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The Honourable Marc Garneau The Honourable Yonah Martin



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• (0845)

[*Translation*]

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

Good morning, everyone. Welcome to meeting number 25 of the Special Joint Committee on Medical Assistance in Dying.

I'd like to welcome the committee members, the witnesses and those watching this meeting on the Internet.

[*English*]

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

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

I have just a few administrative notes.

I would like to remind members and witnesses to keep their microphones muted unless they are recognized by name by one of the joint chairs. All comments should be addressed through the chair.

When speaking, please speak slowly and clearly for the benefit of interpreters. 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.

I'll note, before we get started, that we are expecting bells at around 10 o'clock. Is there unanimous consent to continue for 20 minutes following the bells before adjourning?

Some hon. members: Agreed.

The Chair: Thank you. The clerk will notify me when we're 19 minutes past the bells.

With that, I would like to welcome our witnesses for panel one, who are here to discuss mature minors.

As individuals, we have Elizabeth Sheehy, professor emerita of law at the University of Ottawa. We are awaiting Dr. Eduard Verhagen, who is a pediatrician and head of pediatrics at the Beatrix Children's Hospital. We expect him to be online shortly. Finally, we have Dr. Mary Ellen Macdonald, endowed chair in palliative care. All three are appearing by video conference.

Thank you all for joining us this morning.

We'll begin with opening remarks by Ms. Sheehy, followed by Dr. Macdonald and then hopefully by Dr. Verhagen.

You will each have five minutes, which will be followed by questions.

Ms. Sheehy, you have five minutes. The floor is yours.

Professor Elizabeth Sheehy (Professor Emerita of Law, University of Ottawa, As an Individual): Thank you, Mr. Chair.

As mentioned, I'm a professor emerita at the University of Ottawa, where I taught criminal law and procedure for 34 years. I'm also the sister of Matthew, who has developmental disabilities and some physical disabilities. I have first-hand experience with the extraordinary wait-lists for supportive housing for people like my brother, and with medical professionals who repeatedly urged us to consider "do not resuscitate" orders when Matthew has required medical treatment.

I add my voice to the clear and unequivocal opposition expressed unanimously by disability rights groups across this country to yet another extension of MAID. I testified before the Senate committee that studied Bill C-7 in 2020 to oppose extending MAID to people with disabilities who are not dying. We lost that fight, and so the bonfire started. The wood was laid and a match was lit.

Our worst fears—that people with disabilities would seek MAID not because their disabling conditions are intolerable, but rather because of our failure to provide the social and economic supports they need to lead dignified lives—have come true. When this government then extended MAID to people suffering mental illness, it added accelerant to the bonfire. I wrote opinion pieces pointing out the discriminatory impacts on women, the fantasy that psychiatrists can distinguish between a mentally ill person who is suicidal and one who is expressing a rational wish to die, and the folly of accepting doctors' claims that they can determine that a person's mental suffering can never be alleviated.

Now, here we are, about to toss children into the MAID bonfire. This is what they are. They are de facto children unless and until some professional, not even the parent, decides they can be treated as adults for the purpose of deciding to die.

The proposals of some organizations, such as Dying With Dignity, are absolutely chilling. They appear to support a presumption that children who are 12 years or older have the capacity to elect MAID. This position is impossible to square with how we otherwise treat children. Twelve-year-olds cannot consent to sexual contact. We see the consequences of sexual activity as so life-altering and so full of potential for exploitation that we brook no exceptions. We prohibit many other activities to children, such as the consumption of alcohol or driving vehicles. We do this not only to preserve the life and well-being of children, but also to protect those who love them and other members of our community. How can we even consider allowing children to access government resources to end their own lives?

The MAID bonfire will now spread to neighbourhood trees, and no one's home or loved ones will be safe. What parent has not seen their teenager suffer deeply from anxiety, racism, misogyny, homophobia, depression or social exclusion? I know no one whose child has not struggled with at least one of these challenges.

We live in a historical moment where the rates of mental illness experienced by children and youth have never been higher. We know, too, that intergenerational trauma and sexual abuse play a huge role in generating the mental suffering of young people, and that disabled girls and indigenous kids are disproportionately at risk.

It's morally wrong to abdicate our responsibility to address these traumas and respond to young people's distress with every resource we have. It's wrong to tell them that doctors and governments will help them end their lives if they cannot see the light at the end of the tunnel. Our job is to give them that light, not help them snuff it out.

My heart breaks for the parents and communities who have lost their teenagers to suicide. They and their families will never ever be the same. As we know, suicide among young people can spread like wildfire. We have seen this in indigenous communities, where each young person's death threatens every other sapling. We see this phenomenon in other communities as well, where young people already struggling with alienation are devastated and demoralized by the deaths of their friends.

The proposal to extend MAID to teenagers, regardless of their parents' wishes, is a huge betrayal to those whose kids have taken their own lives and to all communities fighting to keep their teenagers alive. We must put a firewall around the MAID bonfire to at least keep children and teenagers away. We know that young people's brains do not fully mature until they're in their twenties. This makes it impossible for even mature youth to imagine the possibility of a life of purpose and joy when they are stuck in the muck of alienation or adjustment to disability or to their sexuality, or to comprehend the finality of death and the other devastation that their lost lives will wreak upon their families, friends and communities.

Extending MAID to mature minors is reckless. To trust that doctors can predict which young people cannot be healed or helped, or whether they have the maturity to make such irrevocable decisions, flies in the face of our not-so-distant eugenics past. To pass a law that would require communities and parents to do nothing when

their young people throw themselves on the bonfire is to force us to watch our futures burn.

• (0850)

Thank you.

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

We'll now go to Dr. Mary Ellen Macdonald for five minutes.

Dr. Mary Ellen Macdonald (Endowed Chair in Palliative Care, As an Individual): Good morning and thank you, Mr. Chair.

My contribution to this discussion is as a social science researcher with two decades of experience in palliative care research with both younger and older populations. Specific to mature minors, I was a member of the CCA expert panel working group for mature minors. I also supervised a philosophy student's master's thesis on the topic, which was published in the *Journal of Medical Ethics* in 2020, and my team recently completed a qualitative study engaging youth in focus group discussions regarding this potential legislation, with results having recently been submitted for publication.

What I want to focus on is how my research team, following the CCA report, has recently positioned itself to help advance the generation of empirical data to move these discussions forward. This position comes from a collective experience we had on the CCA expert panel, an experience of frustration that we were trying to advance policy and practice ideas without having ample evidence from youth themselves on the topic at hand. We continually circled back to the lack of research we could draw upon to help think forward about what MAID for mature minors could and should look like.

On the CCA panel, clinicians could reflect on their personal experiences with members of relevant populations, and lawyers could think about some adjacent case law, but overall it was clear that there was very limited national or international evidence that captured the voices and experiences of young people and their families regarding terminal illness, suffering, grief and bereavement. Evidence was even more scarce on the views and experiences of young people who may be made particularly vulnerable by the current state of practice, such as indigenous youth, young people with disabilities and those in the child welfare system.

As a researcher abiding by tri-council research ethics and community-based participatory guidelines, I take very seriously the ethical stance towards participants of “nothing about them without them”. It is not okay to be advancing research, policy or practices on MAID for mature minors without actively soliciting and listening to youth voices. The United Nations Convention on the Rights of the Child outlines how and why young people have rights to participate in matters that impact their lives and to express their views in any discussion that affects them based upon their own capacities. Given that young people remain ineligible for MAID, a form of end-of-life care that they may be interested in and may benefit from, it is reasonable to consider that their exclusion from conversations about MAID until this point has been in violation of the right to participate.

In the spirit of addressing this gap, with two colleagues, Franco Carnevale and Sydney Campbell, I have put forward a proposal to Health Canada through the health care policy contribution program. We were solicited by Health Canada to develop this proposal. However, it is not yet finalized and the budget has not been approved, so I'm just going to stay at a high level with respect to details about its design.

We have proposed a three-year study that will meaningfully engage with young people to generate data through focus groups, interviews and arts-based methods from which we can put forward evidence-based recommendations on the next steps pertaining to MAID for mature minors. We are starting with the premise that youth are agents with rights and we are proposing to proactively work directly with young people and their caregivers to understand what is important to them regarding clinical and policy discussions around MAID specifically, and also how they want to be involved in palliative and end-of-life policy planning more broadly.

We will spend the first year consulting with youth and caregivers about how the study should unfold. We have proposed including in our sample young people perceived as being particularly vulnerable, such as youth with underlying health conditions like cancer, with mental health conditions or with disabilities, and indigenous young people. We propose to create a coast-to-coast-to-coast sample involving young people throughout, starting at age 12, from design through to analysis and dissemination. Together with youth, we will produce both a descriptive report on the state of the situation and a more theoretical and ethically focused analysis of what should be done and how policy should move forward.

Thank you.

• (0855)

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

For our third panellist, there was a misunderstanding and that person thought they were in the second hour. Fortunately, somebody from the second hour is here in the first hour, Dr. Arundhati Dhara, and is ready to speak. She is a family physician.

Dr. Dhara, if you're ready, you have five minutes.

Dr. Arundhati Dhara (Family Physician, As an Individual): This is unexpected, but thank you, Mr. Chair and members of the committee, for the opportunity to speak today.

I'm grateful to join you from Mi'kma'ki, the unceded territory of the L'nu.

I'm going to start with what I'm not. I'm not a lawyer. I'm not a bioethicist. I'm not a MAID scholar. I'm a generalist family doctor, and I have more than a decade in practice. I've also been a MAID provider since about 2017 as part of a full scope of palliative care work.

I'm going to tell you today what it's like to provide MAID and what the considerations for a MAID provision might be with regard to minors were it to become legal.

My first experience with MAID was with a dynamic, incredibly funny woman who did not qualify under the legislation at the time. I represented her third opinion because she didn't have a foreseeable death and wasn't suffering sufficiently under the legislation. She lived with constant chronic pain that limited her life, and she told me she was profoundly alone despite being very close to her family. She had plenty of joy, but she suffered nonetheless.

I remember that she gave her glasses to her daughters and she told them to do something useful with them. She then closed her eyes and made some very morbid jokes. We all laughed. Then she went to sleep, and then she died. It was the most profoundly patient-centred moment of my career up to that point.

Why am I telling you that story? This woman was in her nineties. The committee has asked me to think about MAID for mature minors. The truth is that the considerations for her capacity to give informed consent to that procedure are actually no different than they would be for a mature minor. Does she understand what's being offered? Does she understand the risks and benefits? Does she understand the alternatives?

Picture a mature minor, someone who happens to be under the age of 18. That age is mostly arbitrary; 18 is not a magic number. Minors already exercise autonomy over their bodies in other instances, and we don't require them to explore every option to some external standard of satisfaction for every medical procedure. The capacity to consent is specific.

As we move to expand MAID generally, there are a number of other considerations, including how we understand the developing brain and how we understand issues of mental health, which is soon to become an eligibility criteria. How that is or is not appropriately applied to minors would be an important consideration, and I don't feel qualified to understand the developing brain well enough to say that. In jurisdictions where mature minors do access MAID, it's actually quite rare. They tend to have had very long histories with their health care decision-making and with the health care system generally. That's the nature of illness in kids.

In family practice, I have the distinct privilege to see kids grow over time, which is to say that I watch them cognitively develop. I'm pretty confident that I could figure out whether a patient of mine was able to consent, but even if I couldn't, MAID providers exist inside a community of practice, which gives us a network to lean on for resources and for second, third and fourth opinions if we need them.

I want to close by naming the elephant in the room. There's a certain visceral revulsion to the idea that a child could suffer so much that they'd request an assisted death. How is it possible that that does not represent a monumental failure of our medical system? Surely better palliative care services and better social services—all of those things—would mitigate the need to request MAID.

It's okay to feel pain when a child suffers. We should. We would be monsters if we didn't. However, the existence of better treatments and better services does not negate our obligation to have equitable and humane access to MAID if it is appropriate. Respectfully, I think we are obligated to see past our revulsion. The right thing to do doesn't always feel good. In fact, a friend of mine who is an ethicist said that ethics only really come into play when everything makes you really uncomfortable.

We need to approach MAID for mature minors the same way we do for every patient: Each is unique and must be treated with careful consideration of their personal circumstances in the context of their life.

Thank you again for the opportunity to speak before you today.

• (0900)

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

I will now turn it over to my co-chair, Senator Martin, for questions.

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

Thank you to all of our witnesses for their testimony this morning.

I'm going to begin the first round and will call upon Mr. Cooper, who will have five minutes.

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

I'm going to direct my questions to Professor Sheehy.

We heard at our last hearing from a witness who noted that mature minors already make major medical decisions, including the decision to refuse life-sustaining treatment. That witness argued that it follows, therefore, that mature minors are as competent to make a decision with respect to MAID. Do you agree?

Prof. Elizabeth Sheehy: No, I don't agree. I think there's a substantial difference between withholding or ceasing treatment and the act of intervention of the state, with its resources, to end a life. I think we know that MAID is an exception to Criminal Code provisions that criminalize murder and assisted suicide. What we're talking about here is creating some sort of exemption from the criminal law for a specific category of young people.

Currently, withholding life-saving treatment is not an individual decision. It is a decision that's litigated through a court process. There are witnesses, an adversary process, a judicial decision, an open court and reasons for a decision. All of those things are safeguards when it comes to the kinds of decisions that involve the withdrawal of life-saving treatment. To move towards a regime of MAID for mature minors is a completely different exercise and one that's deeply concerning when you're thinking about the fact that this is state intervention in ending a life.

• (0905)

Mr. Michael Cooper: Thank you for that.

It was argued that mature minors understand what MAID is and have the capacity to deem their suffering to be intolerable. It was further argued that to not permit mature minors to make decisions around MAID and to not have such an exclusion would be discriminatory.

Can you comment on those two things? It's argued that mature minors can understand what MAID is and their suffering and are therefore competent to make such a decision, and that to exclude mature minors would be a policy that is discriminatory.

Prof. Elizabeth Sheehy: First, I'd say it's not discriminatory to exclude certain groups from MAID. We limit certain medical procedures to different age groups based on the risks. For this group, a lack of understanding of their fulsome future horizons, which is tied to the fact that their brains are still maturing, tells us that the risks are real and, given the finality of death, that the risks are acute.

I would also say that the group we're talking about that I'm most concerned about is young people with disabilities. We know that children with disabilities are more affected by suicidal ideation. Young people with disabilities absorb the social message that their lives are not worth living and feel anxiety about the burdens they place on their families. It's not really until they mature that they can see that this is actually a social issue. It's social discrimination against people with disabilities.

I think it's extremely dangerous to suggest that a young person, no matter how mature, can understand or predict their ability to accommodate life with disability and to find happiness in the future. I think it's actually deeply worrisome to suggest that we will accept a person's hopelessness, give up on them and allow them to access state resources to end their lives at that point.

Mr. Michael Cooper: It was also noted that when it comes to medical decisions, those decisions tend to be based on capacity rather than a firm age distinction. What do you say about that? Is it somewhat arbitrary to say that at 18 you suddenly have the capacity to consent, versus at 17 and a half months?

Prof. Elizabeth Sheehy: I guess that depends on what you're talking about in terms of consent. If we're talking about medical treatments, the more serious the consequences of a treatment, the less likely it is that a court is going to say that a young person has the capacity. We can't really talk about capacity without also talking about what's at stake in either accepting or refusing treatment or asking for the intervention of the state to assist in suicide. The problem with a shifting age of capacity is this: Are we going to use courts to decide that?

I think it's much more important to have a firm age limit so we have a shared societal understanding of when and when not to allow access to MAID.

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

Next we'll have Madame Brière for five minutes.

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

Dr. Dhara, I will direct my question to you, and I will ask it in French.

[*Translation*]

You stated that in your 10 years of practice, you have administered medical assistance in dying. You also noted that there was no need to establish a standard of consent for every medical procedure.

Of the children you've encountered in your practice, how many might have been eligible for medical assistance in dying had it been possible for them to request it?

In addition, with respect to consent, should we talk about maturity rather than age?

• (0910)

[*English*]

Dr. Arundhati Dhara: The nature of kids is that they bounce back. Generally speaking, when kids are ill, even when they're really ill, they get better. The number of kids in my practice who have been so ill in a life-limiting or life-ending way has actually been fairly small. Even in the hospital, I can probably count on two hands the number of kids I've treated who, if MAID were available, would have been candidates in some way. That isn't to say that it shouldn't be available. A small sample size does not in fact make a piece of information or a policy decision not worth considering.

You speak about maturity, and I think that's exactly what we are talking about. It's the capacity to understand and the capacity to think about what the consequences of a decision might be. To that point, I would say that having a really robust understanding of what is being offered, of what MAID is, is in fact a criteria for eligibility. Without that clear, voluntary understanding, MAID simply wouldn't be on the table.

There are a lot of 90-year-olds I've seen who have requested MAID where I've thought, "Actually, I don't think they really do understand." I would say that even "maturity" is potentially a difficult word. It's really about that procedure-specific capacity: "Do you understand what I am offering you right now, this thing, in this moment?"

In folks with dementia, there are often moments of lucidity when I think, yes, they have great capacity, and then there are moments when they don't. It's time-specific. It's incredibly specific.

I hope that answers your question.

[*Translation*]

Mrs. Élisabeth Brière: Yes, thank you.

You said that we should address the issue of mature minors' consent the same way we look at consent for all other patients.

Do you believe that the current eligibility criteria for mature minors are sufficient, or should we consider additional criteria?

[*English*]

Dr. Arundhati Dhara: I think it's something that, again, is really case-specific. There will be cases, I would argue, where it's pretty obvious that a 17-and-a-half-year-old, to use an example, would be fully able to understand and have the capacity to consent to a MAID procedure.

At the same time, there may be considerations of minors who have mental health issues that overlay a life-limiting condition and a number of different pieces where that capacity may be a little more difficult to sort out. In those cases, I would say that the network of practice that I talked about before—where MAID providers don't exist in a vacuum and there is access to different resources and to different providers who can help shed some light on what's going on for an individual patient at an individual time—would be really helpful.

I take issue, from an equity standpoint, with a blanket statement about age, condition or other sorts of things. I think it's a really complicated situation and incredibly person-specific.

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

[*Translation*]

Mrs. Élisabeth Brière: Thank you very much, Dr. Dhara.

[*English*]

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

• (0915)

[*Translation*]

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

Dr. Dhara, I'd like to make the following comment based on your experience and testimony.

For the time being, the clinical situations that lead or may lead to a request for medical assistance in dying are at the end of life, that is, the process of dying has already begun and is irreversible. Patients are guided through an optimal palliative care process, or at least we hope so, but even in those circumstances, when the patient has osteosarcoma, for example, it's not always possible to relieve their pain and suffering. The patient's pain tolerance may be exceeded. At that point, that mature minor might request medical assistance in dying.

This situation and such cases would arise at the end of life, and we could then oversee the process. We're not talking about a suicidal 14-year-old experiencing depression here. No one's going to be thrown to the lions in this situation, right?

[English]

Dr. Arundhati Dhara: I agree. I think you make an important distinction between different types of conditions and different situations. I think the case that you describe of someone with a cancer that is causing incredible pain and suffering who makes a request for MAID is different entirely from that of someone with depression and suicidality. I think we have to be careful not to conflate requests for MAID with suicidal ideation. They are not the same thing. Certainly in practice, they are not the same thing.

Up until now, at least, and I'm certain going forward, something we would ask about and explore with patients during any assessment is whether there is an element of depression or of a mental health condition that is potentially amenable to treatment. I think conflating all of these things muddies the waters and doesn't actually help us end up with an equitable process for folks to access what they need when they need it.

[Translation]

Mr. Luc Thériault: I'd like to point out that in Quebec, minors are permitted to make a certain number of medical decisions when they turn 14.

Once we start setting guidelines for mature minor access to MAiD strictly for track one patients—they would be at the end-of-life stage—do you believe it would be an acceptable option, based on your experience? This would be in line with cases resulting in MAiD requests and could be the source of the majority of them, even though there are practically no cases like this anywhere in the world, if I understood you correctly.

Would you agree?

[English]

Dr. Arundhati Dhara: In jurisdictions where mature minors can access MAID, it is actually quite rare. It's not a commonly requested procedure. The vast majority of cases—I would say all, but I cannot be certain—are really around track one, so the process of dying has already started and there is a terminal, life-ending disease process in place. In those cases, we know that kids feel pain too; kids suffer too. It is, as I say, viscerally heart-wrenching to see, but they suffer, and I think that would be a reasonable basis upon which a mature minor could request MAID.

• (0920)

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

Next we have Mr. MacGregor for five minutes.

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

Professor Sheehy, I'd like to start with you.

I have taken note of your opposition to extending medical assistance in dying to mature minors. I hope you understand that the questions I'm asking you are coming out of a sense of curiosity, as I'm trying to understand this subject matter.

My home province of British Columbia has the Infants Act. That's a provincial law that does allow someone in the medical field to treat a minor as long as the minor has the necessary understanding to give consent to the treatments. That is provincial law that protects someone in the medical profession. As long as they think that child has the understanding, they can go ahead with treatment if they're under the age of 18. No specific age is required; it's just whether that understanding exists.

Some medical conditions are incurable. Some medical conditions cause intolerable suffering. I'm thinking more of the physical ailments that would be covered under track one when we're quite sure that there is no coming back from them.

If minors in British Columbia already have this ability protected under provincial law, and if, say, a 13-year-old or 14-year-old had a medical condition where it's quite obvious they're not going to be cured, they are not going to come back and you can see they are in an obvious state of physical suffering, why must they wait until they are aged 18? Why must they live three or four years with that kind of a condition when we already have this precedent under provincial law? I'm just trying to understand this.

Prof. Elizabeth Sheehy: First, in terms of B.C. legislation, I don't know every province's variations. I do believe that decisions to get treatment are treated differently in law than decisions that result in end of life. For example, in the situation you mentioned, if a parent disagreed with the assessment that the person was mature enough to make the decision or the parent disagreed with the decision to end treatment, I believe this would be a litigated matter. I believe the official guardian has to be involved when we're talking about treatments that result in end of life.

I don't think MAID would be treated the same way under any province's legislation. It's not a medical treatment. It's actually a treatment to end life.

As for the question of whether we should do this for children who experience this kind of pain, I think we clearly have an inability to distinguish between track one and track two. Once we allow further extensions of track one, we know for sure that these will extend to track two and that we cannot contain them. For example, in Carter, the Supreme Court said that its decision did not extend to mental illness, yet here we are. We've gone ahead and done exactly what the Supreme Court of Canada cautioned against.

Mr. Alistair MacGregor: I'm sorry to interrupt you, Professor Sheehy, but I only have a minute and a half left and I want to get in one question for Dr. Dhara. Thank you for your answer.

Dr. Dhara, I know every province has a different variation of the law that allows for medical treatment of minors. I cited the law from my home province of B.C.

Can you explain to us what the provincial law in your area requires you to do as a physician in assessing that a minor has the necessary understanding to give consent to treatment? What are your requirements under provincial law to make that assessment and arrive at a decision that you're comfortable with? I just want some understanding of that, please.

Dr. Arundhati Dhara: In practice, it's exactly what I said in my initial answer. It's an incredibly specific thing. It's specific to the procedure, treatment or whatever else that's being offered. It can be as simple as taking antibiotics for an infection, versus consenting to a surgical procedure. It's really about whether this person understands what is being offered. Do they understand the risks and benefits? Do they understand the alternatives?

Sometimes it's really obvious. If a six-year-old shows up and says, "I want to cut off my leg" or something ridiculous like that, without any good kind of understanding, it's fairly obvious. In the case of a mature minor who is talking about a very serious condition, it's about getting to the root of whether the person in front of you understands.

In my long-term practice, I'm fortunate that I've watched a lot of these kids grow for many years now. I can say that five years ago, I don't think this person could have shown up in the office, made a request for x, y or z and really understood what they were talking about, but today I think they can.

I speak not as a specialist physician. I speak as a generalist physician—

• (0925)

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

I will now turn this back to my co-chair for questions from the senators.

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

[*Translation*]

I wanted to start with Senator Mégie, for three minutes, but I see that she's not with us.

[*English*]

We will start with Senator Kutcher for three minutes.

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

I have two questions for Dr. Dhara.

You reminded us of what in bioethics is known as the "yuck factor". As a reminder, it's an intuitive emotional response to something that should be interpreted as evidence for the intrinsically

harmful or evil characteristic of that thing. It's the idea that repugnance equals wisdom, or repugnance equals a moral judgment.

That's been used throughout history to justify anti-Semitism, racism, homophobia, alternative sexualities, same-sex marriage, etc. Mr. Trump glorified it with his decision-making motto of "this is my gut feeling and therefore it's right". You warned us against making this mistake in our thinking.

Do you think this yuck factor and its counterpart of moral panic may characterize some of the highly emotional discussions that occur around MAID?

Dr. Arundhati Dhara: That's a difficult question. On the one hand, I think we have to have very rational, evidence-based conversations with everybody and every perspective on an issue like this, which is of real societal importance. I will refer here to Dr. Macdonald's research around getting at the root of what you think about this issue. I think that's critical. At the same time, it is worth interrogating the yuck factor, as you put it. It's worth interrogating why we have that visceral feeling.

Folks who would say that MAID ought not to be accessible to particular populations or in particular circumstances often point to the need for better services. That is always true. To the extent that the yuck factor propels us to do better by our clients, patients and society in general, I think that's a really good interrogative process.

At the same time, we have to look beyond it, even if it's really uncomfortable. I think this is a conversation that makes us all really uncomfortable.

Hon. Stanley Kutcher: That's a wise thought.

In your clinical experience, what proportion of MAID deaths are what physicians—I'm a physician as well—would call good deaths? Those are peaceful, compassionate and family-supported deaths that are a generally positive end to life. What proportion of MAID deaths would be within that kind of category?

The Joint Chair (Hon. Marc Garneau): Give a quick answer, please, Dr. Dhara.

Dr. Arundhati Dhara: Sure.

In my experience, it's every single one.

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

[*Translation*]

Senator Dalphond, you have the floor for three minutes.

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

[*English*]

I thank the panellists for their insights and perspectives.

I will focus on Dr. Mary Ellen Macdonald, because I think the discussions must be focused on data and not on emotions or an ideological stance.

Dr. Macdonald, you referred to the fact that there is a shortage of empirical data to move forward with the discussions. You said that we should accept the principle that young people have the right to equality and the right to participate in the decision-making that concerns their lives. However, you would like to have a study from coast to coast to coast over the next three years.

Can I assume from your answer that you think countries that have so far allowed mature minors to have access to MAID don't have enough data to justify taking a position?

• (0930)

Dr. Mary Ellen Macdonald: With regard to the final part of your question about international jurisdictions, I would say that no, we don't have data from international jurisdictions that is completely amenable to a Canadian situation. I think there are a lot of specificities in Canada that require Canadian-specific data. An obvious one would be speaking with indigenous communities.

The other answer I would give is that there's not much data in international jurisdictions either. I don't think we have a bank of data that we can draw on to do a responsible job with the analysis.

Hon. Pierre Dalphond: I understand that the project you have described is going forward. It is being financed and it's going to move forward.

Dr. Mary Ellen Macdonald: No, it has not been financed yet. We're still in discussions.

Hon. Pierre Dalphond: I see. Are your discussions with Health Canada about financing?

Dr. Mary Ellen Macdonald: That's correct. They invited us to submit the proposal, so the discussions are continuing.

Hon. Pierre Dalphond: What kind of budget are we talking about?

Dr. Mary Ellen Macdonald: I don't really feel at liberty to address that question yet.

Hon. Pierre Dalphond: We're not talking millions and millions. We're talking—

Dr. Mary Ellen Macdonald: No, absolutely not. I'm a qualitative researcher, so our budgets are generally quite small.

Hon. Pierre Dalphond: Do you think that within three years we could get all the information that you propose to gather?

Dr. Mary Ellen Macdonald: I believe so. We were very careful with the scientific design of the study. As I said, we're starting at a zero baseline. There's very little data, so any data would be useful.

We have tried to design a robust study that could be completed in three years and that would give us a lot of information about different jurisdictions and different populations.

Hon. Pierre Dalphond: Thank you.

[*Translation*]

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

Senator Martin, you have the floor for three minutes.

[*English*]

The Joint Chair (Hon. Yonah Martin): I will continue with Dr. Macdonald.

Dr. Macdonald, as you say, there is such a lack of data and specifically a lack of Canada-specific data, which is very important.

I want to ask whether you believe this essential data will be important for lawmakers, especially as we consider any expansion of MAID for minors. How essential will this data be for us?

Dr. Mary Ellen Macdonald: In my professional opinion, it's so essential to have youth opinions, perspectives and experiences at the table as we're having these conversations. I think it's absolutely essential.

By youth, I'm talking about individuals who are embedded in communities and in families. In our design, we intend to see these individuals as embedded so that we're having conversations with caregivers, parents and health care providers to get that whole context. I think that's really important data moving forward.

The Joint Chair (Hon. Yonah Martin): Yes, I absolutely agree with you. As a parent, I think it would be very important to look at the response from parents and such individuals.

Professor Sheehy, you noted that you're concerned that MAID for mature minors could be abused regarding certain marginalized populations. Could you further elaborate on that point?

Prof. Elizabeth Sheehy: Well, to elaborate I would simply say that we know the rates of mental health challenges are extremely high among children with disabilities, and we also see those kinds of rates of struggle with respect to first nations kids living off reserve. We know that these populations will be most affected, as will kids living in poverty and isolation. These are the kids who are going to be most vulnerable to trying to access MAID, and I'm deeply concerned about the discriminatory impacts.

I guess the other aspect of this is our very limited availability of palliative care in Canada, particularly in rural areas. We know that only 15% to 30% of Canadians have access to palliative care. Palliative care is so much more important, and I think MAID unfortunately is the cheap and fast solution compared to investing the resources we should be investing to ensure that all Canadians who are dying have access to good palliative care.

• (0935)

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

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

This brings our panel to a close.

On behalf of the committee, I would like to thank Ms. Sheehy, Dr. Macdonald and Dr. Dhara for their testimony this morning on a very important subject. We very much appreciate you being with us.

With that, we will adjourn temporarily as we set up for the second panel. Thank you.

• (0936) _____ (Pause) _____

• (0935)

The Joint Chair (Hon. Marc Garneau): Colleagues, we will resume a little early, but we need that extra time. Thank you very much.

With that, I would like to welcome the witnesses for our second panel.

We have with us in the room Dr. Gail Beck, interim chief of staff and clinical director of the youth psychiatry program at the Royal Ottawa Health Care Group; Dr. Eduard Verhagen, pediatrician and head of pediatrics at the Beatrix Children's Hospital, by video conference; and Mr. Neil Belanger, chief executive officer of the Indigenous Disability Canada organization, also by video conference.

Thanks to all of you for joining us.

Our procedure today is to give you each five minutes to make introductory remarks. That will be followed by questions.

With that, I'd like to offer Dr. Beck the opportunity to take the floor for five minutes.

• (0940)

Dr. Gail Beck (Interim Psychiatrist-in-Chief and Chief of Staff, Clinical Director, Youth Psychiatry Program, Royal Ottawa Health Care Group, As an Individual): Thank you.

Good morning. *Bonjour. Kwe.*

I'm Dr. Gail Beck. I am the interim psychiatrist-in-chief and chief of staff at the Royal Ottawa Health Care Group, a psychiatric hospital based in Ottawa. I served on the expert panel on the state of knowledge of medical assistance in dying, specifically on the mature minors working group. My remarks this morning really reference that report.

I want to call attention to a couple of those areas, particularly in relation to capacity, and comment that the areas where clinicians struggle with patients and their families considering MAID for mature minors include development, both cognitive and psychosocial. One of the things in particular to highlight from the written remarks you received is the fact that development of cognitive skills continues well into a person's twenties and mid-twenties, and while this goes beyond the age of mature minors, it's important that clinicians keep this mind. As my hospital reopens its medical assistance in dying committee, we are keeping this very much in mind for all of our patients.

For us, culture is also a consideration. For any of us who manage the care of youth, it's always necessary to work closely with families. We try very hard to be humble in consideration of a family's culture and of a family's influence on a young person with a serious illness, especially when that illness is irremediable and causing considerable suffering.

Finally, family and other relationships are very important to youth, but independence in decision-making is something that many of them are coming to grips with. There's nothing that causes a young person to grow up more than suddenly having a chronic

and especially serious illness that can cause death. When we consider the assessment of these young people, we're very careful to make sure that we balance the considerations of their families as well as their own personal developing independence.

In closing, I want to thank you all for the opportunity to address this Special Joint Committee on Medical Assistance in Dying. I would be happy to address any questions you have.

Thank you.

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

We'll now go to our second witness, Dr. Eduard Verhagen.

Dr. Verhagen, you have five minutes.

Dr. Eduard Verhagen (Pediatrician and Head of the Beatrix Children's Hospital, As an Individual): Thank you very much.

I might be able to add a bit of knowledge from a country that has some experience in medical aid in dying for mature minors. I'm a professor in pediatric palliative care, and I'm one of the authors of "The Groningen Protocol for newborn euthanasia".

As important background, I'd like to share with you the situation in the Netherlands. We have a euthanasia law that starts at the age of 12, so those who are 12 years old or older can ask for euthanasia. Parental consent needs to be present until the child is 16 years of age, but if the parent and child disagree on the request, we follow the child. That is in the law.

We've had seven cases up to now of minors asking for euthanasia and whose requests were granted. Most of them—six out of the seven—were 17, and one was a 16-year-old. They all suffered from untreatable end-stage cancer, and they were suffering unbearably. That is one of the items that need to be fulfilled to get euthanasia.

This is infrequent. We have a population of 17 million people, and it has been done seven times, I think, in the last 15 years. All cases were reviewed and published and can be accessed by everyone.

An interesting development has been what we call neonatal euthanasia. We have a legal regulation in the Netherlands that allows parents of newborns up to the age of 12 months to request euthanasia if unbearable suffering is present. If both parents agree, there are some other requirements that need to be fulfilled. All cases must be reported and reviewed. Since the regulation came into place, we've had three cases of neonatal euthanasia in around 15 years. All cases that were reported were reviewed and considered carefully. It's very infrequent, but it is legal; it is a possibility.

The most recent development, which we just finished two years ago, is a four-year study of how children die in the age group of one to 12. This was qualitative research. We've come across some parents who have reported terrible deaths for their children. Some of them had brain tumours. Some of them had other diseases. These parents all asked for the possibility of euthanasia similar to neonatal euthanasia. This request was forwarded to the minister of health, who decided that a regulation should be made as an extension of the Groningen Protocol to include one- to 12-year-olds who are legally not capable of asking for formal euthanasia as written down in the law.

That regulation is now being designed. It's with the ministry of health at this stage, and at the end of this year we'll hear how the final formulation has come along. Personally, I expect that during the course of 2023, the Netherlands will allow euthanasia for minors between one and 12 years of age. Having said that, I'm also convinced that the number of cases we'll see will be as low as in newborns or even lower. However, the main strength of the regulation is that we're talking differently to parents. We can provide and discuss all the options that are available. They have a possibility, if their child's suffering gets awful, of asking for euthanasia.

• (0945)

Practice has shown, both in children above 12 years of age and in newborns, that this doesn't occur very frequently. Three cases in 15 years is not much. Yes, there is a development going on in legalizing deliberate life-ending for minors, but the biggest strength is that it allows a discussion about quality of life and quality of death that currently cannot be held as it should.

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

We'll now go to our third witness, Mr. Neil Belanger.

Mr. Belanger, you have five minutes.

Mr. Neil Belanger (Chief Executive Officer, Indigenous Disability Canada): Thank you, committee members.

My name is Neil Belanger and I am a member of the Lax Seel Clan in the House of Nika'teen of the Gitksan Nation. I am also the chief executive officer of Indigenous Disability Canada. For the past 30 years, I have worked in a variety of roles in the disability and health sectors.

Before I continue, I would like to take this time to acknowledge the traditional territories and peoples of the Songhees and Esquimalt nations, whose territories I work and live on and. I'm presenting from them today.

November 2022 marks the eighth anniversary of Indigenous Disability Awareness Month, an initiative created to celebrate indigenous people with disabilities and the overwhelming contributions they make to all our communities. It is with irony that today, while celebrations of indigenous people with disabilities are happening across Canada, we are meeting here to discuss state-assisted death for indigenous children under the MAID regime.

The United Nations Declaration on the Rights of Indigenous Peoples, UNDRIP, received royal assent in Canada in 2021. The declaration provides that member states must consult and co-operate with indigenous peoples on certain matters, such as legislative or administrative measures that may affect them. This is in order to get their free, prior and informed consent.

Within the reports submitted by the expert panels regarding MAID for mature minors and MAID for mental illness, it has been verified that no tangible engagement or consultation with indigenous peoples on MAID has yet occurred. Despite this reality and the overwhelming testimony of representatives from the indigenous and disability communities against the expansion of MAID, as heard in previous sessions, as well as the countless news stories and social media posts—nationally and internationally—expressing dire

concern about the current state of medical assistance in dying, the slippery slope of MAID remains unfettered.

This begs the question as to why Canada, this committee or anyone would presume to have the authority to make recommendations or implement actions for the expansion of state-assisted death and suicide for indigenous children, indigenous persons with disabilities and indigenous persons with mental illness as a sole condition, without first engaging the very people whom these proposed changes will target. This is difficult to comprehend, particularly considering that Canada has exempted first nations communities from the Accessible Canada Act until 2026 due to insufficient engagement with indigenous communities and, further, to better understand the accessibility barriers facing indigenous peoples with disabilities. Canada additionally states that this exemption reflects the Government of Canada's commitment to advancing reconciliation with indigenous peoples.

Expanding MAID to include mature minors' mental health as a sole condition and other proposed changes to MAID, without comprehensive consultation with the indigenous peoples of Canada, flies in the face of reconciliation, is a further marginalization of indigenous peoples and is the continuation of the destructive colonial systems and their paternalistic mindset of "trust us; we know what's best". The lack of any tangible consultation with indigenous peoples of Canada should compel you as a committee to advise the government that in the spirit of true reconciliation, out of respect for the principles of UNDRIP and to authentically honour and fulfill promises made to the indigenous peoples of Canada, this committee's current work cannot continue and that recommendations regarding the expansion of MAID cannot be made or endorsed.

While I am uncertain as to whether this committee would take such a step, I am certain that if the eligibility of state-assisted death is expanded to include mature minors at the end of life, rather than providing adequately funded and comprehensive palliative care, this will result in the expansion of MAID to include mature minors not at the end of life who live with disabilities or have mental illness as a sole condition. This is not what might happen. This is fact. This is the slippery slope of MAID, and it's exactly the slippery slope we saw in the Truchon decision.

We have heard recommendations from pro-MAID expansion groups and individuals that our children as young as 12 should be eligible for MAID, that we should be able to euthanize our babies born with disabilities anytime prior to their first birthday and that persons with disabilities and those with mental illness as a sole condition who are not at end of life and whose suffering is only due to lack of supports—supports that we as a country could provide but do not—should be eligible for MAID. As a country, Canada has the ability to provide adequate supports to ensure a good life for persons with disabilities and those with mental illness. We can provide adequate funding for and access to comprehensive palliative care for those at the end of life and for their families.

MAID should never be seen as the solution to addressing the absence of those services and those resources, but it is fast becoming that. This is our collective failure as the people of Canada.

Thank you.

• (0950)

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

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

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

Thank you to all the witnesses for your testimony this morning.

For the first questions from the CPC we'll have Madame Vien for three minutes, followed by Mr. Kram for two minutes.

Madame Vien, go ahead.

[*Translation*]

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

I'd like to thank the witnesses for being with us this morning.

Dr. Verhagen, I'd like you to clarify the information you gave us about parental consent, because I'm a little confused: When is parental consent required?

Could you also tell us at what point in the process you would begin considering the minor's opinion when you are dealing with a difference in opinion?

• (0955)

[*English*]

Dr. Eduard Verhagen: The Dutch health law says children and parents decide together in the age group of 12 to 16. The law also states that if the child and parents disagree on health care matters, doctors will follow the child. This is not an opinion. This is what the health law says.

I must also add that in practice, this hardly ever occurs because in most cases that I know of, especially in end-of-life situations and palliative care, parents and children think alike and decide alike. There have been cases in the past where, for instance, one parent would not allow withdrawal of treatments or intensification of treatments, the child wanted the contrary and a second parent was

somewhere in between. Those things sometimes happen, and we would follow the child.

[*Translation*]

Mrs. Dominique Vien: Dr. Verhagen, you told us that seven minors have qualified for access to medical assistance in dying over the past 15 years.

Can you tell us the total number of requests made by minors and how many of them were rejected?

[*English*]

Dr. Eduard Verhagen: No, I cannot, because those were not registered.

The Joint Chair (Hon. Yonah Martin) : Madame Vien, you have 20 seconds.

[*Translation*]

Mrs. Dominique Vien: All right.

Dr. Verhagen, I wanted to ask you a question about decision-making abilities, which seems to be the determining factor for going ahead with MAiD, but my time is up. Perhaps one of my colleagues will be asking you that very question.

Thank you very much.

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

[*English*]

Mr. Kram, you have two minutes.

Mr. Michael Kram (Regina—Wascana, CPC): Thank you very much, Madam Chair.

Thank you to all the witnesses for being here today.

Mr. Belanger, you certainly had some very powerful testimony, so I'd like to follow up with you.

Can you think of any other federal government—

[*Translation*]

Mr. Luc Thériault: Madam Chair, I'm sorry to interrupt my colleague, but I want to let him know that his mike is on mute.

[*English*]

Mr. Michael Kram: Let me just scooch over here to the microphone that does work.

Mr. Belanger, can you think of any other federal government policies that affect indigenous communities this significantly yet had little indigenous consultation?

Mr. Neil Belanger: I can't list them offhand, but I think Canada has a history of implementing laws and legislation without proper consultation with indigenous peoples. Historically we've seen that, which is why Canada implemented the UN Declaration on the Rights of Indigenous Peoples to compensate for that and to bring them in and speak with them.

We often see that indigenous peoples and communities are consulted after the fact with the mindset that we'll fix what's wrong later. This is no different with MAID.

We were involved in meetings in the beginning and very few indigenous organizations were at the table. We had commitments from the government that comprehensive engagement would happen, and it never did. It still hasn't to this day. This seems to be the rule we follow when it comes to indigenous people. Hopefully it will change in the future, and hopefully it will change now with MAID.

Mr. Michael Kram: Is it your view that the federal government should undertake a fulsome consultation with indigenous communities on the expansion of MAID before any expansion moves forward?

Mr. Neil Belanger: Yes, without a doubt.

As I said, with the Accessible Canada Act, which looks at accessibility on the federal side within first nations, Canada has exempted first nations until 2026 so they can do proper consultation and hear their voices.

With MAID and the significant impact it will have on our people and on our communities, why would it not be extended for the same priority? Why would it be pushed forward without proper consultation, without input and without their understanding? It makes no sense.

• (1000)

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

Next we're going to have 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 here.

Dr. Beck, you said earlier that we continue to develop our cognitive abilities into our twenties. With respect to mature minors who want to receive medical assistance in dying, how can we ensure that their cognitive skills are sufficiently developed to understand the nature of MAiD?

[*English*]

Dr. Gail Beck: Thank you very much for your question.

I'm going to read a bit from the notes that I give to residents in psychiatry and child psychiatry to consider when they're addressing capacity, because capacity is not magic. It doesn't happen at one age or another; it happens over a continuum. It's based on a number of factors.

When we consider decision-making capacity in medical treatment decisions, we consider, first of all, whether the young person

involved understands the relevant information of the condition, including around treatment and other measures that are being explained and provided. Secondly, we consider the degree to which they appreciate the situation and the circumstances. Finally, we consider their ability to communicate the decision.

I'll use a really brief example. Consider a young person who is, let's say, about 10 years old, because this would be consistent with their developmental level. They've broken a collarbone for the second time. It happens pretty regularly. They've had a broken collarbone before. They go to the emergency room, and while they're in the emergency room they sit with a hand on their shoulder. They sit like this because they've broken that collarbone before and they know that sitting like this it relieves the pain from that collarbone.

The pediatrician or doctor will come in and ask what they are here for. The child will say, "I broke my collarbone. I broke it once before and the doctor at the time said it might well happen again. I know that if I hold my hand like this, it won't hurt as badly." This isn't an uncommon thing. I work in a pediatric emergency room. The doctor will then say, "We think you need an X-ray." This has happened to this individual before, so they say, "Yes, I need an X-ray."

I only use that particular example to explain that there can be a complexity of medical conditions. Clearly, when a young person is considering something more complicated, such as a mental health condition or a glioblastoma, and they're facing making decisions about dying and they're working with their parents around that, it's a much more complicated situation for the clinician.

Clinicians in child and adolescent psychiatry are very experienced in dealing with capacity, so they would—

Mr. René Arseneault: I'm sorry, Ms. Beck, but I have so few seconds left. If you can provide us with more of this in writing, we would appreciate it.

I'll turn now to Dr. Verhagen.

[*Translation*]

Dr. Verhagen, welcome to Canada, even though you are attending the meeting virtually.

I'd like to know the social status of the seven mature minors who requested medical assistance in dying.

In our country, we're told that we must be cautious, since the poorest and most vulnerable Canadians are the ones requesting medical assistance in dying. However, statistics show that most people who have received MAiD but were not mature minors came from the middle class. They had a roof over their head and 85% to 87% of them had already begun receiving palliative care. However, they wanted to decide how they would die.

[English]

Dr. Eduard Verhagen: The social situation wasn't described in much detail, but generally I can say that they were all well insured, they were all from middle-class or higher-class families and they purposely chose death knowing about the suffering they had gone through and having heard their prognosis of certain death. Also, both parents in all those situations agreed. There was no conflict.

From the medical point of view, there was full understanding and consensus that the suffering could not be ameliorated in another way, so there was no discussion there.

• (1005)

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

We'll move on to Monsieur Thériault for five minutes.

[Translation]

Mr. Luc Thériault: Thank you, Madam Chair.

Dr. Beck, surely you've read the expert panel report on mental disorders, which says that it's good medical practice to exhaust all available treatments and means to achieving a cure and then establish beyond the shadow of a doubt how chronic the disorder is.

Dr. Verhagen, I'm going to include you even though you're not a psychiatrist, because this also applies more broadly.

If a mature minor ends up in this situation, it's because nothing else can be done, and that's mostly the case for track one patients in the end-of-life phase who are already in the process of dying. A mature minor patient in the palliative care continuum could suddenly decide to request MAiD.

If this committee were to recommend that only track one mature minors be allowed to access MAiD, don't you think we would be hitting the nail squarely on the head?

[English]

Dr. Gail Beck: In the case of mature minors, one question that arose on the expert panel was about mental disorders very specifically. As a child psychiatrist—and I've been in practice many years—I could not say for a mental health disorder that by the age of majority, someone would reach the stage that all treatments had been tried, specifically because some treatments that we would use to treat certain conditions would only be used once a person became older.

I think that answers part of your question, but it's one thing that I think people probably consider. In terms of some of the other illnesses, this is the only place where my scope of practice really allows me to comment.

[Translation]

Mr. Luc Thériault: Dr. Verhagen, would you like to say something?

[English]

Dr. Eduard Verhagen: From how I understand it, track one is for children or people who have a disease they are dying from, and that would allow them a yes or no for medical aid in dying. Our euthanasia law requires hopeless and unbearable suffering, which

means that there's no good outcome possible and that there is certainty of the diagnosis.

Those seven cases I described were all somatically ill children who were dying, and it was a shortening of the death process they had asked for and received. I would say that without a track one condition, it would be more difficult to envision a good regulation.

[Translation]

Mr. Luc Thériault: Thank you.

Dr. Verhagen and Dr. Beck, I'm going to circle back to decision-making abilities.

Some practitioners tell us that when a mature minor experiences illness, a synergy or symbiosis starts to develop within their family. So when the minor claims to want medical assistance in dying and wishes to go through with it, very rarely do the parents oppose it and attempt to impose their wishes, even if they are suffering over it.

At the end of the day, is it fair to say parents should be consulted, but obtaining their consent should not be mandatory?

• (1010)

[English]

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

Dr. Eduard Verhagen: No. Consent is not necessary, so we follow the child.

We know that children and parents are often on the same page, but not always. Conflicts have been described frequently. Very importantly, the doctor will only go ahead in providing what is asked if he or she is convinced that this is in line with what is the real and genuine opinion of the child.

If there is any doubt on the side of the doctor, whether he or she is listening to the child or the parents' opinion, he or she will not go ahead and provide it. There needs to be a firm conviction on the side of the doctor.

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

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

Mr. Alistair MacGregor: Thank you, Madam Chair.

Thank you to our witnesses for appearing today.

Mr. Belanger, I'd like to start with you. I take note of your comments about the lack of consultation. I understand the Canadian government and provincial governments have a very sorry track record on that front.

This special joint committee was entrusted to look at five major themes. Mental disorders as sole underlying conditions have already been passed in the previous law. That's going to come into effect in March of next year. However, on the other themes—mature minors, the state of palliative care, the protection of persons with disabilities and advance requests—not only is this committee going to make recommendations on how law and policy might go forward, but it's going to make recommendations on things like consultation with various groups on funding gaps that may exist. I don't want to presuppose what kind of recommendations our report will have, but they might end up being quite varied.

This is your opportunity, sir, to inform this committee about the kinds of recommendations you would like to see in our final report on how the federal government could step up its game on consultation, especially when it comes to indigenous children who are living with disabilities.

Very briefly, in about a minute, can you inform us of what kinds of strong recommendations you'd like to see in our report on that theme?

Mr. Neil Belanger: The recommendation that I would make is to pause the expansion of MAID. Making recommendations to consult indigenous people after the fact and after the changes are in place doesn't make any sense.

We know, historically, that there's underfunding. We know that there's a lack of critical mental health services. We know the effects of poverty, as we have 80% of first nations in Canada living under the poverty line.

Recommendations to consult after you change the law are not good recommendations. Put a pause on it. Engage the people who you are making recommendations for. Get their input. Get their insight.

I can't make recommendations for the expansion of MAID to go forward when you haven't consulted the very people that these laws will be applied to. It would be impossible.

Mr. Alistair MacGregor: That's very well taken.

We've been discussing provincial laws that allow children below the age of 18 to consent to medical procedures if the medical professional is convinced that they have the capacity to understand the treatment and what it may mean. Some of these could be very serious medical interventions.

I take note of your point about the lack of supports that exist. Those have been very well documented. However, if we were to arrive at a situation where a child has, in fact, had access to the full range of supports and is in a state of intolerable suffering with an incurable disease, what's your understanding of a child's ability to give that kind of consent when it is already an established right under provincial law for medical interventions?

● (1015)

Mr. Neil Belanger: I'm probably not as familiar as I should be with the Infants Act in B.C., and I may be wrong in my interpretation. I believe that mature minors under that act can make certain decisions in their best interests for their medical treatment. I also think the hospital can step in and challenge that, or the medical ser-

vice can challenge that if they're refusing treatment that is for their benefit and that will continue. I may be wrong. I believe that's the same in Alberta, from what I know.

These questions about mature minors at end of life look at track one only. We never look at the intersection and what that means for track two. If we pass a law that allows mature minors to do this at whatever age—and we've heard as young as 12—we know that next it will be track two for mature minors with disabilities not at end of life, or with a mental illness. We know that's the progression that will happen. We can't discuss one without the other—

Mr. Alistair MacGregor: Thank you, Mr. Belanger.

I'm sorry, but I only have 30 seconds and I want to get in a quick question for Dr. Verhagen.

Just very quickly, sir, how has Dutch political polling been on this issue? What has society's reaction been to how the law has been implemented and to the possible changes? I just want to compare that to what's going on here in Canada.

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

Dr. Eduard Verhagen: We've had the law since 2002, and there's hardly been any discussion about its implementation. It helps that euthanasia in mature adults is so extremely rare.

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

I'll now turn this back to my joint chair.

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

I regret to say that we'll only have time for one senator. I will arbitrarily go to the first person on my list, Senator Kutcher, for three minutes.

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

Senator Dalphond and I discussed this already, so I'm speaking on our joint behalf.

First, I would ask Dr. Verhagen to send us the four-year study that he referred to so we can have a chance to read it.

I have two questions, one for Dr. Beck and one for Dr. Verhagen. I'll read both out, and then you can please respond.

Dr. Beck, in your opinion, can properly trained clinicians conduct the necessary thoughtful and well-considered assessment and look at all those factors of capacity you discussed for mature minors in consideration of medical conditions, including potential MAID?

The second is for Dr. Verhagen. We've been told that if we allow MAID for mature minors, the floodgates will open and large numbers of young people will die as a result of MAID. In your experience, was a similar sentiment common or talked about in your jurisdiction before the law was put into place? If there was a similar sentiment, what was the reality in terms of what that sentiment actually was?

Dr. Gail Beck: I can answer fairly quickly.

For physicians in particular, clinical psychologists and other practitioners, the assessment of capacity would be considered essential in their scope of practice. They probably wouldn't have succeeded in their exams if they hadn't been able to assess capacity.

Hon. Stanley Kutcher: That would be a yes, then.

Dr. Gail Beck: Yes.

Hon. Stanley Kutcher: Go ahead, Dr. Verhagen.

Dr. Eduard Verhagen: The fear of a slippery slope was mentioned twice, first when the euthanasia law was accepted in 2002, and it never became a reality. The numbers have never gone up.

The second time was with neonatal euthanasia. Some people expected huge numbers of newborns to be killed, but it never hap-

pened. Instead of three cases every year before the legislation, we went down to three cases in 15 years, so there was no slippery slope there.

Hon. Stanley Kutcher: Thank you.

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

With that, I'm afraid we'll have to conclude panel number two.

Thank you very much, Dr. Beck, for being here this morning. Thank you, Dr. Verhagen, for your testimony. Thank you, Mr. Belanger, for your important testimony. We very much appreciate it. It will help us with our deliberations.

With that, this meeting is adjourned.

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