



HOUSE OF COMMONS  
CHAMBRE DES COMMUNES  
CANADA

44th PARLIAMENT, 1st SESSION

---

# Special Joint Committee on Medical Assistance in Dying

EVIDENCE

**NUMBER 028**

Tuesday, November 22, 2022

---

Co-Chairs:  
The Honourable Marc GarneauThe Honourable Yonah Martin





## Special Joint Committee on Medical Assistance in Dying

Tuesday, November 22, 2022

• (1830)

[*Translation*]

**The Joint Chair (Hon. Marc Garneau (Notre-Dame-de-Grâce—Westmount, Lib.)):** Good evening, everyone.

I call to order meeting number 28 of the Special Joint Committee on Medical Assistance in Dying.

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

[*English*]

My name is Marc Garneau. I am the House of Commons joint chair of this committee.

I am joined by the Honourable Yonah Martin, the Senate joint chair.

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

I have just a few administrative remarks before we get going. I remind members and witnesses to keep their microphones muted unless recognized by name by one of the joint chairs, and all comments should be addressed through the joint chairs.

Also, it is very important that when you are speaking to please speak slowly and clearly for the benefit of the 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 either the floor, English or French.

With that, I would like to welcome our witnesses for panel number one, who are here to discuss protections for persons with disabilities.

We have, all as individuals, Dr. Heidi Janz, an associate adjunct professor, who is with us by video conference; Dr. Jessica Shaw, an associate professor, also by video conference; and Dr. Tim Stainton, director of the Canadian Institute for Inclusion and Citizenship at the University of British Columbia.

Welcome to our three witnesses. Thank you for joining us this evening. The process we follow is that you will each be given five minutes to make introductory remarks, and then we'll proceed with questions.

We'll start with Dr. Janz. You have five minutes.

[*Translation*]

**Mr. Luc Thériault (Montcalm, BQ):** Point of order, Mr. Chair.

We have a sound problem. No matter how high I set the volume, I can barely hear the interpreter. Can we get this fixed?

**The Joint Chair (Hon. Marc Garneau):** Okay.

[*English*]

For the witnesses, just stand by. We're having a little sound problem within the room here. We'll be with you very shortly.

We'll pause until we can address the problem brought up by Monsieur Thériault.

• (1830)

(Pause)

• (1835)

**The Joint Chair (Hon. Marc Garneau):** We're reconvened. We will start with Dr. Heidi Janz.

Dr. Heidi Janz, you have the floor for five minutes, please.

**Dr. Heidi Janz (Associate Adjunct Professor, As an Individual) (via text-to-speech software):** Honourable committee members, two years ago, I was one of the Canadian disability rights advocates who testified before the parliamentary justice committee studying Bill C-7, which would expand eligibility for medical assistance in dying to people with illnesses and disabilities whose death is not reasonably foreseeable.

We testified that if this expansion of eligibility for MAID went ahead in a Canadian society plagued by systemic ableism, death by MAID would quickly become a socially accepted path of least resistance for ill and disabled people who are unable to access sufficient supports to live self-determined lives with dignity in the community. Sadly, our warnings were met with a collective shrug, and Bill C-7 was passed into law.

Today, I will offer evidence that Bill C-7's expansion of eligibility for MAID is, in fact, resulting in increasing numbers of ill and disabled people turning to MAID as their only alternative to abject poverty and/or incarceration in a long-term care facility. My hope, faint though it may be, is that you, as Canada's policy-makers, will finally recognize that Canada's current MAID regime is, in fact, eugenics disguised as autonomy, and take bold and courageous action to stop the injustice.

A Hobson's choice is defined as a situation in which it seems that you can choose between different things or actions, but there is really only one thing that you can take or do. Contrary to the claims of some MAID enthusiasts who have testified before this committee—think Dr. James Downar—in the year and a half since Bill C-7 was passed, we have seen death by MAID become a Hobson's choice for growing numbers of ill and disabled Canadians.

Among these are Chris Gladders, age 35, who died by MAID in January 2021. He was battling Fabry disease, a genetic condition which affects the body's ability to break down a specific fatty acid and causes a number of side effects. He had two daughters; Hailee, 13; and Savannah, five. He lived in a long-term care facility in Niagara, Ontario. His brother reported that at the time of his assisted death, "The bedding hadn't been changed for weeks. There was feces on the bed. There was urine on the bed. There was urine and feces on the floor, the room was absolutely disgusting", and that the day before his death "He pulled the call bell beside his bed. I was on the phone with him for 40 minutes and nobody answered that bell. That was his last night."

Equally disturbing is the case of Sophia. Sophia was the preferred pseudonym of a 51-year-old Ontario woman who had multiple chemical sensitivities. She underwent a medically assisted death after her desperate search for affordable housing free of cigarette smoke and chemical cleaners failed.

"The government sees me as expendable trash, a complainer, useless and a pain in the ass", Sophia said in a video filmed on February 14, 2022, eight days before her death.

She died after a frantic effort by friends, supporters, and even her doctors to get her safe and affordable housing in Toronto. She also left behind letters showing a desperate two-year search for help, in which she begs local, provincial, and federal officials for assistance in finding a home away from the smoke and chemicals wafting through her apartment. Four Toronto doctors were aware of Sophia's case, and they also wrote to federal housing and disability government officials on her behalf. In that letter, the doctors confirmed that her symptoms improved in cleaner air environments and asked for help to find or build a chemical-free residence.

"We physicians find it UNCONSCIONABLE that no other solution is proposed to this situation other than medical assistance in dying", they wrote.

Finally, there is the equally troubling and tragic story of Sathya Kovak. Sathya Dhara Kovak was a Winnipeg woman who died by MAID on October 3, 2022. Kovac lived with amyotrophic lateral sclerosis, ALS. Her condition was worsening, but she felt she had more life to live, just not enough home care support to do so.

"Ultimately it was not a genetic disease that took me out, it was a system," Kovac wrote in an obituary to loved ones."

Her obituary continues, "There is desperate need for change. That is the sickness that causes so much suffering. Vulnerable people need help to survive. I could have had more time if I had more help."

There is indeed a desperate need for change.

• (1840)

In the words of Canadian disabilities scholar, Jerome Bickenbach, when an individual chooses death as the only viable way to escape an intolerable situation partly brought on by the social environment, it seems "perverse and unfair to say that this is an expression of self-determination or autonomy." It is incumbent upon you, as Canadian policy-makers, to take courageous action to correct the perversion of justice that is Canada's current MAID regime.

Thank you.

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

We'll now go to our second witness, Dr. Jessica Shaw.

Dr. Shaw, you have five minutes.

**Dr. Jessica Shaw (Associate Professor, University of Calgary, As an Individual):** Thank you very much.

Thank you, Dr. Janz.

My expertise is not in disability, so I am honoured to share this space with my esteemed colleagues. I suspect that I was invited to participate in this panel—and I thank the committee for the invitation—because I have done quite a lot of work with people experiencing homelessness, with substance users and with prisoners, who also face incredibly limited medical and social supports. Because I know that I'm the only researcher in Canada who's done MAID research with prisoners, my statement is going to focus on them tonight. I'll end with a comment about vulnerability as it relates to people with disabilities and also prisoners and many others.

To align with international human rights norms, all prisoners ought to have access to the same standards of health care that are available in the community. This is referred to in the United Nations as the principle of equivalence of care. In Canada, between the legalization of MAID and August 2020, there were 11 requests for MAID by federally incarcerated people. Three were granted, and three deaths were completed. I have had a request in to Correctional Service Canada, CSC, for quite some time, but I don't yet have the new numbers to date.

I want to draw on the research that I've done with prisoners in Canada, as well as on reports from the Office of the Correctional Investigator, to focus on three main points this evening.

The first is that parole by exception for end-of-life care needs to be expanded and more readily approved.

You might be asking, “How does this relate to MAID?” Well, what we informally call compassionate release is actually called parole by exception, and being granted parole by exception in Canada is exceedingly rare. In two of the three known MAID cases for patients in CSC custody, the prisoners had applied for and been denied parole. The third prisoner didn't apply. Apparently he knew that his prospects for release were minimal, even considering his advanced stages of illness.

Especially given that palliative patients pose very little risk to the public due to their bodies and minds being incapacitated by illness, the rationale for denying parole by exception is not clear to me. I would just offer a quote from one of the prisoners I interviewed. He shared, “We had one guy in here... he had dementia and I don't even think he knew he was sick. We have another guy...that's got Parkinson's, and there's no reason...he should be in here. He can barely walk. He's not going to go out and rob a bank or anything. Put him in an institution... even if you have to start a prison old-age-home. One where there is a little [bit] more dignity.” He said, “It's really sad to die in a cage.”

The second point I'd like to make is about the Correctional Service Canada guidelines. They need to align with federal policy, but there are actually several key areas where they don't. In 2017, Correctional Service Canada released “Guideline 800-9, Medical Assistance in Dying”, which provides operational direction for MAID with regard to federally incarcerated people. Canada is the only jurisdiction in the world where assisted dying is legal who does have specific guidelines about how it ought to be implemented for prisoners. I appreciate guidelines for the clarity and consistency they can provide, but in this case, there are a few key areas where the guidelines don't align with federal policy. I'd be happy to elaborate on those more during question period, or I would direct the committee to the extensive report titled “Philosophical and Practical Considerations of MAID for Canadian Prisoners”, which I was commissioned to write for Public Safety Canada last year.

Third, as we move towards allowing MAID for people where mental disorder is the sole underlying medical condition, I think particular attention is going to need to be given to how prison weariness and the psychological suffering caused by imprisonment are addressed. This is because incarcerated people have described their living conditions in prison, the monotony of prison life and the fear of not knowing when or if they'll be released as reasons that might drive them to seek death, whether through suicide or MAID. We know that seeking MAID as an alternative to a prison sentence is not something that's legal in Canada, nor do we see its being legal anytime soon. I think the fact that prisoners are talking about it and potentially seeking it demands our attention.

When MAID eligibility expands to include assisted dying for reasons of mental illness, consideration is going to have to be given to differentiate between MAID requests due to an incurable and ongoing mental disorder and MAID requests due to psychological suffering that could be relieved if the person's circumstances were different. I think that ties into Dr. Janz's opening statement as well.

• (1845)

It's true for both prisoners and the general public that in a country as wealthy and as resourceful as ours, there is no reason some-

one should feel that the only option they have is death because their medical and social supports are so limited.

That is where I'd shift to a brief statement on vulnerability. My time is probably almost up.

I am going to frame the statement in relation to disability. I think it's perhaps a bit of a different perspective from my colleagues tonight, but it is applicable to anyone who suffers from limited medical or social supports.

I would begin by saying that it's not my place to speak on behalf of people with disabilities, and I would offer that it's not the place of this committee to speak on behalf of people with disabilities either. However, we need to trust people to make decisions about their own lives and deaths, recognizing that if someone is incapable of making decisions, they're already not eligible for MAID in the first place.

In terms of vulnerability, I am also concerned about people being vulnerable to having their health care rights denied because of who they are, and about people being vulnerable to discriminatory policies and procedures that would deny them access to MAID under the guise of protection. Excluding in order to protect is both patronizing and discriminatory.

I'll leave my thoughts there for tonight, with thanks for—

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

We'll now go to Dr. Stainton. You have five minutes.

**Dr. Tim Stainton (Director, Canadian Institute for Inclusion and Citizenship, University of British Columbia, As an Individual):** Thank you, Mr. Chair, and members of the committee, for the opportunity to speak to you tonight.

I have reflected many times on the process surrounding Bill C-7. The failure to appeal the Truchon decision was shocking given the significance and scope of its impact.

As Bill C-7 worked its way through Parliament, some 200 disability organizations, including all of the major national bodies, were clear and united in their opposition, warning the government of the threat it posed to disabled people and other vulnerable populations. Numerous witnesses shared their concerns, often with compelling personal narratives. In addition, serious concerns were raised by three UN human rights experts. Not only were all of these concerns ignored, but the bill was massively expanded by a Senate amendment to require the inclusion of mental illness within two years—a significant expansion on the original intent of Bill C-7—without study or review.

Despite this, on March 17, 2021, Bill C-7 received royal assent after the government invoked closure to cut off debate.

It's hard to imagine a similar overwhelming dismissal if we were discussing any other equity group, were they were to voice unified concerns over a bill and were backed by UN human rights experts. Why this was the case can only be explained by recognizing a deep, pervasive and often unconscious ableism that pervades Canadian society.

Canada's euthanasia and assisted suicide laws have always been about balancing individual autonomy to decide when to end one's life and the protection of the vulnerable. Subsequent to the passage of Bill C-14, it would seem that protection of the vulnerable has largely been ignored in favour of an increasingly atomistic interpretation of autonomy.

It is somewhat ironic that as we come out of an unprecedented era of COVID-19 where we were all asked to make sacrifices of some of our personal autonomy in favour of broad protection for the whole of society, in the debate on euthanasia and assisted suicide we persist in privileging a view of autonomy more akin to one used by those who railed against the vaccine mandate as an infringement on their individual liberty.

John Stuart Mill, one of the fiercest defenders of individual liberty, provided an analogy for when interference with individual autonomy was permissible. He wrote that if a man is trying to cross a bridge that is unsafe, it is permissible to impede his progress as he does not wish to fall into the river, but rather his will is to cross the bridge.

This committee will be aware of the numerous reports of disabled persons who do not desire to end their lives, but feel they no longer have tenable options given the crushing demands of poverty, forced institutionalization and the lack of necessary services and supports. They are our bridge crossers. They do not wish to fall into the abyss, but without the repairs to the bridge—ending poverty, ending unwanted institutionalization and improving our disability and mental health supports—they feel they have no other option. Rather than restraining them, as Mill suggests, we are shepherding them to the edge and over through MAID.

I'm also concerned as to where this all ends, given the rapid and ill-considered expansion that will be making Canada the world leader in cases of assisted suicide and euthanasia in a mere six years. I worry that we will soon see calls for legalizing the killing of disabled people who are unable to formally consent at the request of their parents or guardians.

Sadly, we know from public reaction to things like the murder of Tracy Latimer and many other cases that so-called "mercy killing" has widespread public support.

If we continue to weaken the need for direct consent through permitting advance directives and allowing children to be euthanized, it is a very small step to involuntary euthanasia of disabled people who are considered unable to consent.

I have a son with an intellectual disability. He cannot directly tell you the value of his life, but he shows us every day in his accomplishments, his laughter, his smile, and those he touches, yet I know that most people who see him in passing assume his life is one of tragedy, suffering and dependency. These people would see an end to his life as a mercy. The Canada I want to believe we live in

would value, support and celebrate his life. I increasingly fear it is becoming one that seeks only to end it.

Thank you.

● (1850)

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

We'll now go to questions.

I'll hand it over to my co-chair, Senator Martin.

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

Thank you to the witnesses for your testimony this evening.

We will begin the first round with Mr. Cooper.

You have five minutes.

**Mr. Michael Cooper (St. Albert—Edmonton, CPC):** Thank you very much, Madam Co-Chair.

I will ask my first question of Dr. Janz.

Dr. Janz, I recall your impactful testimony at the justice committee during the study on Bill C-7, and you are quite right, as Dr. Stainton said, that there was overwhelming, near universal if not universal opposition to Bill C-7 from the disabilities rights community. You're right that pleas of the disabilities rights community did fall on deaf ears with the passage of that bill.

Dr. Janz, I take it that it would be your recommendation that a safeguard that death be reasonably foreseeable be reinstated in the law. That's the first point, but second, if it were not reinstated, do you have any recommendations for additional safeguards in the law to protect vulnerable persons with disabilities?

**Dr. Heidi Janz (via text-to-speech software):** Thank you for the question.

Yes, I do believe that ultimately our best course for making MAID a truly just practice is to reinstate the reasonably foreseeable death criterion. Failing that, I believe that we should have adequate income supports, housing and personal care services as a prerequisite before anyone can apply for MAID. These things need to be met, and that should be our criteria for eligibility for MAID. This needs to be a federally paid thing, not a provincially paid thing.

● (1855)

**Mr. Michael Cooper:** Thank you for that.

Can you provide the committee with your thoughts on how the passing of Bill C-7 has impacted Canada's reputation as an international leader in human rights generally and, more specifically, in terms of rights for people with disabilities?

**Dr. Heidi Janz (via text-to-speech software):** I think the passing of Bill C-7 did grievous and irremediable damage to Canada's reputation as an international leader in human rights generally and also in disability rights. In particular, to have not one, not two, not three, but four United Nations human rights experts officially condemn an impending law as a violation of our country's commitments as a signatory to the United Nations convention is a big deal, or at least it ought to be a big deal for a country that fancies itself a leader in human rights. Unfortunately, this wasn't the case at all when it came to the UN human rights experts' condemnation of Bill C-7 as violating the rights of people with disabilities.

It's guaranteed by the Convention on the Rights of Persons with Disabilities, but on the contrary, the government ignored this for months, and even had the nerve to quote from the UN Convention on the Rights of Persons with Disabilities in the preamble of Bill C-7. That, of course, takes nerve and/or a badly malfunctioning ethical compass.

**Mr. Michael Cooper:** How much time do I have?

**The Joint Chair (Hon. Yonah Martin):** I ended up adding a bit of time when you asked a question, because of the delay. We are very close to five minutes.

**Mr. Michael Cooper:** Dr. Stainton, do you have anything to add on that point?

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

**Dr. Tim Stainton:** To the first point, I would agree that without reasonably foreseeable criteria, there are no safeguards that will prevent the kind of things we're talking about. They just aren't there. I've written about this in several publications.

Yes, I've spoken to the UN special rapporteur. I've spoken to people in New Zealand and Australia over the last two or three months, and people are saying, "What's going on with Canada?". That's an embarrassment for a proud Canadian.

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

Next, we will go to Mr. Maloney. You have five minutes.

**Mr. James Maloney (Etobicoke—Lakeshore, Lib.):** Thank you, Madam Co-Chair.

Thank you to all of our witnesses. This is a challenging and very emotional topic. I know that everybody around this table shares your concerns about trying to get this right.

Dr. Stainton, my first question is for you, sir.

I'm not familiar with any of your writings, but are you opposed to MAID in any circumstances?

• (1900)

**Dr. Tim Stainton:** No. I've been quite clear about that.

If I felt MAID could be contained, I don't have an issue with it. I believed from the beginning, and we were warned, that it couldn't be contained. I think those fears have been borne out in spades, and actually much more quickly than I feared.

**Mr. James Maloney:** Okay. Thank you. That's helpful.

My next question is for all three witnesses.

Given where we are.... Again, I share your concerns that MAID should not be used as a solution to your financial circumstances or other unfortunate circumstances people might find themselves in. It seems to me that what we have to do—our challenge that we're faced with at this committee, and why you're here—is come up with solutions to make sure that those things don't happen and to build in those safeguards.

What I would like to hear from you is what the safeguards are you would like to see added to any legislation to make sure these horrible circumstances like Dr. Janz described at the outset don't happen again

Dr. Stainton, why don't we start with you?

**Dr. Tim Stainton:** Thank you for that question.

As I said, I do not believe there are safeguards that can be put in place at this point that will address those issues without bringing back the reasonably foreseeable death criteria. We could certainly do a much better job of data collection and monitoring. We don't know how many people are in the circumstances that Heidi has described. That would be a minor step forward.

I think the issue is whether we can improve our disability support system enough. Can we take care of the issues of institutionalization? We've been saying we're doing that for 30 or 40 years now, and we're still not there. Obviously, the best-case solution is that we make those arrangements. The reality is...are we putting people's lives at risk while we're waiting for Nirvana?

There are 15,000-plus people of working age with disabilities in long-term care homes at the moment, most of whom do not want to be there. We see how long it's taking to deal with the Canada disability benefit. You seem to be able to move MAID changes along quite quickly, but it has already been a couple of years that the bill has been kicking around. We have another three years of study and we don't even know if it's going to be enough to begin to address the problem.

I don't mean to sound completely cynical, but I don't want to offer a set of safeguards that I don't think will do the job.

I'll pass it over to my colleagues now.

**Mr. James Maloney:** Dr. Janz, why don't we move over to you?

**Dr. Heidi Janz (via text-to-speech software):** Yes, I think I do agree with Dr. Stainton. I think we have created a system where death is easier for people with disabilities than living, than living with dignity.

So really, until Health Canada as a whole admits its systemic ableism within MAID, then frankly I don't see much hope. MAID currently is eugenics disguised as autonomy, and the only way to fix that is to make it so that people with disabilities are able to live before they are able to die.

Thank you.

• (1905)

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

I think I'm out of time.

**The Joint Chair (Hon. Yonah Martin):** I was pausing for the translation, so you have about 30 seconds if you want to hear from Dr. Shaw.

**Mr. James Maloney:** Yes.

Dr. Shaw, do you have anything to add to that?

**The Joint Chair (Hon. Yonah Martin):** Please be very brief, Dr. Shaw.

**Dr. Jessica Shaw:** Sure.

I would just say that I think the approach to developing MAID legislation and the implementation of it in Canada has been very intentional, and that we do have safeguards in place. I don't disagree with my colleagues about the need for better social and medical supports, but I worry about who gets to decide who is suffering too much in the meantime. I think we do have safeguards, and that at this committee like yours you're making these decisions with all of that in mind.

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

Next we will go to Monsieur Thériault for five minutes.

[*Translation*]

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

I will address Dr. Stainton first.

I will cite an article by Maria Chang published on August 11, 2022, in which experts express concern about Canada's euthanasia laws and find the situation worrisome.

You said the Canadian legislation was likely the greatest existential threat to people with disabilities since the Nazi program in Germany during the 1930s. I imagine you were referring to Bill C-7.

That's a little strong, in my opinion. Do you stand by that statement and did you really say it?

[*English*]

**Dr. Tim Stainton:** Yes, I did—

[*Translation*]

**Mr. Luc Thériault:** Okay, thank you. Since I don't have very much time, I will continue.

I take it you are appearing here as an expert and stating that the totalitarian regime, the terror regime of Nazi Germany, which sought to exterminate people, to practice eugenics, is equivalent to what we're doing as representatives of the people to try to respond to diseases, to ailments, to people with disabilities who are suffering. You're comparing that to a voluntary intention on our part.

Earlier, you also mixed up the concepts of mercy killing, euthanasia and assisted suicide. These are not the same things. Euthanasia must and can only be strictly and exclusively voluntary. You know that.

From the moment that decision becomes the person's, the patient's, how could you make a statement like that? It's a little heavy-handed.

[*English*]

**Dr. Tim Stainton:** Perhaps I—

[*Translation*]

**Mr. Luc Thériault:** I'm not done yet.

You're asking us to consider what you're saying, and I'm willing to consider it, but what is your understanding of the government's role in this matter?

I think the government's role at the most intimate time in a person's life, their own death, is not to decide for them what is right for them. It is to be able to create the conditions for them to exercise their free will and to guarantee that they will be free to decide what they want when they die, because they are suffering irremediably and irreversibly.

There's a difference between an intolerable situation and a disability that creates irremediable and irreversible suffering.

Now that I've issued these warnings, you may go ahead.

[*English*]

**Dr. Tim Stainton:** Thank you for the opportunity to clarify.

What I said was that the comparison was with the existential threat to disabled people. I did not compare what we're doing to what the Nazis did. I compared the threat to the lives of disabled people. You're quite right that they're not comparable and I'm certainly not accusing our government of pursuing the same intentions.

What I was saying was that the outcome can have a similar effect and what we've heard from Dr. Janz and the other stories—there was another story in the paper yesterday—is that it's not as you described in all circumstances that people are being moved towards MAID. They're going to MAID out of despair, not that their suffering can be relieved with proper housing or proper supports and that's the existential threat that I'm concerned about.

Just to clarify, I was not comparing the processes or the motivations, I was comparing the outcome, if you like, and the threat level to people with disabilities and I stand by that. If someone can tell me another point in history when there has been this level of threat to the lives of people with disabilities I will happily retract that statement.

Thank you for the chance to clarify that.

• (1910)

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

That's five minutes, so we'll next go to Mr. MacGregor, also with five minutes.

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

I'd like to turn to Dr. Jessica Shaw. I really appreciate the niche expertise you're bringing to our committee with your experience in Canada's federal prisons.

I was very fortunate last summer to go on a tour of the Mountain Institution and the Kent Institution in Agassiz, British Columbia. That was certainly quite a wake-up call. I had some fantastic conversations with both the program officers and the parole officers who work so hard at their job and with such passion to try to make a difference.

Just with the conditions in Canada's federal prisons, you did talk a little bit about prisoners and their access to medical assistance in dying. From the stats that you had suggested, I'm guessing those were track one, that is, their death was foreseeable. Do you have any stats on track two, that is, prisoners who are living with disabilities? I'm just wondering if you can fill in some of the blanks on that area.

**Dr. Jessica Shaw:** The short answer is no. I don't have information on track two yet.

We do need to look at those updated numbers since August 2020. I know there's certainly fear within the prison system of bringing up the possibility of seeking MAID because it's sometimes still equated to suicide, and the risk of being put in segregation and under mental health watch is highly undesirable.

Finding "MAID friendly" staff is an issue.

But no, we don't yet have information on track two.

**Mr. Alistair MacGregor:** Kent is British Columbia's maximum security institution. Mountain was medium security and there was certainly a huge difference in terms of the freedoms on both sites.

For prisoners who may develop a disability, who have been there for a long time and their health really starts going downhill, how does the Correctional Service of Canada start accommodating their unique needs as a disease might progress?

**Dr. Jessica Shaw:** Several facilities offer specialized care. For example, Pacific Institution in Abbotsford has a palliative care program within the prison facility. They also have a peer support program. Some of the younger, healthier men care for some of the older, less healthy men. There has been some talk, or some rumblings,

that perhaps that might be a model worth looking at replicating across the country, but people are moved as their needs shift and change.

I would again bring it up that when someone gets to the point where either they don't understand why they're in prison anymore because of dementia or they are incapable of harming themselves or anyone else, I would question why they're still in the prison system.

**Mr. Alistair MacGregor:** Despite that, "parole by exception" is still an exceptional use. It's rare, as you said.

**Dr. Jessica Shaw:** It is. In another study that one of my colleagues did with 14 palliative care prisoners who had applied for parole by exception, four were granted parole. Those are folks who really are at the end of their lives.

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

Dr. Stainton, I'd like to turn to you now. You did make mention of the struggles Parliament has had in getting a Canada disability benefit act. I certainly understand that and sympathize with it. We're still unsure as to what that federal benefit will be. There's a legislative framework for it, but we don't yet know.

I think tackling the economic insecurity that so many disabled people in Canada live with.... I mean, we know the statistics. I have a constituent who's a real activist, and he refers to it as "legislated poverty".

I guess for me, when we come to this theme of autonomy and respecting a person's autonomy, can we ever reach a point where a disabled person has—hypothetically, let's say—all of the supports necessary and is leading a fulfilling life; you can bring yourself to a position where you're satisfied that someone is living a dignified life with a disability; and you can bring yourself to respect that they may, even with that level of support, decide that it's in their own best interest that they want to engage with medical assistance in dying?

I think this is the struggle our committee is having. How do we respect that personal autonomy, which is so important to so many people who live with disabilities?

• (1915)

**The Joint Chair (Hon. Yonah Martin):** I'm sorry, Dr. Stainton. You have about 30 seconds for a brief comment.

**Dr. Tim Stainton:** Okay.

Certainly, if we got to a point where it was clear that people had the support they needed to make the choices that we all value, and that they had the money they needed to lead a life, then I would have a lot less reservations about them making the choice, as I would about people at the end of life. Obviously, disabled people should have that same choice as every other citizen. It's just that we're an awfully long way from being at that point. That would be my concern.

**Mr. Alistair MacGregor:** Your point is well taken.

Thank you, Madam Co-Chair.

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

At this time, I will hand it back to my co-chair for the next round of questions.

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

[*Translation*]

We will now go to questions from the senators.

Senator Mégie, you have the floor for three minutes.

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

My questions are for Dr. Shaw and are about prisoners.

I'm going to ask you several questions, and I ask that you take the time you need to answer them.

As we know, prisoners live in a closed and monitored environment. Does this affect the professional's assessment and the patient's choice? Does it affect the voluntary aspect of requesting medical assistance in dying?

How can a physician assess a patient in this monitored environment? Where does one draw the line in terms of confidentiality of medical information?

Which physicians assess detained patients and provide medical assistance in dying? In other words, are independent outside physicians used or do the correctional facility's physicians do it?

Please go ahead, Dr. Shaw.

[*English*]

**Dr. Jessica Shaw:** The issue of voluntariness is an important one.

To answer your question, I've spoken with and interviewed physicians involved in each of the three known MAID cases. Certainly, the questioning by the assessors and the providers of the necessity of having guards, for example, or Correctional Services officers in the room did come up. I know that, in at least one case, a hospital ethics person was brought in to be present in the room to make sure that there was an extra level of eyes to ensure that the voluntariness was protected.

Similar to why we would keep people in prison if they can't hurt anyone anymore and they're dying, in the same vein, if someone is incapable of harming himself or someone else, probably those few moments of privacy are essential, and these have happened during assessments.

When I think about the three cases, assessments were done both within the prison system and after a transfer to community hospital. To answer your question, the process is that first the chief health services officer reviews the request for an assessment. The guidelines say that ideally a physician internal to CSC would be the first person to provide an assessment. If it has to be external, it goes external. The second, and sometimes the first and the second, is always external to Correctional Services.

Does that answer your question?

[*Translation*]

**Hon. Marie-Françoise Mégie:** Yes, thank you.

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

[*English*]

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

• (1920)

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

My question is first for Dr. Shaw and then Dr. Stainton.

I think that every member of this committee would agree that lack of appropriate housing and community supports should not be the determining factor to access MAID for anyone with a disability; however, not all people with a disability live in such circumstances, and their choice for MAID may be completely divorced from the need for any additional supports.

What advice would you give this committee to ensure that we have safeguards for people with disabilities who require additional supports so that they don't seek MAID as an alternative, but, at the same time, not deny those people with a disability who wish to choose MAID as a choice and who are not deciding to do so because of a lack of resources?

**The Joint Chair (Hon. Marc Garneau):** We'll start with Dr. Shaw and then Dr. Stainton.

**Dr. Jessica Shaw:** Perhaps this is quite a bold response, but who are any of us in this room to decide how long someone has to suffer and how much their suffering has to be before they're granted the right to access an assisted death? I worry about having additional measures imposed on to people that then affect their ability to exercise their health care rights.

I want to reiterate that I think it's clear, and everyone has said it's clear, that no one wants to see someone die because of a lack of access to social and medical supports. If that ends up being a determining factor in why they're seeking death, who am I and who are we to prevent that?

I suppose that is where I would push the envelope a little bit in our thinking, meaning that, if we don't live in a country where people are supported—and this is not specific to people with disabilities—it still comes down to who decides how long and how much suffering is enough, and I think that rests with the person.

**The Joint Chair (Hon. Marc Garneau):** Go ahead, Dr. Stainton.

**Dr. Tim Stainton:** I'm going to disagree a little bit with Jessica. The premise has always been balancing the protection of the vulnerable and autonomy. On one level, yes, who are we to decide for anyone else? The trouble is—

**Hon. Stanley Kutcher:** Excuse me for a second. I don't want you to get into a philosophical debate with the witness. I want you to answer the question. We need your advice, so could you answer the question, please? Thank you.

**Dr. Tim Stainton:** Sure, and I thank you for the question.

As I've said, I struggle to see what safeguards there could be, beyond restoring the reasonably foreseeable death criteria. There are some things that could be done.

In the past it's been recommended that for track two there be an independent panel that reviews in detail a detailed psychosocial assessment similar to what we would do in child placement or in sentencing. It could look at all of those factors and at whether there are things like housing and alternatives. That would need to step out of the doctor-patient and into a somewhat removed panel with a broader set of expertise.

The problem, which the senator will be more than aware of, I'm sure, is that with our jurisdictional division of provincial and federal responsibilities, the MAID law can't order the provinces to meet people's disability or housing needs—not without a very long and torturous fight.

That's one thing I think could improve the situation. It's that kind of independent review, psychosocial assessment and ordering. Perhaps if those supports aren't forthcoming, then approval for MAID wouldn't be given until they are.

From a policy perspective, that's really hard to pull off.

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

[*Translation*]

Senator Dalphond, you have three minutes.

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

[*English*]

Since I have only three minutes I would like first to thank the witnesses.

I will address my questions to Dr. Shaw.

I understand that you have done a lot of research with vulnerable people. You wrote an article called “Perceptions and Experiences of Medical Assistance in Dying Among Illicit Substance Users and People Living in Poverty”.

Can you comment on that? I think you commented in your article about the lack of knowledge about the end-of-life care options.

Also, did you find that it was a slippery slope with vulnerable people being coerced or pressured to end their lives?

• (1925)

**Dr. Jessica Shaw:** Thank you for that question.

The short answer is no, we did not find that there is a slippery slope of people being pressured to end their lives.

On the contrary, the folks who I spoke with—roughly 50 people who were quite impoverished and there were some substance users as well, in Alberta and in British Columbia, primarily in Vancouver and Calgary—rather than being worried about being pressured to end their lives, were concerned about being prevented and not knowing where to go to access end-of-life care. That's what you raised about not knowing the resources.

There was a concern that, like all other aspects of their health care, they would be prevented from accessing this. It's very difficult when you're living on the street to access any health care. End-of-life care and MAID in particular was seen as an extension of that. Rather than feeling pressured, there was a fear of being prevented from accessing it.

If I can add a comment to that as well, I will never forget this one gentleman who said to me that not every overdose is unintentional. He reminded me that people have the ability to end their lives quite readily available to them.

I think the question we have to grapple with in this committee and as a society is that the state doesn't owe anyone a dignified death, but if we can provide one to someone who is suffering grievously, why would we withhold that from them?

**Hon. Pierre Dalphond:** Do I gather that for vulnerable people, you don't feel there is a need for additional safeguards?

**Dr. Jessica Shaw:** There is a need for additional social supports. Vulnerable people, in many different experiences, are asking for more support, but the folks—I'm talking about people experiencing homelessness—are fighters. They're fighting to survive every day. They need more support to survive, but they certainly don't need additional supports on whether or not they can die.

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

[*Translation*]

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

[*English*]

Senator Wallin, you have three minutes.

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

My question, too, is for Professor Shaw.

It is my understanding that, given the Charter of Rights and Freedoms, human rights law and even common decency, to put it that way, disabled people cannot be denied or excluded from access to medical assistance in dying. I think that was the point you were trying to make.

There will be many in the disabled community and in the communities you have done specific work on who will understand that and believe that they should not be excluded from access to MAID.

How do you assess where we are on that issue of accessing this right they have to make this choice, which is what you've just been discussing a little bit with Senator Dalphond?

**Dr. Jessica Shaw:** For me, it is how we frame vulnerability, too. What I was trying to say in my opening statement is not to shift away from thinking about vulnerability in the ways that people are personally experiencing it. It's thinking about who is vulnerable to having their rights to make that rights link, who is vulnerable to having their rights infringed upon because of policies and, potentially, extra safeguards that are not necessary, which then prevent our having further steps and hoops for people to jump through, when it's already incredibly difficult for some of these folks to access health care, end-of-life care, of which MAID is a part.

Putting it into a human rights perspective and making that link about vulnerability, not based on life circumstances alone, but vulnerability to policy and procedure, is where my thinking is right now. I think that's where your opportunity as a committee is, to really get this right when you are thinking about expanding eligibility criteria to do so, as you have done in a very intentional way, without adding unnecessary additional levels that will actually harm people who do need support.

● (1930)

**Hon. Pamela Wallin:** I raised it in part, because even provinces like my own have taken the information about MAID off the 811 system. Are you finding that it is more difficult for vulnerable people, people who are disabled, perhaps the communities in prison, to even get basic information about the choice that is their constitutional right?

**Dr. Jessica Shaw:** Yes, and when we think about access to any health care information.... My fellow witnesses spoke about systemic ableism. We have systemic racism. We have all kinds of reasons why people are discouraged from accessing services and feel that they're not safe. Health care is one of those systems that feels very unsafe for people to access. Basic health care information, and MAID in particular, is an issue.

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

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

Now finally we go to Senator Martin for three minutes.

**The Joint Chair (Hon. Yonah Martin):** Thank you to all of our witnesses, first of all.

My first question is for Dr. Janz.

How do you think the expansion of eligibility for MAID to people with disabilities, who are not at end of life, will impact the current generation of children and youth growing up with disabilities?

**Dr. Heidi Janz (via text-to-speech software):** It's something that I've been thinking about a lot since the expansion of eligibility for MAID to people with disabilities who are not at end of life.

As someone who had most of my K-to-12 education at a school for kids with physical disabilities, I find that the latest expansion of eligibilities for a state-sanctioned death particularly chilling. Roughly half of the kids at our school had a life-limiting condition like muscular dystrophy, which at that time had a life expectancy of 14 to 18 years.

Every student in that school grew up knowing that some of us would live longer than others, but we also knew that all of us would live with the best quality of life possible until we died. This is not the message that Canadian kids with disabilities are growing up with in this "brave new world" of MAID.

For a mature minor, they are more likely going to hear that "It's only natural that you're depressed and you're tired of your life. You're disabled. Maybe you should go get MAID."

I feel for kids with disabilities in this country. I fear for kids with disabilities in this country.

**The Joint Chair (Hon. Yonah Martin):** Do I have time for one more?

Okay, Dr. Stainton, can you comment on the over 15,000 working-age Canadians in long-term care homes, and any concerns you have regarding this population under the current track two framework.

**Dr. Tim Stainton:** Very quickly, most of those people don't want to be in long-term care. They are there because the home care system has ceilings on what it will fund. We had the tragic case in B.C. of Sean Tagert who just wanted to stay in his home for his remaining years with his son. He needed a few more hours of home care to do that and was told that it was not possible and that he needed to go into a long-term care home, where really he couldn't have a relationship with his son, so he chose to access MAID because of that.

I'm working in Nova Scotia right now where they just had a human rights judgment against the province ordering it to get, I think, it's 400 some people in Nova Scotia alone.

All of us would think that. If you're 30 years old and all of a sudden you're told you're going to live in a long-term care facility, what kind of life is that? What kind of prospect is that? What kind of autonomy is that? You have no significant life choices.

If you look at from Jean Truchon and multiple other people, Truchon said that the cause of his suffering was that he couldn't face the prospect of life in an institution. There is no reason from a care perspective that he couldn't have been supported at home other than the funding.

• (1935)

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

This brings our first panel to a close. I would like to thank, on behalf of the committee, Dr. Janz, Dr. Shaw and Dr. Stainton. Thank you very much for your opening remarks tonight, for expressing your views and for answering all of our questions on this difficult issue with respect to MAID in the context of people with disabilities.

An extra thank you to you, Dr. Shaw, for speaking to us about inmates in correctional services in the context of MAID again. Thank you very much. It's very much appreciated by our committee, which has to deliberate on this very important matter.

With that, we will suspend briefly and prepare for the second panel.

• (1935)

(Pause)

• (1935)

**The Joint Chair (Hon. Marc Garneau):** Colleagues, we will start our second panel.

Just before we start, I will make a few administrative comments.

For all of the members as well as the witnesses, before speaking wait until I or my co-chair recognizes you by name. I remind you that all comments should be addressed through the joint chairs. When speaking, please speak slowly and clearly for the benefit of the interpreters.

You may have questions in French or in English. Use the interpretation button on your screen if you are in virtual.

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

Our witnesses tonight are all appearing as individuals. We have in the room with us Liana Brittain. Virtually, we have with us Dr. Karen Ethans, associate professor, and David Shannon, a barrister and solicitor.

Thank you all for joining us this evening as we continue our study of MAID in the context of people with disabilities.

I will ask Ms. Brittain to start off. Each of the witnesses will make a five-minute opening statement and then we will get to questions.

The floor is yours, Ms. Brittain, for five minutes.

• (1940)

**Ms. Liana Brittain (As an Individual):** Thank you, Mr. Garneau.

Thank you for the opportunity to have our collective voice heard in this forum, where decisions are being made that directly impact our individual lives when we are at our most vulnerable. I'm here to

symbolically represent an enormous group of physically disabled people who are making their end-of-life journey. We are the experts who are actually living the MAID experience.

You brought up the word "vulnerable". After five and a half years of volunteering as an advocate in this field, I've come to understand that medical assistance in dying is so much more than just a series of injections or a self-administered cocktail provided by expertly trained staff during a medical procedure. It is in fact a very broad spectrum of services provided by our medical community at the request of the individual.

First, I want you to envision changing your perception of what a medically assisted death is. Paul, my late husband, was a psychotherapist in private practice. He maintained that if you could make a five-degree shift in your perception, you would see an issue from a very different perspective, one that you had never realized existed. So I'm now challenging you to make that five-degree shift in perspective and look at medically assisted death from a fresh new angle.

I would like to share with you some examples of ways in which the medical community helps people voluntarily end their suffering and die with dignity on their own terms every day across Canada. They are MAID, medical assistants in dying, and yet we don't call them that. Why not? These medical practices have been in use for decades, and in some cases hundreds of years in cultures throughout the world. I call it a "spectrum" of choices, because it flows from a more passive action at one end of the scale to a more hands-on, active role at the other end.

I believe it is our responsibility as a society to educate everyone, in particular those with physical disabilities like me, about what options are available to them in collaboration with the medical community as they make the final leg of their end-of-life journey. This is true people/patient-centred care, care where the individual is in charge of taking responsibility and actively participating in their own plan. I may be physically disabled, but I want to know what my choices are. I want to weigh those options and make an informed decision about what I can choose to do next, in consultation with the experts. I don't want to feel vulnerable.

There is a medically assisted spectrum of choices that a person could make if they only knew they existed.

There's cessation of treatment. There may come a point in a person's illness when they decide that further treatment is of no value to them for whatever reason. It's their decision. It's their choice. No one can decide what is too much suffering except the individual. At this juncture, the medical community and the individual agree to stop treatment, knowing that to do so will ultimately result in their death. This is a form of medically assisted death.

With a “do not resuscitate” order, one can say the same. DNR is a mutually agreed-upon contract between the medical community and the individual. In medical crisis, no treatment will be offered to sustain life, thus leading to the person's death. Once again, this is a form of medically assisted death.

There are self-injected morphine pumps. Before MAID was available, my father chose this option. He knew he was dying and had only a few hours left. He was given a morphine pump and was allowed to make his own decision.

The same goes for voluntarily stopping eating and drinking. Our medical community supports people in a variety of circumstances and eases their symptoms when they choose to stop eating and drinking, knowing that their life will end when they stop.

• (1945)

Palliative sedation and palliative coma are two more examples of medical assistance in dying. The MAID procedure, as we call it today, is one that most readily comes to mind when we think of medical assistance in dying. If we choose to acknowledge that there are other forms, then I suggest we rename these.

By sharing this type of information and changing people's understanding of what a medically assisted death really is, we can educate people with physical disabilities about what their options could be. When people become educated about their rights and options, they can make truly informed decisions: decisions that reflect their own needs and wants, ones that empower them and grant them their human right to die with dignity on their own terms. What an incredible gift to give a person as they transition from this life to whatever comes next.

Most importantly, please remember the three Es: envision, educate and empower. It is imperative that you provide us with the knowledge and the information we need to make our own informed choices: the ones that best meet my—our—individual needs. Empower us to die with dignity on our own terms.

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

If you could wrap up very quickly, we're way over time.

**Ms. Liana Brittain:** I'm done. I had one more sentence.

**The Joint Chair (Hon. Marc Garneau):** That's perfect. Thank you, Ms. Brittain.

We'll now go to Ms. Karen Ethans.

You have five minutes, Ms. Ethans.

**Dr. Karen Ethans (Associate Professor, Internal Medicine Section, Physical Medicine and Rehabilitation, University of Manitoba, As an Individual):** Good evening.

As a rehabilitation specialist physician, I have 23 years of clinical and research experience with people with spinal cord injury. I follow them from acute care through rehab and transition to the community, and lifelong to manage symptoms, prevent complications and help improve quality of life.

Most people with spinal cord injury live for years—some up to normal life expectancy. My concern with MAID since Bill C-7 is the removal of the criterion that one is expected to die in the fore-

seeable future. People with a new, severe neurologic disability are now able to ask to end their life after only three months. I hope to convince you that three months is far too short.

I do not believe that people with new severe neurologic disability will have the ability to make an informed choice to choose death until they have had the opportunity to live with their new impairments and disabilities, reintegrate into the community and realize the excellent quality of life that is experienced by most with these disabilities.

Imagine waking up after a severe car accident, for example, and learning you have a spinal cord injury. You can't move your legs and maybe not even your arms. Many of you will think, that you wouldn't want to keep living like that. Yes, that's what many people with new spinal cord injuries think in the early months. Many of the acute care health providers that person meets early on have the same viewpoint. A lot of them have never cared for someone with a significant neurologic disability who is living a full life in the community. Many of the friends and family of that person who visit early on have the preconceived view that their loved one won't have much of a life going forward.

The person with a new spinal cord injury will spend months in hospital and in the first few years will still be adjusting to their new life. In these early months and years, suicidal thoughts and wishes to die are held by many. People can go through some very dark times. However, I can verify from my own research, other research done by colleagues and others, and my clinical experience that most people who have a chronic spinal cord injury—that is, at least a few years—rate their quality of life as very good and equivalent to or better than many people who are able-bodied.

In a research paper that I recently published with colleagues, it was found that most people with chronic spinal cord injury admitted that early after their injury, they had a wish to die. However, all of those people who we interviewed declared they no longer wished to die and would not accept MAID at that point in their life. They felt that being offered MAID too early on was wrong and that people were needing to live the life experience with spinal cord injury before they could make that kind of choice.

Literature supports that it takes years for people with new neurologic disabilities, such as stroke...and people cannot make such a decision and adjust to their new normal for at least two years.

I want to tell you a story that's reflective of many of the scenarios I've witnessed.

I was asked to see a young man in ICU on a ventilator with a high spinal cord injury. I was asked to discuss prognosis. The patient and mom were so relieved when I reported that he had a good chance of getting some significant improvement, based on my exam. The mom came to me crying and reported to me that the ICU doctor was advising them that they should turn off the ventilator—that his life would be terrible and not worth living. Guess what? That young man in ICU walked out of rehab to go home months later.

My point isn't that many of these patients get such excellent recovery, but it is rather to reinforce that we can't let our preconceived notions of what we think life with a disability would be like to cloud our judgment or care decisions, as we have not lived that life.

• (1950)

MAID now being part of care choices early on in the times when the person is really vulnerable, struggling to accept their new disability and before they've had the opportunity to realize what excellent quality of life their future may hold is a grave failure to these patients. It should not be part of a care choice for a long time, even up to years after their injury.

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

We'll now go to Mr. David Shannon for five minutes.

**Mr. David Shannon (Barrister and Solicitor, As an Individual):** Thank you very much.

Inflammatory stories about a painful end of life have often been shared with this committee to promote ideology rather than to encourage proper analysis and cogent debate. I will not do that tonight.

I am not speaking about the far end of life. I am talking about a person such as me, a person who's lived with an upper-level spinal cord injury for over 41 years, a person who has practised in the area of disability rights and mental health law for over 25 years, a person who, early on, shortly after that accident, had dark days and for 41 years has been grateful to be able to embrace life, its wonders, its altruism and its aspirations.

That's not available, I know, to many people shortly after their accident or other catastrophic injury or disability, and there's pressure now with this new legislation directed by the state that says, "Your life may not be worth living. Extinguished is okay."

At the outset, though, I do ask each of you to accept the stark truth that is often ignored, and that is that often suffering experienced by persons with disabilities in Canada is at the hands of the state. The suffering is caused by the state. We experience a pernicious form of human rights denial that includes poverty and unacceptable markers in the social determinants of health.

Tonight I wish to especially speak, though, to an inherent flaw, given my limited time, a flaw or contradiction in the law. Paragraph 241.2(1)(c) of the Criminal Code, which many of you know, states that a medical condition will make a person eligible for MAID because that condition is "grievous and irremediable".

Canadian human rights legislation and the Supreme Court state that physical and mental conditions are personal effects to be protected from human rights abuses in a manner no different from race, sex, gender, religion and many other grounds of discrimination. Moreover, courts have stated that disability is a social construction; therefore, remove the social barriers and you remove the discrimination. This indicates that discrimination is fully remediable.

We ask, what is disability? Is it a physical or a mental condition that makes one eligible for medically administered death or is it a remediable social construction?

In an analysis for MAID assessment, people, when assessing for MAID, must consider more than just an extreme medical-only determination and be balanced with established human rights norms. I'm talking about human rights that find that, if you can stop the suffering through changing socio-economic condition, then, in fact, it's a remediable condition.

I would submit that nurses, nurse practitioners and physicians do not have the expertise. For people such as me, people who live in the world of independent living, you need to understand us as a community, a community that does and is able to speak to independent living and speak to the importance that the disability, the social construction, can be remediated. That will give the full weight and meaning of the word "remediation". It will also put an important factor into the physician-patient relationship in that, if a physician, through broad and deep analysis, sees that the condition can be remediated by removing discrimination, then a person should not be eligible.

• (1955)

We should not just jump to provide MAID. We never jump to provide death in any other legal context. This, of course, should be given the same and even greater respect, consideration and analysis. Time does not allow me to speak much further, but I want to say and emphasize again that regulations must include a human rights analysis.

Another recommendation is that access to MAID must guard against allowing MAID to be a facilitation for suicide for individuals who are suffering a mental disorder or weakness due to anxiety, depression and vulnerability.

Also, there should be a regulated MAID oversight body that is independent and provides annual reports with full substantive analysis to the minister and the public.

Lastly, MAID should not be utilized to target a population, to target a community, especially an equity-seeking community. It would be unheard of, unthinkable, for any other group or population in Canada. It equally should be disregarded and called what it is—ableism in Canada—should it be directed in a pernicious way at persons with disabilities.

Thank you.

• (2000)

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

We'll now go to questions, and I'll pass it over to my joint chair, Senator Martin.

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

Thank you to all of our witnesses today for their testimony.

We will begin the first round of questions.

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

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

Dr. Ethans, you spoke about informed consent in the context of persons who were diagnosed with a new, severe neurological disability. Can you speak a little bit about your research on informed consent? Second, you stated in your testimony that in such cases the 90-day wait period, reflection period, provided for in track two cases is not appropriate. However, you went on to say that, in order to come to terms with and be able to, I guess, comprehend what life looks like, that can take years.

So, if not 90 days, what is the appropriate timeline, and what would be the parameters around that?

**Dr. Karen Ethans:** It's a good question, and nobody has the exact answer.

The study that we did and the one that my Saskatchewan colleagues published this year are very similar studies. The questions by my Saskatchewan colleagues to the people living with disability... As we've heard today, the experts are the people living with the disability. Those people we interviewed are the experts. I'm not the expert.

For the Saskatchewan colleagues, it was the same thing. They interviewed people with spinal cord injury and with chronic spinal cord injury. We got a variety of answers, with anywhere from a year to five years. One in the Saskatchewan group even said 10.

We know that it can be years. We don't have a definition of exactly how long it will be. The study I talked to you about, on stroke and other neurologic disabilities, found it's two years. We know that suicidality rates in spinal cord injury decrease quite dramatically by seven years.

Hearing the experts—who are the people we interviewed and the people the Saskatchewan people interviewed, and who were the people living with and who had gone through this—they all consistently said that offering MAID before people have had that chance to reintegrate into the community... They can't make an informed decision until they've had that opportunity.

One lady I work with has a high spinal cord injury. She is amazing. She's a Ph.D. She has three children. She runs the university department she works at. She's a paralympic athlete. She said it took five years before she woke up and realized she was happy that she was alive, and she thinks her quality of life is excellent.

How do you define that? I don't know, but according to the people interviewed, it was anywhere from a year to up to 10 years.

• (2005)

**Mr. Michael Cooper:** Would it be your recommendation that the government consider amending the legislation, or at least explore amending the legislation, to take into account these types of cases?

Again, what would that look like, if that is your recommendation? You talk about spinal cord injuries, but where do you draw the line?

How do you establish another track?

**Dr. Karen Ethans:** It could be a new severe...any medical issue, really, that makes people say, "I wouldn't want to live like that."

A lot of patients who come into it, like I said, have this preconceived notion that many of us would have if we hadn't worked with that population, which is that living with a severe disability is a life not worth living. People have to get past that. They have to be able to live that experience and be offered the chance to go to university if they need, or whatever.

We talked about a lot of the problems with not offering social resources, like housing, psychological services and everything else. However, we have to make sure that people have lived a true life experience with their new impairments and disability before being able to assess it.

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

Next we have Monsieur Arseneault. You have the floor for five minutes.

[*Translation*]

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

I'd like to thank all the witnesses for their testimony on this difficult issue of medical assistance in dying and safeguards.

I was fortunate, as was my colleague Michael Cooper, to have served on the first Special Joint committee on Medical Assistance in Dying in 2015-16.

We heard from a number of witnesses at that time, and one of them made a big impression on me. It was former federal MP and minister, and also former MLA, Stephen Fletcher.

As you probably know, Mr. Fletcher was severely disabled. He was career-oriented and he had an incredible career. He told us he was not suicidal, but that the day he had enough of his irreversible condition, he would not hear of anyone lecturing him.

He had quoted an English poet:

[*English*]

"I am the master of my fate: I am the captain of my soul."

[*Translation*]

if I put this in the context of the Carter decision, there's no question that the decision to go ahead with medical assistance in dying must come from the individual, not from others.

I'm setting the stage for the questions I'm going to ask the witnesses.

Mr. Shannon, I'd like to hear your opinion on the centrality of the person seeking medical assistance in dying and the safeguards.

With respect for the person's condition and their profound request, and knowing that they are of sound mind, do you feel any other safeguards should be put in place?

I'm asking you this in hopes of getting a short answer no more than one minute long, as I'd also like to ask questions of other witnesses.

[*English*]

**Mr. David Shannon:** I'm glad you raised the point of Mr. Fletcher, a gentleman whom I call a friend, a person who embraced life through living. At the outset of my comments I said that, at the very end of life, as Carter spoke to questions about end of life, I believe that debate is not here tonight.

I was speaking of people with much life to live. What is important in terms of safeguards is to ask the question: Is suffering being caused by the social conditions of that person? If so, then a physician should not be in a position where they are just forced to provide MAID. Those social conditions should be addressed.

The question is right there in the Criminal Code. If it's remediable, then MAID should not proceed. These are the safeguards. If it's remediable, then it must be a reciprocating relationship and the conditions be remediated.

• (2010)

[*Translation*]

**Mr. René Arseneault:** Thank you very much, Mr. Shannon. You were very specific.

Dr. Ethans, you mentioned the case of a young patient you are treating. One of your colleagues had suggested that he be taken off the ventilator because he would have an impossible life, an extremely hard life.

Had a request for MAiD been when this was done?

[*English*]

**Dr. Karen Ethans:** No. Thank you for asking that.

I should clarify. My point was to show you that—

[*Translation*]

**Mr. René Arseneault:** I'm sorry, Dr. Ethans, but I have very little time.

My question is about the example you gave us.

Had MAiD been requested?

[*English*]

**Dr. Karen Ethans:** No.

[*Translation*]

**Mr. René Arseneault:** The question that comes to mind is, did you or your colleagues, who knew the physician who made this incredible suggestion, file any complaints under your code of ethics?

[*English*]

**Dr. Karen Ethans:** No. It wasn't a code-of-conduct issue. The ICU doctors have to make counselling decisions with patients every day. They have to help patients and family members realize what is going to be worth keeping—

[*Translation*]

**Mr. René Arseneault:** All right. Thank you, Dr. Ethans.

I don't have much time. I'd like to ask Ms. Brittain a question.

Ms. Brittain...

[*English*]

**The Joint Chair (Hon. Yonah Martin):** I'm sorry. There are about 20 seconds.

**Mr. René Arseneault:** Madam Brittain, is there any safeguard when we put the patient in the centre of asking for MAID? Is there any safeguard that we should put in place for people who are heavily handicapped?

**Ms. Liana Brittain:** I think the only safeguard necessary is to inform them of all the options so they can make informed decisions. Without knowledge, without understanding and education, they don't know all the facts. They need them in order to make an informed choice that is best for them.

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

[*Translation*]

**Mr. René Arseneault:** I'd like to thank all the witnesses.

[*English*]

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

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

[*Translation*]

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

I'd like to thank all the witnesses for being here. I don't know if I'll be able to ask everyone questions, but I really appreciated your testimony.

I will address Dr. Ethans first.

If I were 25 years old and had a spinal cord injury, I would be reassured to have you as my doctor. For example, you say that it's up to the patient alone to decide on their quality of life. You also talk about the whole adjustment period.

Don't you think that all of this is part of what might be called good medical practices in managing spinal cord injury cases? Would you agree that a practice that would go against what you have described to us would be ethically questionable?

[*English*]

**Dr. Karen Ethans:** Thank you.

As a physiatrist or a physical medicine and rehabilitation specialist, there are lots of people like me who deal with spinal cord injury in a rehab centre who would have the perspective I have. However, it's the acute care health care professionals who have their preconceived notions. I believe it's because they haven't had the opportunity to look after people with chronic, severe disabilities who live in the community.

There are studies that show that if physicians are asked what people's quality of life would be like, they rate the people with disabilities' quality of life quite low. That's a general physician. When I'm talking about my colleagues, that's their job: They deal with people with disabilities. But when you ask the patients or the people with disabilities, what their quality of life is, especially with spinal cord injury, it's rated quite high.

[Translation]

**Mr. Luc Thériault:** There's no doubt that people from all walks of life need to be educated. You're saying that yes, it should be part of good medical practices. Some people in your field are not experts and they might have certain biases. However, they won't have to one day assess your patient requesting MAiD who has been through all the procedures and is not in a suicidal state. Everyone who has appeared before us has clearly indicated that, in all cases, a suicidal state completely disqualified all patients requesting MAiD. It's important that it be said again.

Mr. Shannon, do you consider yourself a vulnerable person?

• (2015)

[English]

**Mr. David Shannon:** I'm now 41 years post-injury. I can speak to the first two years. I was highly vulnerable. I was only 18 years old, starting university, and then I wasn't there anymore. I'd lost my place and my identity.

I returned to university later. I have friends, I have a career. I have things that would have been lost to me, although MAiD wasn't an option then. If in those acute stages I had opted for MAiD, it would have been a life extinguished. I was so thankful that option wasn't there.

I think of the learned colleague just a few minutes ago who quoted a poet. I think also of Dylan Thomas. That is:

Do not go gentle into that good night,  
....  
Rage, rage against the dying of the light.

I think that's a personal motto now for me.

[Translation]

**Mr. Luc Thériault:** Thank you.

If good medical practices were used, do you really believe that those working with you would have proposed MAiD to you had it been an option? You were 18 years old. Do you think they would have proposed that to you rather than give you all kinds of examples of people who had lived a very full life after age 18? I don't know how long ago you were 18.

We have some glaring examples. Ms. Gladu was a severely disabled woman, but she lived a very full life. She had to go to the

Supreme Court to demand what she wanted. As soon as the foreseeable death criterion is back in place, all these people will be excluded.

Is that not discrimination?

[English]

**The Joint Chair (Hon. Yonah Martin):** Please be brief, Mr. Shannon.

**Mr. David Shannon:** I am not speaking to putting foreseeable death back into the law. That is removed. That is the current law. What I am suggesting is that if it can be remediated, if the state has caused the suffering, then the state must remove the suffering.

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

Lastly, we have Mr. MacGregor for five minutes.

**Mr. Alistair MacGregor:** Thank you very much, Madam Co-Chair.

Thank you to our witnesses.

Dr. Ethans, I'd like to start with you. Your opening remarks reminded me of a high school friend who once was an amazing soccer athlete. I played on the same team as him. He was involved in an unfortunate car accident and went through some pretty dark days. Nowadays, he's a remarkably successful lawyer and has his own family. That's a personal observation of mine about someone who has come through a very dark place and has adjusted to very life-altering circumstances.

Maybe I'll give you some leeway in what you'd like to say here. In our committee, yes, we do have five broad themes that we're looking at, but I also think our committee has a bit of latitude in the types of recommendations we can make.

For your field of specialty, when we're looking at supports for people who are dealing with spinal cord injuries, are there any specific recommendations you'd like to see our committee focus on for some of the supports that are necessary to help people achieve that full potential later on?

**Dr. Karen Ethans:** Thank you.

One thing that is lacking here in my program, and that I think is lacking in many places across Canada, is psychological support. You can imagine what that person you were talking about went through in his dark days. In our study we heard the same thing. The people I interviewed had very little in the way of psychological support as they went through those dark days.

I'm not just talking about in rehab or in acute care. We need to be providing psychological supports for people out in the community, and social supports. We need to be able to provide housing. We need to provide accessible housing. We need to provide accessible housing where people can be cared for, as we heard. We need more home care to keep people in the community. For some of my young patients, it's like what we just heard about with regard to personal care homes in the last session. Some of my young patients are living in personal care homes because there is not enough care support in the community for those people.

Then we need to do a better job at some pain management. Pain clinics have very long wait-lists. I mean, sometimes the pain just can't be managed well, but we need to really be managing pain aggressively.

• (2020)

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

Ms. Brittain, I'll turn to you. I appreciated the perspective you brought with your opening remarks. You really centred on a person's autonomy and their ability to make a choice that's their decision. Whether it's palliative sedation or do not resuscitate orders or declining further medical interventions, these are all, in a way, different forms of medically assisted death.

When we've been looking at the issue of protection for persons with disabilities, often we're struggling with that theme of a person's autonomy being constrained by the social conditions in which they find themselves—the dire poverty, the lack of economic supports, the lack of housing—and that theme of really focusing on a dignified life before someone can actually make a decision to get a dignified death.

I'll give you some leeway as well if you want to add anything that you want to see our committee report focus on when we table it in February of next year.

**Ms. Liana Brittain:** I think the most critical thing here is the individual rights and focusing on those.

I recognize that there are people in difficult circumstances. However, over the past five and a half years, many people—dozens and dozens from all across Canada, New Zealand and Australia—have approached me and shared their personal stories with me. I've written about them in the Dying with Dignity Canada blog. It all comes back to the same thing: these people are not destitute. They have homes. They have the means to live a life with all of the necessities. However, it is an individual choice.

There comes a point when your quality of life is so poor that there is no desire to continue. That is critical. It's the individual making the choice. It's what's acceptable to them. There's no point in the doctor saying, “Well, I think you have another good three or four years ahead. If you just wait a few more years, you'll feel differently”. That's not the point. The point is, I feel that way right now, and it is my right.

When my condition, to me, is irremediable, I have the right to make the choice about what's right for me.

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

**Ms. Liana Brittain:** And I can tell you that—

**The Joint Chair (Hon. Yonah Martin):** Mr. Brittain, thank you very much. We are over time.

**Ms. Liana Brittain:** I could go on all evening. I apologize.

**The Joint Chair (Hon. Yonah Martin):** No. Please don't apologize. It's very tight with all of these time limits.

Mr. Co-Chair, I'll return it to you for the round of questions from the senators.

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

[*Translation*]

First, Senator Mégie has the floor for three minutes.

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

I'd like to thank all the witnesses. My question is for Dr. Ethans.

Dr. Ethans, I'm going to repeat what Mr. Thériault said to you. This is a classic example, all the expert witnesses in the field told us that if a patient is depressed, in an acute crisis or suicidal, MAiD is not an option. That's the case with your patients in the early stages of consultation at the rehabilitation centre.

On the other hand, I would see them after rehabilitation, to help them continue to live in their environment. Many of them wanted to live. However, after several years, some may find that life is hard, that it's hard to go on for all sorts of reasons. They may find their situation intolerable at some point.

Do you consider them to be in a position to request MAiD? Do you trust the professionals treating them and assessing them to decide if they truly meet all the criteria, including intolerable suffering, and so on?

• (2025)

[*English*]

**Dr. Karen Ethans:** There a couple of things there.

When someone has lived in the community and they've lived their life with a spinal cord injury.... I've talked to patients and some of my patients have applied for MAiD. Some of them have qualified, but have put in on the back burner. They just want to leave it there, in case.

One fellow has lived with his spinal cord injury for over 50 years. He's quadriplegic. He wants it on the back burner, in case he decides at some point that this is too much. He's definitely able to make an autonomous and well-informed decision. He's lived with this for a lot of years. He knows it better than anybody.

Now, do I trust the people...? In my province, the lead physician in charge of MAiD is excellent. I trust her to make.... I've talked to her about all of this and how people in the early days, before they've realized what it's like to live with their disability, can't make that informed choice, and she agrees with me. I'm glad that I have her in this province and that I can trust her to do that.

Does that answer your question?

[*Translation*]

**Hon. Marie-Françoise Mégie:** Yes, thank you.

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

[*English*]

Thank you, Dr. Ethans.

We will now go to Senator Kutcher for three minutes.

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

Thanks to the witnesses.

I have a couple of questions. The first is for Dr. Ethans, and then I have one for Ms. Brittain.

Dr. Ethans, you have highlighted the importance of highly trained MAID assessors. You just talked about someone in your province who is highly trained and understands the issues that you talked about.

I'm sure you're aware of the training program that is currently being developed and accredited by the Royal College of Physicians and the Canadian Nurses Association. Not everybody who requests MAID receives MAID, so the crux here is the assessment and the quality of the assessment.

Would you agree that if the MAID assessors are properly trained to assess an individual with a spinal cord injury, such as the person you talked about, they would be able to conduct a proper and thorough assessment of the issues?

**Dr. Karen Ethans:** It's just the control of it, and I can't say that everybody.... If somebody gets asked to see somebody who's asking to die in the first several months of their spinal cord injury, even if they've gone through this course, I don't know.... As David Shannon said—

**Hon. Stanley Kutcher:** I'm sorry. We only have three minutes.

How many cases do you know of persons with a spinal cord injury having actually received MAID within 90 days of their injury?

**Dr. Karen Ethans:** I don't know of anybody in my province, but I know of one in another province—

**Hon. Stanley Kutcher:** I'm sorry, but I have just so much time.

Ms. Brittain, not every person with a disability struggles to obtain needed services. Some do, but not everyone, and some are very financially well off.

Should people with a disability be denied access to MAID simply because they have a disability?

**Ms. Liana Brittain:** No, under no circumstances....

**Hon. Stanley Kutcher:** You would think there would be circumstances where individuals who have a disability should be able to access MAID.

**Ms. Liana Brittain:** I think anyone who has a physical disability has the right to access MAID. I'm sorry, but I'm not understanding the question.

**Hon. Stanley Kutcher:** We've heard concerns that people with disabilities who don't have housing and other support services may

sometimes feel that they need to access MAID because they can't get those services, but there are some disabled people who are financially well off and don't have that problem.

Do you think that second group should be denied access to MAID?

● (2030)

**Ms. Liana Brittain:** No, not at all. I think it's important to understand you don't wake up one morning and say, "I'm going to have MAID." This is something that is thought of, and it goes on for months and weeks and years. It is not a capricious decision, and if you are in a position and wish to make that choice for you personally, then I think everybody should have that right, whether they're physically disabled or not.

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

**The Joint Chair (Hon. Marc Garneau):** Thank you. We'll now go to Senator Dalphond for three minutes.

[*Translation*]

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

[*English*]

Thank you to the witnesses.

My question is for Dr. Ethans. You were cited in a National Post article that was published earlier this year as saying that patients with spinal cord injuries are being counselled to die, but that they don't know what their quality of life will be like after six months.

I guess you made that statement based on the things you have encountered. How many patients were counselled to die? In that type of patient you have a relationship with, I suppose you will explain to them that there is a quality of life after six months or a year.

**Dr. Karen Ethans:** I can't tell you the number of patients. Again, that's talking more about those very early on, when the ICU doctors do have to make counselling—again not just to people with significant new disabilities, but all the time—about whether they should be carrying on with their aggressive treatment or whether they should be withdrawing.

When I said counselling about dying and that choice, that's what I was referring to. Like I said, I haven't personally had any patients being counselled about MAID within the first few months.

**Hon. Pierre Dalphond:** But you were referring to colleagues who will be referring to these people that they should consider dying, but these doctors are not assessors. They're not involved in the assessment if the person decides to apply for MAID, are they?

**Dr. Karen Ethans:** No, these are the—

**Hon. Pierre Dalphond:** Are you familiar with the—

**Dr. Karen Ethans:** MAID assessors aren't counselling people to die. They're counselling—

**Hon. Pierre Dalphond:** You're referring to some colleagues who practice in the same hospitals as you, for example.

**Dr. Karen Ethans:** As I was saying, I'm talking about the acute care very early on.

People have to make those counselling... They have to counsel people about these things every day, again not just about—

**Hon. Pierre Dalphond:** If they counsel a patient to die, what does it mean—that the advice to the patient is to apply for MAID?

**Dr. Karen Ethans:** No, as we heard from our other witness, there are many ways to die, and one of them is to withhold treatment. In the ICU, the doctors have to counsel patients all the time about whether we carry on with aggressive treatments or whether we back off and basically pull the plug on the ventilator.

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

I think this is very important. I think you also said that MAID was a death serum. In such a case, it's not an issue of MAID; it's about the relationship between the patient in the intensive care unit and the doctors.

Thank you.

**The Joint Chair (Hon. Marc Garneau):** Be very quick if you wish to comment, Dr. Ethans.

**Dr. Karen Ethans:** I was just going to say that it's the perspectives that are given to people in the acute care that they will take with them as to what their life value is worth. If it's not the appropriate perspective, because they don't know what people will live like in five years, then, as I've said, it's a preconceived notion that people bring with them to their injury. Their health care providers bring it with them, and their loved ones often bring with them. It's putting them in that mindset so that person wishes to die even more.

We've heard that many people in their first several years wish to die. My point was to compound why many of these patients wish to die. They feel that they have low worth now that they have their severe disability, because that's their preconceived notion.

• (2035)

**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):** First of all, thank you to all of our witnesses.

My question is for Mr. Shannon.

In your testimony you said that paragraph 241.2(1)(c) states that a grievous and irremediably medical condition will make a person eligible for MAID. You said, "Canadian human rights legislation and the Supreme Court state that physical and mental conditions are personal effects to be protected from human rights abuses in a manner no different from race, sex, gender, religion and many other grounds of discrimination."

I would like you to elaborate further on this point that you made during your testimony.

**Mr. David Shannon:** Thank you.

That goes to the following. While I'm not an expert in Dutch or Belgium law, I speak to the issue of the importance of having a reciprocating relationship between a physician and a patient who might have a question about MAID.

The analysis pursuant to the assessment needs to be thoughtful. The question of remediation has to be more than just talking about spinal cord injury, which I have. Is that grievous and irremediable or it is something such as post-stroke?

It's also whether the person has an apartment that has heat in the winter. Can the person get home care? Can the person get personal support workers?

These are matters that are fundamental to the basics of life. In addition, these are questions that are critical to ask. If that means that a person just needs a small apartment with heating, then I would suggest that they should not be eligible for MAID.

The real sad story in Canada today is that people are getting MAID because they are unhappy with the circumstances of their life, not because of their medical condition. That's un-Canadian.

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

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

That brings panel two to a close.

I would like to thank our witnesses tonight, Ms. Brittain, Dr. Ethans and Mr. Shannon. Thank you. We're very grateful to you for expressing your views and, of course, for answering our questions. We're, as a committee, seeking clarification so that we can make the right decisions with respect to this extremely important issue. We very much value your testimony tonight. Thank you very much for giving us your time.

With that, we will bring this second panel to a close.

Our committee meeting is adjourned.





Published under the authority of the Speaker of  
the House of Commons

---

### SPEAKER'S PERMISSION

---

The proceedings of the House of Commons and its committees are hereby made available to provide greater public access. The parliamentary privilege of the House of Commons to control the publication and broadcast of the proceedings of the House of Commons and its committees is nonetheless reserved. All copyrights therein are also reserved.

Reproduction of the proceedings of the House of Commons and its committees, in whole or in part and in any medium, is hereby permitted provided that the reproduction is accurate and is not presented as official. This permission does not extend to reproduction, distribution or use for commercial purpose of financial gain. Reproduction or use outside this permission or without authorization may be treated as copyright infringement in accordance with the Copyright Act. Authorization may be obtained on written application to the Office of the Speaker of the House of Commons.

Reproduction in accordance with this permission does not constitute publication under the authority of the House of Commons. The absolute privilege that applies to the proceedings of the House of Commons does not extend to these permitted reproductions. Where a reproduction includes briefs to a committee of the House of Commons, authorization for reproduction may be required from the authors in accordance with the Copyright Act.

Nothing in this permission abrogates or derogates from the privileges, powers, immunities and rights of the House of Commons and its committees. For greater certainty, this permission does not affect the prohibition against impeaching or questioning the proceedings of the House of Commons in courts or otherwise. The House of Commons retains the right and privilege to find users in contempt of Parliament if a reproduction or use is not in accordance with this permission.

---

Also available on the House of Commons website at the following address: <https://www.ourcommons.ca>

Publié en conformité de l'autorité  
du Président de la Chambre des communes

---

### PERMISSION DU PRÉSIDENT

---

Les délibérations de la Chambre des communes et de ses comités sont mises à la disposition du public pour mieux le renseigner. La Chambre conserve néanmoins son privilège parlementaire de contrôler la publication et la diffusion des délibérations et elle possède tous les droits d'auteur sur celles-ci.

Il est permis de reproduire les délibérations de la Chambre et de ses comités, en tout ou en partie, sur n'importe quel support, pourvu que la reproduction soit exacte et qu'elle ne soit pas présentée comme version officielle. Il n'est toutefois pas permis de reproduire, de distribuer ou d'utiliser les délibérations à des fins commerciales visant la réalisation d'un profit financier. Toute reproduction ou utilisation non permise ou non formellement autorisée peut être considérée comme une violation du droit d'auteur aux termes de la Loi sur le droit d'auteur. Une autorisation formelle peut être obtenue sur présentation d'une demande écrite au Bureau du Président de la Chambre des communes.

La reproduction conforme à la présente permission ne constitue pas une publication sous l'autorité de la Chambre. Le privilège absolu qui s'applique aux délibérations de la Chambre ne s'étend pas aux reproductions permises. Lorsqu'une reproduction comprend des mémoires présentés à un comité de la Chambre, il peut être nécessaire d'obtenir de leurs auteurs l'autorisation de les reproduire, conformément à la Loi sur le droit d'auteur.

La présente permission ne porte pas atteinte aux privilèges, pouvoirs, immunités et droits de la Chambre et de ses comités. Il est entendu que cette permission ne touche pas l'interdiction de contester ou de mettre en cause les délibérations de la Chambre devant les tribunaux ou autrement. La Chambre conserve le droit et le privilège de déclarer l'utilisateur coupable d'outrage au Parlement lorsque la reproduction ou l'utilisation n'est pas conforme à la présente permission.

---

Aussi disponible sur le site Web de la Chambre des communes à l'adresse suivante :  
<https://www.noscommunes.ca>