominant gene for Huntington's disease or the gene for early Alzheimer's and will most certainly develop the disease in the future, but may be diagnosed with another grievous and irremediable condition in the meantime. Consider a person who has been living with Parkinson's disease for several years, knows that the end stage of the disease might be accompanied by dementia and wishes to plan for this possibility whilst they still have the capacity to do so.

It is important that a study of advance requests take this broader range of circumstances into account.

• (1850)

The Joint Chair (Hon. Yonah Martin): I'm sorry to interrupt, Dr. Gibson.

Would you kindly move your mike up a little bit and also slow down for our translators?

Thank you very much.

Dr. Jennifer Gibson: I'm happy to. Thank you.

A second point to consider is that persons with dementia can be supported to live with dignity. There is much work to be done to strengthen and create conditions for this. However, for some persons, regardless of these conditions, advanced dementia may nevertheless be experienced as a source of intolerable suffering.

As you have heard from other witnesses, recent public opinion surveys in Canada show strong support for advance requests for MAID. Some witnesses have attributed this to a general fear of dementia and institutionalized care, to limited accessibility of palliative care services or to embedded ageism and ableism within society. The worry is that advance requests for MAID may tend to exacerbate and reinforce systemic barriers and societal attitudes that render persons with dementia, particularly seniors, vulnerable as a group, and to displace needed efforts to provide dignity-enabling care for all persons living with dementia.

However, a focus on vulnerable groups as such tends to occlude the experience of individuals in the unique circumstances of their lives, including the impact that illness may have on their personal identity, their fundamental values and their ability to engage in the world and the projects that matter to them and with the people they care about. A study of advance requests must consider both the vulnerability of groups and of individuals without collapsing one into the other.

A final point to consider is that, as several witnesses before me have underlined, advance requests for MAID are complex undertakings with known uncertainties; however, there may be ways, as Dr. Reiner has pointed out, to reduce the complexity and narrow the uncertainty gaps.

Advance requests for MAID raise important challenges about, first, the clarity with which a person has described their circumstances under which their advance request should be enacted; second, the concordance of a person's current situation with the circumstances outlined in that advance request; and third, the extent to

which the patient's wishes are known and understood by the care team, the substitute decision-maker and family members. No piece of legislation alone can do this, and indeed, our previous experience with MAID in Canada underlines that multiple actors have a role to play.

As this special joint committee study proceeds, one offering you might serve all of us with is not only to be able to provide recommendations regarding what legislation may look like, but a broad canvas of what you've heard through each of these meetings that may be able to foster directions for the fuller range of actors who may have a role to play in its implementation and continuing evolution.

I look forward to exploring these points further with you and with my panel colleagues.

Thank you.

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

Thank you to all our witnesses.

We will now move into questions from our MPs, and we will begin with Dr. Ellis.

Dr. Ellis, you have the floor for five minutes.

Mr. Stephen Ellis (Cumberland—Colchester, CPC): Thank you very much, Chair.

Thank you to our witnesses for being here.

Through you, Chair, my first question will be for Dr. Perrot, if I may.

You talked about frequent reassessments or, in Professor Reiner's words, periodic reaffirmations. Can you give us a sense of how often those would be better suited to be done?

Dr. Chantal Perrot: I think Professor Reiner and I were talking about two different things. When I see patients who would like an advance request, but because they're not available we can't have them, I will meet with them and then I'll touch base with them every few months just to confirm their interest in MAID and to update my assessment. I think he was talking about reaffirming an advance request periodically, every three to five years or something like that, which I certainly agree with.

Mr. Stephen Ellis: Just to be clear, Dr. Perrot, you believe that if someone has a desire for MAID, their desire should be revisited every two or three months.

• (1855)

Dr. Chantal Perrot: No, not in general. This is for patients who are not ready to complete the assessment. If someone has completed the assessment, they want MAID and they're prepared to set a date for MAID, then we do that. That date can be days, weeks or even months down the road. However, if someone's not ready to have the assessment completed, then I do what is called a "rolling" assessment. It's done over time. Sometimes that is spread out over a couple of years, even.

Mr. Stephen Ellis: Okay. I understand very clearly.

Through you, Chair, I'll once again go to Dr. Perrot, if I may.

Do you believe that, in the words of Professor Reiner, there should be reaffirmations as we go forward—i.e., “Hey, you know what? Even if you say, yes, you want MAID, are you ready to continue with that?” Is that an important part of this for you?

Dr. Chantal Perrot: It's certainly an important part for advance directives or advance requests. I think anybody who writes an advance directive, which one can do now, should be reaffirmed periodically, three to five years or something like that, because then you see the consistency over time of somebody's wishes. If you can look at someone's advance directives over a period of five, 10, 15 or 20 years and you can see that their wishes are consistent over that time, as a clinician I would feel much more comfortable providing MAID to somebody whose wishes I knew were consistent over their lifetime as opposed to somebody whose wishes were suddenly changed with a more recent advance directive that had never previously mentioned something like MAID.

Mr. Stephen Ellis: Understood. Thank you.

Through you, Chair, I'll once again go to Dr. Perrot.

As we get closer to that time, let's say you've established a relationship with that patient and you realize they have a dementing illness. Would it then be important to increase the frequency of those reassessments?

Dr. Chantal Perrot: Yes, absolutely. Those would be reassessments as a MAID provider for somebody who's actively seeking MAID, certainly. As well, if somebody has an advance directive, then that should be affirmed periodically in the course of their early dementia. At some point they'll lose the capacity to understand what the advance directive is, and at that point it should be stopped.

Mr. Stephen Ellis: Would it be on a case-by-case basis, or do you believe there are more general ideas that could be implemented here with respect to these aspects?

Dr. Chantal Perrot: I think any assessment should be done on a case-by-case basis. There should be a certain amount of flexibility built into the assessment process, but for something like advance directives for MAID, and advance directives in general, I think they should be reaffirmed or rewritten periodically. That should be written into whatever rules or regulations come out with advance requests.

I don't think a clinician could reasonably be expected to act on an advance request that was written 25 years ago and was never revisited or reaffirmed. That affirmation could be as simple as adding a line to an advance directive with a statement saying, “I confirm the wishes above of this advance directive”. That could be done periodically. I do think an advance directive or an advance request for MAID has to be reaffirmed periodically.

Mr. Stephen Ellis: Thank you for that, Dr. Perrot.

Certainly, that makes it very difficult, for those of us trying to create legislation around this, to understand those benchmarks and barriers that need to be in place. I thank you for your comments with respect to that.

In my last 30 seconds, through you, Chair, I have a question for Professor Reiner.

Do you have any comments specifically around that?

Prof. Peter Reiner: Yes. I guess what I would say is that it's really in the interest of the patients, the requesters, to reaffirm as often as is appropriate, given their relationship with the provider, to ensure that the consistency of their views is heard, because that makes it more likely that they will get the result they asked for.

Mr. Stephen Ellis: Very good. That's understood, sir.

I guess the—

The Joint Chair (Hon. Yonah Martin): I'm sorry, Dr. Ellis. You're out of time. Thank you very much.

Next, we'll have Mr. Maloney.

You have the floor for five minutes.

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

Thank you to all of our witnesses for their comments so far. It's very helpful.

Professor Reiner, I want to start with you.

Of your five points, I'll go to your fifth point, which was about asking the requester to deal with unforeseen scenarios, or the third party objections or obstacles that might arise at the end, when you're not in a position, or don't have the capacity yourself, to respond to them.

To get right to the point, can you flesh that out a bit for me?

Prof. Peter Reiner: Yes. It's entirely possible that you, as an individual—particularly as a dementing patient—might behave in a fashion where you might resist at the time of provision. You might be resisting all kinds of treatment at that point. That is a very difficult situation for a MAID provider to deal with. That's what they have told us. Those sorts of situations are extremely stressful. They're trying to figure out what the right thing to do is.

If it's explained to you, as an individual, that this sort of thing happens from time to time, you can say, “If I am resisting, I want you to go ahead.” That provides a degree of comfort. I don't think it provides 100% assurance that everything will go as you wish, but it provides a degree of comfort to the MAID provider—that they are doing the right thing, at the right time, in the right circumstance. There are a number of these kinds of things that go south, regularly, as people's dementia progresses. Families intervene in various ways that are problematic. There is even the situation discussed, here in the committee, of the happy demented patient.

If you delineate what you want done in those situations, you give clearer instructions to the MAID provider.

• (1900)

Mr. James Maloney: You're never going to get a situation where you can cover off every scenario. Is that fair?

Prof. Peter Reiner: Yes.

Mr. James Maloney: What you're talking about is trying to anticipate as many of the challenges as you can. That goes to your fourth point, which is discussing the issue with family and close contacts.

Prof. Peter Reiner: That's correct.

I think you already heard from some MAID providers who have suggested that nothing will be foolproof and guaranteed. What we want to do is set up the situation so it is likely you get the outcome you want, with the kinds of constraints that are important to you. If your situation is that you don't want MAID if you're a happy demented person, that's what you also need to put forward. For many people, that might be the way they want to go.

Mr. James Maloney: This goes back to your premise that it's not as simple as filling out a form. Doctors want to make sure the instructions are clear and there's informed consent, so that, when the time comes, they know they are acting in accordance with the instructions of the individual.

If I understood you correctly, your point was that, if you add this clarity, the number of doctors willing to comply with those instructions increases. Did I misunderstand you?

Prof. Peter Reiner: That's what we anticipate, yes. Of course, we don't have advance requests for MAID. All we have is the hypothetical we presented to those MAID providers.

Mr. James Maloney: Informed consent is the biggest part of this. Informed consent means that the person providing instructions to a medical practitioner understands as many of the scenarios, risks and problems as can be anticipated at the time. If I'm in a situation where I'm coming to a doctor and making an advance request, I understand that I might be in a position where I don't have the capacity, physically or mentally, to change my mind or convey a different message at the time.

Isn't that informed consent? I'm giving you consent, being fully informed of the risks that are in place at the time.

The Joint Chair (Hon. Yonah Martin): We need a brief answer, Professor.

Prof. Peter Reiner: Yes. That seems to satisfy what I would consider to be informed consent.

Mr. James Maloney: Thank you very much.

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

Next we'll have Monsieur Thériault for five minutes.

[*Translation*]

Mr. Luc Thériault: Thank you, Madam Chair.

I'd like to thank all the witnesses for their enlightening testimony.

I'll start with Prof. Reiner.

You were talking about periodic reaffirmation. We've heard from several witnesses that, in all cases of degenerative neurocognitive disease, the prerequisite is to make the diagnosis. I imagine you agree that the first thing that's needed is a diagnosis and that there is no question of an advance request without a diagnosis. For example, there couldn't be an advance request that would be valid for 20 years. From what we've heard, a neurodegenerative disease can worsen over a 10-year period, but it rarely takes 20 years. Do you agree with that?

• (1905)

[*English*]

Prof. Peter Reiner: I can speak for myself that I generally agree, but what I'm trying to represent for you are the perspectives of the MAID providers. We didn't discuss that, so I'm hesitant to comment.

[*Translation*]

Mr. Luc Thériault: So you're not sure that there has to be a diagnosis first before an advance request is accepted in the case of a degenerative neurocognitive disease. Is that correct?

[*English*]

Prof. Peter Reiner: It's not that I'm not certain. It's that it was outside of the domain of our study. It wasn't something that we looked at.

[*Translation*]

Mr. Luc Thériault: Okay.

If I summarize the fourth and fifth possible solutions that you proposed in your opening remarks, you say that there must be a discussion with the family. We've had several witnesses tell us that, in preparing for the advance request, in addition to establishing the diagnosis, it is absolutely essential to designate a third party, that is, the person who, when the time comes and according to the patient's wishes, would initiate the medical team's assessment process.

Do you support that? In other words, this responsibility would fall to this third party much more than to the family.

[*English*]

Prof. Peter Reiner: Yes. I think that's an extremely excellent suggestion. The more people you confer with, the more people you lodge your autonomous wishes with, the more likely you are to have them expressed at the right time, when provision of MAID should be delivered.

[*Translation*]

Mr. Luc Thériault: Treatment for degenerative neurocognitive diseases is usually a process that takes place over time. A health care team is involved in this process, and the person's wishes are known to all.

Do you think legislation should be created to open up this possibility, while leaving it up to the regulatory authorities to decide on all the procedures for applying advance requests, given that they are the ones with the necessary expertise?

[*English*]

Prof. Peter Reiner: I'm not sure I understand the question.

[*Translation*]

Mr. Luc Thériault: Actually, what I'm saying is that it's the people working in this area and the colleges of physicians, for example, that have the clinical expertise required. Instead of putting everything in fine detail in a piece of legislation, we could have a minimalist piece of legislation that, in practice, would leave it to the regulatory authorities to set the guidelines.

[English]

The Joint Chair (Hon. Yonah Martin): We need a very brief answer, Professor.

Prof. Peter Reiner: Yes. I think that's quite reasonable.

As I understand it, ultimately the decision to provide MAID is going to rest with the MAID provider. The point of all of the recommendations that I put forward here, which came out of suggestions from MAID providers, is setting up the structure so that they are confident they are doing the right thing at the right time.

I don't think we want to add more work and burden on them. I think the idea of a designated decision-maker who acts as a support person for ensuring that the providers know it's the right time to do what they need to do is what we should have.

• (1910)

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

Next we'll have Mr. MacGregor.

You have the floor for five minutes.

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

Dr. Perrot, I'd like to start with you.

On this concept of relieving people's suffering and the existential dread they have when facing end of life, we know that a major reasoning behind the amendments in Bill C-7 in the previous Parliament—the waiver of final consent—was to allow people to have a little more peace of mind. If they were diagnosed with an incurable disease that was on a downward decline, they at least could give final consent before worrying about a loss of capacity.

You talked about how allowing for advance requests would allow that as well for other patients, to relieve their suffering and any existential crisis they may have regarding a future loss of capacity. Can you fill us in with a bit more detail on that, please?

Dr. Chantal Perrot: Sure. I think the main difference is that with Audrey's amendment in Bill C-7, the person has to have set a date for MAID. Many patients don't want to set a date for MAID yet, but they can't sign that waiver of final consent until they have set a date for MAID.

What patients are asking for is to be able to have an advance request that they could, in the event that they become incapable before they're willing and ready to set a date for MAID.... That's what would relieve their anxiety and suffering. I have many patients who would like MAID six months or a year down the road, but they don't know exactly when and they feel stuck.

Mr. Alistair MacGregor: You would say that's been negatively affecting their life, having to weigh the decision that's before them?

Dr. Chantal Perrot: Absolutely. There were two patients I met with yesterday. One is a 72-year-old man with chronic pain and vascular dementia. He's living quite happily, but he wants to know that if he had a stroke next week he would be able to have MAID. However, he doesn't want to set a date for MAID. He's not suffering intolerably yet, so he wouldn't meet the criteria. He's not able to....

Another is an 85-year-old woman with terminal cancer. What she's living with kind of boggles my mind. She also doesn't want to set a date. She knows that if she develops brain metastasis, she is quite likely to lose capacity. She wants to be able to set an advance request. She's somebody I will stay in close contact with, because I am concerned about her losing capacity. I want her to have the choice of MAID, but she's just not ready to set a date for MAID.

It would really make a difference for people like that.

I'm providing MAID for a woman in a couple of weeks. I first met her a year and a half ago. What she really wanted was an advance request. Her past year and a half would have been much more peaceful had she known that, in the event of incapacity, she would be able to receive MAID. Now that she has set the date and has a waiver of final consent, she's happy. She's much more at peace.

Mr. Alistair MacGregor: Professor Reiner, I'd like to turn to you now.

I appreciate the five key points that you asked our committee to pay attention to: the list of specific circumstances, a regular update of wishes, why each circumstance would constitute suffering, discussing decisions with the family and also providing some context when things don't go according to plan.

A lot of our witnesses talked about the present self making decisions for the future self. I'm wondering, as a professor of neuroethics, how you have approached that particular argument. We had a lot of people talk about how their present self....

I may not fully understand, as a 43-year-old, what my 75-year-old self would want. Therefore, how could I properly make the decisions for 75-year-old Mr. MacGregor? Can you lend some of your expertise to that conversation?

Prof. Peter Reiner: Yes, I'd be happy to address this.

It's about autonomy. It's about how we project our autonomy. Really, what advance requests do is project our autonomy into the future, into the person that we will become. We know that we change all the time, from day to day. You are changed by my words in some way at this moment. It's not that we are fixed people at any time in our lives. It's really a matter of this question: If somebody is to decide for me when I am in this debilitated condition at some unknown time in the future, who best is in a position to make that decision?

I think that as a scholar of the neurobiology of autonomy—because I've published on it extensively—I would say that clearly it is me, but there is also a penumbra of autonomy that exists in the reality where we're not quite as atomized individuals as we think. That's where the family and friends and other people come in, and including them in that discussion is very important. However, the decision should properly rest with me.

• (1915)

Mr. Alistair MacGregor: Thank you for that.

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

At this time, I will hand this over to my joint chair, Mr. Garneau, for questions from senators.

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

[*Translation*]

We're going to start with Senator Mégie.

You have three minutes.

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

I have a question for Dr. Gibson.

You said earlier that the patient had to describe the circumstances for initiating the process. In other words, the person indicates when it should happen. For example, it could be when they no longer recognize their family.

You also said that some of your patients need to be assessed every three months. Who assesses them? Is it the physician who did the initial assessment and determined that the person was eligible for medical assistance in dying or could be after being diagnosed with dementia? Is it this assessor who should see the person every three months to determine if they want to continue with the request for medical assistance in dying?

[*English*]

Dr. Jennifer Gibson: Madam Mégie, I think it may have been Dr. Perrot who was talking about the iterative process of checking in with her patients, but I'm happy to touch on this point because I think it's really important. One of the reasons we may want to set up a regime—whether it's legislative or regulatory, or whether it's a focus on clinical guidelines—to have regular check-ins with patients who might have made an advance request is to confirm that the terms and conditions of that request continue to be current. As we see, especially with longitudinal neurological conditions, there could be changes, life experience changes. As Dr. Reiner actually pointed out right now, our views may actually change over time.

Being able to have those checkpoints is an opportunity for confirmation and affirmation, but as I learned from Dr. Poirier, who spoke at a recent committee meeting, also reinforced by Dr. Perrot, there are, depending on where patients may be in the trajectory of their illnesses, more frequent check-ins or reassessments, and reaffirmations may be both valuable and welcomed, especially for patients who may be concerned and want to ensure that their conditions are in place and that their advance requests will be honoured.

We need to be able to find a way to ensure that we have mechanisms in place for that iterative reaffirmation without constraining patients or the care providers who are working with them to a set of guidelines that is so strict that it doesn't acknowledge and doesn't follow the trajectory of particular patients in the circumstances of their illnesses, where it's their affirmation of their continued advance request that needs to be confirmed.

[*Translation*]

Hon. Marie-Françoise Mégie: I apologize for putting those words in your mouth.

I'll turn to Dr. Perrot.

Do you have enough resources to do this assessment every three months? Is it something you've done before? I'm talking about similar assessments that you might have done in other circumstances, of course, since nothing has been adopted yet for advance requests. How do you see that?

[*English*]

Dr. Chantal Perrot: I think there has been a misunderstanding about my three-month re-evaluation. That comes when I'm actively assessing a patient for medical assistance in dying. That's completely separate from an advance request.

An advance request, I think, should be reaffirmed every three to five years; whereas, if I'm assessing a patient for MAID who is not ready to set a date for MAID yet, I will check in with them in three months' time to see to where they are in their illness process. Usually, when patients contact me for MAID, they're closer to end of life and their conditions are more fragile and unstable, so I want to make sure that I catch them, if they want MAID, at a time when they're still able to proceed with it.

I apologize for that misunderstanding.

• (1920)

[*Translation*]

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

Hon. Marie-Françoise Mégie: Thank you.

The Joint Chair (Hon. Marc Garneau): Go ahead, Senator Dalphond. You have three minutes.

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

Dr. Reiner didn't really answer my colleague Mr. Thériault's question, but I'll ask Dr. Perrot the same question.

You've sort of defined advance directives, but I'm not sure what you mean when you talk about directives being given 15, 20 or 25 years before the event. Are you talking about cases where a person gives an advance directive that they want to receive medical assistance in dying if they have a heart attack or end up in this or that condition, which could happen 20 years later, for example?

Other experts have told us that we need to focus on dementia and irreversible neurocognitive diseases instead. That's what Canadians seem to be concerned about. In these cases, isn't a diagnosis needed beforehand so that the information and reflection process can be initiated, and the person can give advance directives indicating very precisely at what stage in life they want to receive medical assistance in dying?

Dr. Perrot, did you hear the interpretation of what I just said?

[*English*]

Dr. Chantal Perrot: Was that question for me? I thought it was for Professor Reiner.

Hon. Pierre Dalphond: No. I said that he did not answer the question, so I ask the same question of you. I can repeat it in English.

You sometimes refer to 15 years or 20 years ahead of the condition, which seems to indicate that I could do it and say, if I had a car accident and I remained brain damaged, I could receive MAID. Other experts have said that it should be limited to neurocognitive diseases. Therefore, once the diagnosis has been given that you're suffering from Alzheimer's and you still have the ability, you can inform yourself, you can talk with the consultants, you can talk with your team and then start planning, if you want it, at what stage, defined precisely, you should receive it.

Dr. Chantal Perrot: I think an advance request should be able to be made for anybody, whether they have a diagnosis of an illness or not, because, with some illnesses like cancers with brain metastasis or dementia, you can be pretty certain that, at some point, there's is going to be a loss of capacity.

Any of us could lose capacity tomorrow through a stroke, a heart attack, a car accident or whatever. I personally would like to be able to have an advance request for MAID, and I have clearly delineated the criteria that I would want to be met in order for me to have that, and I have that in my advance directive for if and when it becomes legal.

I think that's really important, so yes, I don't think it should only be for neurodegenerative conditions.

Hon. Pierre Dalphond: Then, if I understand properly, what you're saying is that, since that might be over a long span, it should be reaffirmed or reassessed periodically every three to five years.

Dr. Chantal Perrot: Absolutely. I think one should rewrite or reaffirm an advance request, the same way that I think we should do that with wills and powers of attorney in general, to make sure that our wishes are consistent.

To Mr. MacGregor's point, his 45-year-old self may not know what his 75-year-old self will be, but I would hope that, if he writes an advance directive at 45, he would review it at 50, 55, 60, 65, 70 and 75. His 70-year-old self might know better what his 75-year-old self would want.

The other thing—
[Translation]

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

[English]

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

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

I have two questions. The first question is for Dr. Reiner and Dr. Perrot, and then the second question is for Professor Gibson.

There's a difference between legislative dictum and standards of practice and regulation of practice. How would you look at what we're talking about today? Would you look at it as legislation telling physicians and patients how they should interact with each other, or should there be a standard of practice that physicians and regulators rely on to oversee the practice of MAID, particularly around this area as well? If you are in agreement, who should set that standard of practice and how should it be regulated?

Prof. Peter Reiner: I'll speak first.

I think it makes sense for it to be a standard of practice. It could fall under the regulation of provincial colleges of physicians, or something like that. I think that would be sufficient.

The point of all of this is to try to make sure that everything goes as smoothly as possible, rather than tie it up in some regulatory regime that ensures that tick boxes are checked.

• (1925)

Dr. Chantal Perrot: I agree 100%. I think it should be standard of practice, not legislated. It doesn't make sense to put in the legislation all the details that should be met. There are some details that are in the legislation currently that I wish were standard of practice. It would give more flexibility.

However, I think the standards of practice can be created. There will be advance directives or advance requests that will be written today. If they're written today, they will be refined over time. We will get better at it as we have experience.

As a clinician, I include things in my MAID assessments today that I did not include five and a half or six years ago, because I have learned over time. There are things I include in the waivers of final consent agreements that I write with patients now that I did not include when I first started out, because I've learned through experience. It's my own experience, in particular, but also my colleagues'.

A template for an advance request would evolve and improve over time.

Hon. Stanley Kutcher: Professor Gibson, you mentioned you felt that "multiple actors have a role to play". I wonder if you would mind expanding on that statement for us.

Dr. Jennifer Gibson: Thank you for the question. I think it builds on your previous one.

If we think about it, there's the legislation. The clinical guidelines being developed by those who are best equipped, as clinicians, to inform what the practice may look like are going to be important. However, there are other actors who we want to be thinking about.

One key actor here—whom I know has been identified at this committee and who surfaces fairly frequently—is the substitute decision-maker. They play such an essential role in this process. Dr. Reiner's process that he's outlined is very well suited to supporting a substitute decision-maker to be well equipped with an understanding of why a patient may be seeking an advance request, and to be able to be part of that deliberative process. That is an actor. I think there are other actors who have essential roles to play in ensuring that the system around this works well.

A strength of the original Bill C-14, our original legislation, was that there was a monitoring system in place. We were able to track and understand what was going on in the practice and be able to guide continuing policy evolution. However, that is high level, and it often uses quantitative data in reporting statistics. It's very helpful at a population level, but we need to go further down.

Some of the other opportunities we have to strengthen this system as a whole are to continue to foster the types of research that Dr. Reiner has been pursuing and to continue to foster the learning and the training of health professionals that Dr. Perrot is sharing as well. Everyone is in.

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

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

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

I don't have enough time to ask all of my questions. As we come to a close on advance directives, I feel like we have so much more to explore. This is a very important and big topic.

Maybe I can focus on the restrictions that are needed to ensure that we really are doing the right things. For instance, under what strict conditions should the arrangements be made for advance directives, and under what conditions should the procedure be abandoned?

We talk about family involvement along the way. I know there are sometimes issues with family involvement, both positive and negative. At what point should an advance directive or a procedure be abandoned? If we're expanding advance directives beyond the waiver of final consent currently allowed, what protections are necessary? I'm focusing on the protections that are needed for a very reliable system.

I'll begin with Dr. Perrot, and then Professor Reiner.

Go ahead, Dr. Perrot.

Dr. Chantal Perrot: I would say the clearer and more filled with detail an advance request can be, the more information will be provided to a MAID provider.

It's important to recognize that MAID providers won't meet a patient until an advance request is acted upon and the MAID provider is contacted to provide MAID for somebody. The MAID provider never meets the person when they are capable. They have to be able to understand what that person would have wanted, based on their advance request—

• (1930)

The Joint Chair (Hon. Yonah Martin): Is the form consistent? Is there a standard such that you're collecting these details consistently across the board? Would you explain a bit about the form that is used or the process?

Dr. Chantal Perrot: An advance request is written usually in a lawyer's office, with a power of attorney document, I would think. The centre for bioethics had an excellent template a couple of years ago. I wish they had not stopped producing it. Dying with Dignity Canada has an excellent template. There are a number out there that I have used, and I pull from a number of them to create the advance

requests that I have written and the ones that I recommend my patients use, but there is no master template that is used universally.

We don't have a master template, certainly, for advance requests for MAID, because it's not possible yet. There is no master template for the waiver of final consent. I drafted my own when it became legal, and I have revised it over time, improving it and adding things to it, so that it's as clear as possible to me. When I meet the patient, I want to understand what they need and want, what their suffering is and what their criteria would be. I ask them to write things down, and I help them to draft it in a way that makes sense to me.

Usually, there are family members or friends present when that's done, so that they understand what's going on as well. However, I have to say that I also have a lot of patients who do not have family members close by—who don't have family members at all or don't have family members that they can trust to do this—so I am concerned with the idea of having to include family.

I have a couple of patients right now whose families are being very obstructionist and are not allowing them to proceed with MAID, and I can't do anything without their co-operation. It makes it very difficult for the patients who are not getting access. I think that may be even more pronounced if there's an advance request that requires a family member to be involved.

I hope that answers your question.

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

I'll now turn it back to you.

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

If I may, I will again thank our witnesses for their testimony this evening. It's very helpful to all of us as we continue our study. Thank you so much.

We'll suspend for a few minutes to get ready for our second panel.

• (1930)

(Pause)

• (1935)

The Joint Chair (Hon. Yonah Martin): We will resume, colleagues.

I have a few comments for the benefit of our new witnesses. Before speaking, please wait until you are recognized by name by one of the joint chairs. I will remind you that all comments should be addressed through the joint chairs.

When speaking, please speak slowly and clearly. Interpretation in this video conference will work like it does in an in-person committee meeting. You have the choice at the bottom of your screen of floor, English or French. When you are not speaking, please keep your microphone on mute. Thank you very much.

Welcome to all of our panellists for this discussion on mature minors. It's a very important topic for us. We really appreciate the time you're giving our committee.

We have three panellists with us—Dr. Kathryn Morrison, clinical and organizational ethicist; Dr. Gordon Gubit, professor, division of neurology, department of medicine, faculty of graduate studies at Dalhousie University; and Kimberley Widger, associate professor—all by video conference.

I will begin with Dr. Kathryn Morrison.

You have the floor for five minutes.

Dr. Kathryn Morrison (Clinical and Organizational Ethicist, As an Individual): Thank you.

Good evening. Thank you to the committee joint chairs and members for the invitation. I am deeply honoured by the opportunity to speak with the committee on this very important topic.

I am a philosopher, having completed my Ph.D. in applied philosophy at the University of Waterloo last year. My dissertation research considers moral arguments regarding mature minor eligibility for medical assistance in dying, MAID. The scope of this work is focused on cases of minors who have a reasonably foreseeable natural death—that is, track one.

I also bring the perspective of a practising health care ethicist at a large hospital network in Ontario, where our service supports patients, families and health care teams who encounter challenging situations regarding informed consent, capacity and quality end-of-life care. As part of my clinical ethics role I support one of four specialized pediatric hospitals in Ontario. Our service also supports the institution's MAID team, where I had the privilege of doing MAID coordination during my ethics fellowship.

The views I bring to the committee are my own and do not represent the views of the organization I work for.

MAID for mature minors is an emotionally challenging topic presenting unique challenges when it comes to core values outlined in the Carter decision. Society has an interest in protecting vulnerable persons, and children are often perceived as vulnerable, entailing stronger duties to child well-being than that of adults. However, at the same time, there are societal duties to autonomy, especially respecting capable persons to make decisions about their own medical care and avoiding forcing persons to endure intolerable suffering against their will.

Children have a legal right to decision-making autonomy corresponding to their level of maturity. This tension between welfare and autonomy puts significant scrutiny on a mature minor's capacity to make such a serious decision.

I wish to present three considerations to the committee, which I believe provide compelling reasons for mature minors to be eligible for MAID under track one. The first is the concern that excluding

minors from accessing MAID is discriminatory. The 2016 report of the Special Joint Committee on Physician-Assisted Dying articulates that mature “minors can suffer as much as any adult”. It is also conceivable that minors with a grievous and irremediable medical condition who are prohibited from MAID can experience the same harms as adults.

This differential treatment is challenging to justify in the same way we would justify age distinctions in other contexts, including decisions to marry, drive, drink alcohol, smoke tobacco or use cannabis. After all, in the context of treatment decisions, decision-making authority is usually based in presumptions of capacity rather than a firm age distinction.

Secondly, child well-being is not always synonymous with prolonging life. In end-of-life decisions, well-being can be informed by dignity and quality of life, and should take into account the harms of forcing mature minors to endure intolerable suffering against their will.

Lastly, it's important to acknowledge that mature minors already make incredibly high-stakes medical decisions, including the decision to refuse life-sustaining treatment. I argue that refusing life-sustaining treatment—that is, a decision to die when one could otherwise live—is a far more serious type of decision than the decision for MAID under track one, which is choosing to control how one dies when death is unavoidable. In this sense, mature minors are already treated as meeting the threshold of capacity and maturity required to understand the implications of MAID.

It is challenging to reconcile these considerations under track one with the recent expansion of the law to include persons without a reasonably foreseeable natural death—that is track two—and anticipated inclusion of mental illness as the sole underlying condition. While at face value track two and mental illness as the sole underlying condition requests carry a similar weight to the decision to refuse life-sustaining treatment, there is considerable uncertainty regarding the particular vulnerabilities of these patient populations. I would be concerned at the prospect of extending eligibilities to these groups at this time.

I will close by emphasizing that the uncertainties raised by track two and mental illness as the sole underlying condition should not undermine the case for a mature minor to access MAID under track one.

Again, I thank the committee members for their attention and consideration.

• (1940)

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

Next we'll have Dr. Gordon Gubit for five minutes.

Dr. Gordon Gubit (Professor, Division of Neurology, Department of Medicine, Faculty of Graduate Studies at Dalhousie University, As an Individual): I would like to thank the committee for having me here this evening to provide some insights and opinions.

First off, I have an apology. I thought I was going to be speaking about advance directives, but I'm happy to provide comments and thoughts about any aspect of MAID and MAID care.

I work as a neurologist in my day-to-day work. I work with people who have had strokes, many of whom experience intolerable suffering after and cannot access MAID because of a lack of capacity. I have been a MAID assessor and provider in Nova Scotia since the law began in 2016. I am the clinical lead for medical assistance in dying in Nova Scotia with respect to administration and trying to promote good policy, etc. Finally, I am co-chairing and chairing a national committee that's looking at developing educational standards for MAID across the country. It is funded by Health Canada and I'm very grateful for their involvement in this process.

When medical assistance in dying for mature minors was mentioned, I was taken immediately to a case that I actually saw and worked with. It was a young woman who began her medical journey when she was 19, which was just above being a mature minor. She suffered from an intolerable pain problem. She lived with that pain problem for five years. She saw endless numbers of medical specialists, surgical specialists and underwent numerous different treatments for her problem.

When I was asked to see her, it was because track two legislation had just been introduced. I was asked to do an assessment to determine whether she was eligible for a medically assisted death even though her natural death was not reasonably foreseeable.

On the basis of a review of her entire medical history, my understanding of the nature of the problem, which was neurological in nature, and in discussion with consulting experts across the country, I came to the understanding that her natural death was not reasonably foreseeable, but there was no option for further treatment for her. Just shy of her 23rd birthday, she had a medically assisted death in her home surrounded by her family and I was there to provide the medication that brought that about.

In many ways, the experience of that death was an experience for the entire family. They had gone through this journey with her, from when she was underage and beginning to experience the difficulty with this problem, all the way through helping her understand and move forward with the treatment decisions, etc.

In getting to know her, it became quite obvious that she had become an expert in her own problem. She had done the research, she had listened to the doctors and she had listened to the therapists, etc. She weighed her options and she finally made the decision that she would not want to go through some experimental therapies, which were not likely to help her going forward. She engaged in very frank and open conversations with her parents. They were not necessarily onside initially and there was some family strife as a result of that, but eventually they came around and were able to support her.

At the end of the day, she is the closest experience I have with a mature minor in terms of an ability to go through this process and see it through to the other end. Her death was peaceful. She was surrounded by her family and her friends, who lingered. We stayed around after and I can't remember how many pots of tea we drank while talking about her journey and telling stories. I'm still in contact with her family to this day, periodically.

Unfortunately, I don't have the academic background that Dr. Morrison brings to this process, but I think the clinical aspects of this are very similar to what goes on with adults. It's all about communication. It's all about ensuring capacity. It's all about understanding your options and being able to act upon them. Age doesn't necessarily define what that understanding ought to look like or could look like. I know plenty of people who are in their forties who are not capable of making decisions and they are not unwell.

I think I will yield at this point because I am finished.

● (1945)

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

Next, we will have Professor Kimberley Widger.

You have the floor for five minutes.

Professor Kimberley Widger (Associate Professor, Lawrence S. Bloomberg Faculty of Nursing, University of Toronto, As an Individual): Thank you very much, and thank you for the invitation to speak today.

I am an associate professor in the Lawrence S. Bloomberg faculty of nursing at the University of Toronto, and I hold a tier-two Canada research chair in pediatric palliative care. Prior to shifting my focus to research, I worked for 12 years as a staff nurse, mostly providing care to children with cancer but also to those with other types of life-threatening illnesses.

The overarching goal of my program of research is to examine and enhance the provision of palliative care for children living with a life-threatening illness and their families so that every child who might benefit receives optimal care.

Unfortunately, my research continues to show that many children do not have access to specialized pediatric palliative care, and there are some concerning inequities in who accesses this care. Much of this research was highlighted in the final report of the expert panel working group on MAID for mature minors through the Council of Canadian Academies. I was a member of the working group.

My comments will focus on the implications of my research for the care provided to mature minors and their potential eligibility for MAID.

Palliative care is seen as a fundamental human right. It focuses on minimizing suffering and maximizing quality of life. It is meant to be provided from the time a child is diagnosed with a life-threatening condition through to the end of their life.

Palliative care can be delivered in different ways, but my research has primarily focused on the care delivered by specialized pediatric palliative care teams, namely, interprofessional teams of health professionals, typically doctors, nurses, social workers, child life specialists, spiritual care providers and others who have expertise in both the care of children and in palliative care.

One of my first studies was to examine the teams who provided this specialized care and the children who received it. In 2002, there were only seven teams like this in Canada, and they provided care to only about one in every 20 children who might benefit. We repeated the study in 2012 and found there were 13 teams providing care to one in five children who might benefit.

As of 2022, there are 17 teams, but I don't yet have the statistics on how many children have been receiving this care across the country in the last year. However, based on a couple of relatively recent studies we've done just focused on Ontario, about one in three children who died from a life-threatening condition received care from one of these teams. Clearly, there have been improvements over time, but the progress has been very slow over the last 20 years.

In Ontario, we've looked more closely at children who died from cancer and found that those living in the lowest-income areas and those living furthest away from a tertiary children's hospital were least likely to receive specialist palliative care. Given the Canadian geography, it may not be surprising that those living further away were less likely to access care.

Couldn't it just be provided by adult palliative care providers or general pediatricians? Absolutely. Many of the specialist teams work with these other providers to be able to provide care closer to home, acting as consultants so the child still gets the benefits of the specialist team.

We were able to compare the children who received at least some of their care through the specialized teams with those who received palliative care but without involvement of a specialist team and those who had no indication that they had received any type of palliative care. We found that those with the specialist care were dramatically less likely to have frequent visits to the hospital, to the intensive care unit and to the emergency department in the last 30 days of their lives, and they were much less likely to die in the hospital than those who got no palliative care. Unfortunately, the middle group, the ones who got some kind of palliative care outside of a specialist team, were no different in terms of hospital visits or dying in the hospital from those who got no palliative care.

Specialist teams make a difference in the support provided to children and families. As I said at the outset, these teams are experts in providing pain and symptom management, addressing psychosocial and existential concerns, supporting families and maximizing quality of life while minimizing suffering. However, not all Canadian children are able to access these services.

I cannot see how we could allow a mature minor to choose MAID unless all support options are fully explored by a specialized team of health professionals who do this work every day. My greatest fear would be that a 16- or 17-year-old who does not have ac-

cess to this type of care would be left feeling that MAID is his or her only option.

• (1950)

Thank you.

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

Thank you to all our witnesses for their testimony today.

We will begin our first round of questions with Madam Vien.

Madam Vien, you have five minutes.

[*Translation*]

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

I'd like to thank all the witnesses for sharing their thoughts and knowledge with us. We've studied many aspects of this legislation in the course of reviewing it, and probably the most affecting is this one, the whole issue of mature minors.

Dr. Morrison, thank you for your testimony. I have three questions for you. Take the time to explain what you think.

First, how do you determine that a young person has the capacity to make such an informed decision?

Second, do we have enough data on that? After all, there are very few places on the planet where medical assistance in dying is available to mature minors. It seems to me that it hasn't been documented well enough for us to embark on this journey. I'm not saying that I'm against it—quite the contrary—nor that I'm in favour of it. It's just that I have a lot of questions.

Finally, what criteria or safeguards should be included in this revised legislation if, in our power as legislators, we decide to allow mature minors to have access to medical assistance in dying?

Those are my three questions. You're an expert, so I'm listening.

[*English*]

Prof. Kimberley Widger: Thank you. I think—

[*Translation*]

Mrs. Dominique Vien: My questions are for Dr. Morrison.

[*English*]

Dr. Kathryn Morrison: My apologies. I did hear Professor Widger as well, but I'm happy to take a stab at answering some of the questions.

I'll start with the question of capacity. We know that capacity is often formulated as being time- and treatment-specific. A patient could be found capable of making one kind of decision while incapable of making another kind of decision. In the context of some of my research and some of my practice, we have seen mature minors in situations where they are able to make decisions that entailed quite a bit of complexity as far as understanding and appreciation were concerned. There are many factors at play there, whether it be experience of illness, experience of suffering, child development or how their beliefs, values and cultural norms might apply to the decisions where there are elements of subjective value inherent in some of these questions.

We also see that there are usually different weights assigned to decisions. The more grave the decision, usually we see a need for a higher threshold. What some of my work argues is that we actually see situations where mature minors make incredibly weighty decisions that have grave consequences, especially when it comes to a decision to choose to die where there's the option of having a long and lengthy future in some cases. In those situations we regard minors as being capable. In situations where a mature minor is at the end of their life, they are not facing a lengthy future and they're thinking through all their options on how they wish to die. Oftentimes we see those decisions as, I argue, comparatively less weighty.

When it comes to safeguards, I just want to mention that there are many safeguards outlined quite clearly in the Council of Canadian Academies report.

• (1955)

The Joint Chair (Hon. Yonah Martin): Madam Vien, you have one minute remaining.

[*Translation*]

Mrs. Dominique Vien: Mrs. Widger, you were going to jump in. If you have anything to add, we'd be happy to hear it.

[*English*]

Prof. Kimberley Widger: Yes. I had heard my name in the first round as well. I'm sorry.

At any rate, in terms of the safeguards, my safeguard is maybe obvious. Pediatric palliative care specialists need to be involved in assessing these children and making sure they truly have explored all options that are available. It's sort of "you don't know what you don't know" in some cases. Someone might feel they are doing a fabulous job of doing that exploration, but it really takes a team effort of specialists in the area. For me, that would be the minimum to have available.

COVID has made it better, in some ways, that some of this care can be done more so over long distance—

[*Translation*]

Mrs. Dominique Vien: Since this is a very important issue, do you think that health care professionals could refuse to administer medical assistance in dying to young people simply on the basis of their age, when they would otherwise administer it to adults?

[*English*]

The Joint Chair (Hon. Yonah Martin): Madame Vien, we are over time.

Please answer very briefly, Professor Widger.

Prof. Kimberley Widger: I couldn't catch the end of that. I'm sorry.

The Joint Chair (Hon. Yonah Martin): Okay, we are over time, so we'll move on.

We'll go next to Monsieur Arseneault for five minutes.

[*Translation*]

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

I'd like to thank all the witnesses for being with us. They're here this evening to discuss a very sensitive issue, the issue of mature minors.

My first question is for Dr. Gubitz.

Dr. Gubitz, you candidly admitted to us that you thought you were here to talk about advance requests. Ultimately, your work experience allows you to be part of the discussion.

You told us about a young girl who had suffered intensely for five years, before she reached the age of 19 and was able to apply for medical assistance in dying. You said that, in her case, it wasn't a question of age, but of ability to understand.

Can you tell us more about that, taking into account the framework of an application from a mature minor?

[*English*]

Dr. Gordon Gubitz: In this particular circumstance, I'll link back to something Dr. Morrison mentioned. It's the idea that capacity is a fluid thing. We can recognize that children might have capacity to make a decision about what they want to wear to go to school, what they want to do or how they want to do it based on the information that's available to them.

Obviously, Dr. Morrison's experience and research have demonstrated that children certainly do have capacity to make health care decisions, medical decisions, within the context of their understanding. I think it really does come down to ensuring that enough has been done to allow the child to explore the issues as best they can, to speak about it in a language that is common to them, that makes sense to them, and to reflectively respond to questions about their experience to get a sense of their understanding, the same as we do in the adult world: Do you understand what happened to you? Do you understand where you're at now? Do you understand what the future is likely to hold? What do you think about that? Do you understand what your options are?

We might have to do this in slightly different ways—

• (2000)

[*Translation*]

Mr. René Arseneault: I'm sorry to interrupt, but my time is very short, and your comments lead me to my next question.

When it comes to analyzing a person's capacity, is there a difference between a mature minor, that is, a young person who, by your definition, has the intellectual capacity to reason and understand their situation, and an adult? Are there additional safeguards to consider?

[*English*]

Dr. Gordon Gubitz: I think it will be very situationally specific. It has to do with the child's development and their overall understanding. I'm not a pediatrician. I'm not a pediatric neurologist. I think, as Ms. Widger has said, making sure that we have the right people engaged with the children who are in the process of understanding their mortality, etc., is similar to what we do in track two for adults right now, where we need to have someone doing an assessment who has expertise in the condition.

If the people who are doing the assessments don't have expertise in that condition, I really need, as an assessor, to understand that all that can be done has been done to allow us to understand that the patient in front of us knows what's going on. It will probably be much more complex, but I agree with Ms. Widger that there will need to be very specific safeguards for these children, who, hopefully, are not going to be coming by the hundreds. That would be terrible. There will be very specific children who will meet the criteria and will be found by people doing the assessments to have capacity to make decisions about their health.

[*Translation*]

Mr. René Arseneault: Dr. Morrison, after hearing Dr. Gubitz's testimony, can you tell us if you think there should be additional safeguards for mature minors? If so, what should those measures be?

[*English*]

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

Dr. Kathryn Morrison: Thank you very much for that question.

I will endorse the testimony of the other two expert witnesses on the need for clinicians with expertise with this population.

I also want to emphasize that, when we think about decision-making, the alternatives to a decision are essential parts of informed consent. That's also true of mature minors. When we think about a decision, the alternatives need to be clearly laid out and as accessible as possible.

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

Next, we will have Monsieur Thériault.

You have the floor for five minutes.

[*Translation*]

Mr. Luc Thériault: Thank you very much, Madam Chair.

Dr. Gubitz and Dr. Morrison, in the case of mature minors between the ages of 14 and 17, should the legislation require parental consent, if not parental consultation?

• (2005)

[*English*]

The Joint Chair (Hon. Yonah Martin): Dr. Morrison can begin, followed by Dr. Gubitz.

Go ahead, Dr. Morrison.

Dr. Kathryn Morrison: I apologize. It felt as if we were in Zoom freeze.

That's a really important question to ask, because we know, in the Benelux countries where mature minors are able to access medical assistance in dying, parental consent is a requirement, at least in some cases.

It's a challenge because parental presence in medical decision-making is often seen as autonomy enhancing, in some respects. However, we encounter cases where there are deep concerns about how the role of the parents might impact autonomous decision-making for minors. As we see in the adult context, when it comes to MAID practice, the role of family members can be a dual challenge—autonomy supporting but also autonomy limiting.

One big challenge, when it comes to mature minors, is compatibility with our framework around treatment decisions. Oftentimes, when a patient—including minors—is capable, there is usually no role for family members to be making decisions on that patient's behalf. I think it would be a challenge to require parental consent.

Consultation is a bigger conversation.

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

Dr. Gordon Gubitz: I would agree.

Once again, I'm not an expert on the legal definition of “mature minor”, so I think the committee may wish to have a look at that and get an opinion about what we are actually speaking about when we speak about a mature minor, as opposed to an emancipated minor, etc.

I agree that family is important. In the over-18 world, when we think about medical assistance in dying, we don't necessarily talk about family. We talk about those who are supporting them, because families come in all sorts of shapes and sizes. Some are very toxic and some are very supportive, so fortunately—

[*Translation*]

Mr. Luc Thériault: I'm sorry to interrupt. You said at the outset that you agreed. Do you agree with Dr. Morrison that there should be a legislative requirement for consultation, and not a legislative requirement for consent?

[English]

Dr. Gordon Gubit: I think an assent approach would be more useful. It's really about the conversation, the nature of the relationship with the family and recognizing that, if this child is very ill and will die, the family is going to carry on afterwards. You would rather have a family that can carry on together, as a unified whole, than a family that is fractured into pieces and never speaks to each other again.

That can be the role of the team involved in doing the assessments and providing that level of support.

[Translation]

Mr. Luc Thériault: I imagine that these decisions, which are very rare, are made harmoniously in the majority of cases. Is that what you see in your practice, Dr. Gubit? That's the first question.

Second, should access to medical assistance in dying for mature minors be limited to track one patients?

[English]

Dr. Gordon Gubit: Unfortunately, sir, I'm not a pediatrician, so I can't really comment on that. It is not my practice. I deal with people who are able to give their own consent.

I would defer to the expertise of the other witnesses around that who study—

[Translation]

Mr. Luc Thériault: In this case, I'll ask Dr. Morrison to answer.

I'm sorry for interrupting you, Dr. Gubit.

[English]

The Joint Chair (Hon. Yonah Martin): We need a very brief answer.

Dr. Kathryn Morrison: My apologies, but could the question be repeated? I also want to stay in my lane, as I am not a pediatrician either.

The Joint Chair (Hon. Yonah Martin): We are running out of time.

[Translation]

Mr. Luc Thériault: Thank you, Madam Chair.

Should access to medical assistance in dying for mature minors be limited to track one patients, in other words, patients at the end of life, whose death is reasonably foreseeable?

[English]

The Joint Chair (Hon. Yonah Martin): Answer briefly, Dr. Morrison.

Dr. Kathryn Morrison: My apologies, but I'm just hearing the translation. I'm having some trouble interpreting the question.

I interpret it as allowing for mature minors to access MAID under track one, and I think—

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

Unfortunately, with the time, we have to move on. You have my apologies for that.

I'm going to give the floor to Mr. MacGregor for five minutes.

• (2010)

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

Thank you to our witnesses. It is a very difficult subject.

I appreciate this as a parent, first and foremost. I think the difficulty is that parents are driven by a desire to protect their children, but at the same time are juxtaposing that with a child who might be undergoing obvious suffering.

I guess we are lucky in a way, in that each of our provinces already have provincial laws in place, health care laws in place. In my home province of British Columbia, they state, "In general, parental consent for health care in BC is sought for children 12 years of age and younger. However, there is no legal age of consent". Basically, "Mature minor consent" is the consent a child or youth gives to receive health care after the child has been assessed by a healthcare provider as having the necessary understanding to give consent."

Dr. Morrison, I know it's not so much tied to an age. It's tied to the general understanding that the child has.

Can you, first of all, give us an example? When a child comes in with their parents, how do you guide that relationship? Do you have a time when you sit down with the child alone? Can you give us an example of the types of questions that are asked to try to assess whether that child has an understanding of what's coming their way?

Dr. Kathryn Morrison: Thank you for the question.

Unfortunately, I am not a physician and I'm not a frontline health care provider, so I do not do capacity assessments.

I would defer to the other witnesses on this question.

Mr. Alistair MacGregor: Dr. Gubit, do you have anything to add that could help guide us on that?

Dr. Gordon Gubit: I can only reflect on what happens in a situation with adults.

We often will do interviews with the person seeking a MAID assessment and their supporters—their loved ones or whomever. We will often find a way to have a conversation separately with the person, just to ensure that they're not being coerced one way or the other into making a decision.

More often than not, when people are thinking about this, they've been thinking about it for a long time. Oftentimes when they come, they come with somebody who has been there with them on that journey. They understand the illness. They understand that this is going to be a difficult conversation. They're there to be supportive. Rarely, we have circumstances where people are not supportive, so clearly, they picked the wrong person.

I could see the same thing happening with parents and children, except ramp that up tenfold in terms of the concern and, as you mentioned, the idea about thinking of this as a parent.

Once again, it gets down to the degree of comprehension and the degree of support from the team around this group of people to work through this process together, recognizing that the decision is not going to be made just like that. The decision is going to be a process rather than just this immediate...and we're done.

Mr. Alistair MacGregor: Dr. Morrison, maybe I'll try to word this in a way that respects your expertise in clinical ethics. To what extent should the quality of end-of-life care be considered as a factor when we're assessing this?

I take Dr. Widger's comments about wanting to make sure that specialized palliative care is available so that every child who may potentially find themselves in this situation has at least had the opportunity to make that informed choice and to experience the full range of care options. Does your practice or your expertise in this field inform anything that you can say on that?

Dr. Kathryn Morrison: Yes, because oftentimes clinical ethicists navigate very challenging situations regarding informed consent to treatment. I think Professor Widger's really important comment around the accessibility of palliative care is important: to inform mature minors around all of their options when it comes to end-of-life care. In some ways, it's very challenging to say that an informed decision has been made without full knowledge of and accessibility to all available options.

Mr. Alistair MacGregor: Thank you for that.

That's it for me, Madam Chair.

● (2015)

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

I will now turn this over to my joint chair for questions from senators.

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

[Translation]

Senator Mégie, you have three minutes.

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

My question is for Mrs. Widger.

As a nurse, you work in the field with children with cancer or other terminal illnesses. How important do you think it is to promote the involvement of young people in discussions and decisions on this very important issue facing them? Is this something that should be discussed with children who are already sick or with healthy children?

Is there any research on that? If so, what were the findings?

[English]

Prof. Kimberley Widger: Yes. In terms of my experience as a nurse, I have not been at the bedside for quite a while, but I certainly have been involved with children and young adults—older teenagers, I guess—who are making decisions that impact their lives, very much so, and there's a range. No two 16-year-olds are the same.

I've cared for, at the same time, two 16-year-old girls. One made all the decisions, with her father with her, but he absolutely let her

make all the decisions. I think she could have very much made this kind of decision. Another 16-year-old didn't want to be a part of any of the meetings and really didn't want to talk at all or make any decisions.

They're completely different children. They bring different experiences to the situation. Also, there's a big difference in terms of being diagnosed with something when they were three years old, are now 17 and have lived with and been involved in decision-making all the way through, versus someone who was diagnosed three months ago. It's hard. I can remember many children who could have made this decision, in my assessment, and many of the same age who could not have made this kind of decision.

[Translation]

Hon. Marie-Françoise Mégie: Do you think that the best way to have a debate on this would be to use research bases from countries that have already had this experience? There aren't many, but are you aware of their findings?

[English]

Prof. Kimberley Widger: No, there are not very many other jurisdictions, and in those that do have it in place, the numbers are very small. To be honest, I haven't looked up the numbers since we did the report on mature minors as part of the working group, so I don't know if their numbers have gotten bigger over the last few years. However, the numbers were small.

A study was done asking Canadian pediatricians how many times in their career they've been asked about it. It wasn't even called medical assistance in dying at the time. They talked about how over their careers there was a total of maybe 20 mature minors who had asked about MAID explicitly over the course of many pediatricians' entire careers.

I think—I hope—the number would be very small, but I think the number of adults who have taken advantage of MAID is much higher than what we thought it might be when Canada started down this path, so who can say?

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

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

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

I have three questions. They are all for Dr. Gubitza.

In a slightly different area, I think you can help us in your role as chair of the MAID curriculum development process. I'll just ask the three questions and then ask you to respond.

The first question is this: Will this curriculum that the group is working on be of a similar standard to other curricula currently used in the training of physicians, family physicians or specialists for the royal college?

Second, will this curriculum provide an opportunity to standardize MAID assessment and delivery across Canada—so, to improve that standardization?

Third, will this curriculum assist professional and regulatory bodies to set standards of care for MAID similar to what we currently have in all other aspects of medicine in Canada?

• (2020)

Dr. Gordon Gubitz: The first question has to do with the quality of the educational curriculum that we're developing. The curriculum will be accredited by all of the royal colleges—the Royal College of Physicians, the College of Family Physicians of Canada, and the Canadian Nurses Association—as they are actually partnering with us on the development of this. They have eyes on the project through all of its stages of development, but it will go through an accreditation process.

With respect to the second question about creating an educational standard across the country that's comparable to what one might see elsewhere, the reason this curriculum was developed is that there is no formal training for MAID in any form across the country. It arrived as a legislative change. Then it was “see one, do one, teach one”. Eventually, through the Senate request for CAMAP to develop the program, we now are developing a basic training program for clinicians who are interested in developing their skills around MAID assessment, MAID provision through a series of a more basic assessments through to more complex assessments, capacity and vulnerability, etc.

I think that, with respect to the third question, all of the provinces and territories presently have standards that we follow. In Nova Scotia, our college of physicians and surgeons has a standard that I must adhere to. We work with our college to ensure that they will have access to this information, and we would work hand in hand with them to improve the legislative standard as it would be required. I think there are only upsides to having a national standardized education process for MAID.

To anticipate the question that might come... We don't have a standard at the present time for pediatrics or for mature minors only because it's not part of the law yet. I imagine that, as time goes by, that might be something that happens if this becomes part of the federal legislation.

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

Senator Dalphond.

[*Translation*]

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

[*English*]

I'm going to follow up on... My question was the one that Mr. Thériault tried to get an answer on. I will repeat it so that we will answer his question and mine.

I understand from the testimony of Dr. Morrison that she thinks there are two things that are important. We should look at maturity instead of age because this is not necessarily equivalent. The sec-

ond thing is that, if access is provided to MAID for mature minors, it should be limited only to track one.

Would you, Dr. Gubitz and Professor Widger, agree with that?

Dr. Gordon Gubitz: I'll go first.

I totally agree. I think that when MAID came about back in 2016, only track one existed. We learned over a period of time what that looked like. Through that and through gauging the Canadian response to this, we were eventually able to lead to track two and to Audrey's amendment and all of those sorts of things—the low-hanging fruit first, and then working and getting a sense of what makes sense and what our experience teaches us. I think to go immediately to track one and track two for mature minors might be more than the Canadian public is willing to handle. I think we need to approach this thoughtfully, cautiously, and in a stepped approach.

That's my opinion.

Prof. Kimberley Widger: Yes, I would agree with the same.

[*Translation*]

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

[*English*]

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

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

My question is for Professor Widger.

As you are aware, the CCA working group concluded that there are many gaps in knowledge that make it “difficult to arrive at definitive answers”, and only three countries, as you mentioned, allow MAID for minors. There are so few cases that there's very limited data.

Given this lack of data, do you think it's prudent to move ahead with MAID for mature minors in Canada, or would Canadians be better served if this committee recommended that government undertake further expert research on the issue?

Prof. Kimberley Widger: That's a very big question.

I think the youth voice is still missing from the work that's been done to date. I know that Dr. Franco Carnevale testified before this committee in June, I believe, and that's some work that he is doing. I think it really is important work.

It's important to not just rush into things, as you say. A more stepped approach may be better and serve us better in the long run. On the other hand, if I were 17 years and 250 days old, forcing me to wait just seems crazy if I'm capable of being able to make a decision, so I don't have a good answer to that question.

• (2025)

The Joint Chair (Hon. Yonah Martin): It was a big question, so thank you for responding as you did.

Beyond specialized pediatric palliative care, which I think is so important, are there other services and supports that are needed for certain groups such as indigenous, racialized or disabled youth?

Prof. Kimberley Widger: Yes, and I think those are the groups who we really still have not heard from, the indigenous population in particular in terms of how this fits with their views and ways of being in the world. We have not looked at that really at all.

Yes, it's absolutely a critical component, and I think, yes, mature minors with disabilities are a different population from those with a terminal illness. They're the track one group whose death is foreseeable in the very near future. For most of those with disabilities, it would not be something that's in the near future, so maybe that's a different track.

Yes, more research is needed in those areas for sure.

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

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

With that, I'll return it to you.

The Joint Chair (Hon. Yonah Martin): I'd like to say thank you to all of the witnesses. It's a difficult topic, and your expertise, your recommendations and your guidance are very important to us.

Thank you very much on behalf of our committee.

With that, colleagues, we conclude. Thank you.

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