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The Honourable Marc Garneau The Honourable Yonah Martin



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• (0850)

[English]

The Joint Chair (Hon. Yonah Martin (Senator, British Columbia, C): We will call this meeting to order.

Good morning, colleagues. Thank you for your patience. We had a few technical elements to sort out.

I want to welcome everyone to the meeting of the Special Joint Committee on Medical Assistance in Dying. I welcome especially our witnesses this morning. I know we have one witness from the west coast, so it's very early there. Welcome to everyone who is watching on the web.

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

Today we're continuing to examine the statutory review of the provisions of the Criminal Code relating to medical assistance in dying and their application.

In fact, this is our last meeting with witnesses, as colleagues know. Next Tuesday, we will be discussing instructions for the drafting of the report. Thank you to all of my colleagues who have worked very hard throughout the past few months.

I would like to remind members and witnesses to keep their microphones muted unless recognized by name by one of the joint chairs. I'll remind you that all comments should be addressed through the joint chair.

When speaking, please speak slowly and clearly. Interpretation in this video conference will work like an in-person committee meeting. You have the choice, at the bottom of your screen, of either floor, English or French.

We are going to begin our testimonies shortly for panel one. The witnesses are here to discuss protections for persons with disabilities.

We have, as individuals, Dr. Catherine Frazee, professor emerita, School of Disability Studies at the Toronto Metropolitan University, by video conference. We also have Isabel Grant, professor, Allard School of Law at the University of British Columbia. Lastly, we have Ms. Megan Linton, a Ph.D. candidate, who is here with us in the committee room.

Each of our witnesses will have five minutes to give their remarks.

We're going to begin with Dr. Frazee, who has a pre-recorded testimony. Due to the nature of the testimony, it will be slightly longer, so I wanted to let my colleagues know.

We will begin with Dr. Frazee, followed by Professor Grant and then Ms. Linton.

Dr. Frazee, we will hear from you at this time.

Dr. Catherine Frazee (Professor Emerita, School of Disability Studies, Toronto Metropolitan University, As an Individual): Thank you for the opportunity to testify.

I speak from Mi'kma'ki, the unceded lands of the Mi'kmaq people whose dignity in the face of betrayal offers a lesson, I hope, close to my heart.

My focus in these precious minutes for which I have your attention is track two MAID.

• (0855)

I understand that the suspension of track two MAID is not something that you will consider, but underlying my comments today are four strongly held views.

First, Truchon was wrongly decided and should have been appealed. If nothing changes as a result of this committee's process, that law will have to be challenged in court.

Second, track two MAID is not end-of-life care, and any rebuttal that its opponents are seeking to interfere with end-of-life choices is specious and beside the point.

Third, there are three possible ways to interpret why our government did not appeal Truchon: because of political calculations that had nothing to do with the issue before the court; because a grievous and irremediable disability is somehow akin to end of life insofar as it is believed to be the end of meaningful life, or a life of value; or because beyond the end-of-life context, there are sound policy reasons to terminate the lives of certain persons who desire death.

These reasons, it appears, would extend exclusively to disabled persons who suffer intolerably and request MAID. Presumably the government would oppose a special pathway to MAID for other suffering persons who are not disabled, such as women trapped in conditions of violent domestic abuse, or parents bearing the irremediable grief of the sudden death of an only child.

Of these three explanations, the first would be unconscionable; the second, unacceptable; and the third, both disingenuous and discriminatory.

I therefore take as my starting point that track two is not an expression of equality. It is an exemption to equality.

However, track two is embedded in law, so here we are. The genie is out of the bottle, and we are left counting our dead. That the government that brought us track two is now seeking ways and means to ensure the “protection” of people with disabilities is a hard pill to swallow.

While practitioners lawfully administer the three-minute procedure that turns life into death, we now spend every waking hour, every moment and resource not already spent on our own survival throwing out lifelines to pull our disabled kinfolk back from the vortex that funnels them into the beckoning arms of track two MAID.

We pour cash into GoFundMes for food, shelter, medicine and therapy. We pour our hearts into rescue efforts for friends and strangers, bearing witness to the injustice that afflicts them. We rigorously record every tragic case where our efforts failed, or came too late. I believe you call these “anecdotes”.

We are not trained or resourced for any of this, but our people are dying, and we must step up to save them.

You have heard a consistent message from disability rights defenders to stop the carnage of track two. You must do everything within your power to reinstate the equality-affirming requirement for reasonably foreseeable natural death, and delay indefinitely any further expansion of track two MAID.

While you are at it, shore up the requirements for track one MAID, at the very least, by explicit affirmation of existing guardrails in the law that have been quietly set aside in actual MAID practice and discourse.

These measures will save lives, but they will not restore equality or undo the incalculable damage from a catastrophic social experiment. That is because much of the harm that was unleashed as you celebrated the passage of Bill C-7 was somehow beyond your imagining.

The underlying message of track two was clear, and it entered our cultural bloodstream with the speed of an infectious pathogen. The toxic notion that life with disability is optional, and by extension, dispensable, is now in the ether. We are detecting its presence in everyday discourse in unsolicited coaching from social service gatekeepers, crisis-line workers and ordinary citizens having their say in letters to the editor of the local paper.

- (0900)

MAID has swiftly been normalized as a way to relieve the cost and toil of those who are “burdened” with our care. Its euphemistic framings have not fooled anyone, and everyday plain-spoken Canadians are giving voice to the law’s subtext. We have important examples to share.

Track two MAID assaults disabled people everywhere. It harms us through its discriminatory formulation and effects that undermine rather than expand our equality.

So much to say, so little time; so much to grieve, so little hope.

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

Next I’ll invite Professor Isabel Grant for her remarks.

You will have five minutes, Professor Grant.

Professor Isabel Grant (Professor, Allard School of Law, University of British Columbia, As an Individual): Thank you very much.

While I’m grateful for the opportunity to speak to you today, I do so with a profound sense of despair over what is happening with track two MAID. No matter how many people tell you that Bill C-7 is dangerous and no matter how many people die because they can’t afford to live, it feels like a runaway train careening towards a human rights disaster. Ableism is so deeply embedded in our political and social structures that we don’t see it as ableism but rather as a form of common sense.

The Supreme Court of Canada describes discrimination against people with disabilities as being premised on a distorted view that disability is a flaw that needs to be fixed or eradicated. It is precisely this ableist view of disability that fuelled Bill C-7 and is now killing disabled Canadians.

This ableism, sadly, has also permeated these hearings. Imagine that you are disabled. Perhaps you live in a one-room apartment. Perhaps you need diapers to deal with your incontinence. You’ve been listening to these hearings and heard your legislators talk about whether it would be better to be dead than to be like you. Far from feeling that your autonomy has been enhanced, you feel demoralized and depressed. You tell your doctor you are struggling, but she just reminds you that you are now eligible for MAID. Is it any wonder that so many disabled Canadians feel devalued and afraid?

If you take only one thing from my words today, it is this: There is only one safeguard that will protect people with disabilities from wrongful deaths, and that is reasonable foreseeability of natural death. That is the only safeguard that can prevent people from dying because they are too poor, too isolated or too exhausted from fighting for their survival to continue living. Death is the great equalizer. Everyone dies, and this is the only safeguard that removes making value judgments about the worth of disabled lives from the equation.

It is impossible to separate the suffering caused by disability from the suffering caused by the social, economic and political accompaniments of disability. If I cannot access smoke-free housing, is that my multiple chemical sensitivities or is that the inadequacy of social housing? If I can't afford an apartment with an elevator, is that my disability or my poverty? If I am facing institutionalization at 40 because the government won't provide me with home care to ensure I can get to the bathroom at night, is that my disability or is that the abject failure of the state to provide the basic necessities of life?

These situations have led to the deaths by MAID of real people who did not want to die. This is a system that would not provide Sathya Kovac with home care but gave her death by a house call. She wrote her own obituary before her death, saying, "It was not a genetic disease that took me out, it was a system."

The Supreme Court of Canada has held in the death penalty context that one wrongful death is too many. I ask you how many wrongful deaths are too many for track two MAID? To those who say that MAID is just another form of health care, remember that it is legislated as an exemption to murder and aiding suicide, and that is the only reason Parliament has any jurisdiction. The Criminal Code makes explicit that ending a life is so serious that we don't allow people to consent to their own deaths. The MAID regime makes an exception to that, but only for disabled Canadians. Only their lives are not worth saving. How can you not see that this is discriminatory?

It is irresponsible to delegate the definition of murder and aiding suicide to doctors and ask us to trust a health care system that is strapped for resources and near the breaking point. When we look at Canada's record of eugenics, from residential schools to warehousing of the mentally ill and the sterilization of indigenous and disabled women and girls, we see that doctors were deeply implicated in all of these.

This government has focused not on eradicating the suffering of people with disabilities but rather on eradicating the sufferers. I urge this committee to take meaningful steps to prevent the impending human rights catastrophe that will be MAID for mental illness and to put an end to track two MAID.

Thank you.

● (0905)

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

Last, we'll turn to the room.

Ms. Megan Linton, Ph.D. candidate, the floor is yours.

Ms. Megan Linton (PhD Candidate, As an Individual): Thank you.

Thank you for having me here on the unceded territories of the Algonquin people.

I research institutions for disabled people, an ongoing phenomenon stretching back more than a century and a half in Canada. As a result, I have sifted through hours of class action settlements and years of inquests, archives and interviews with survivors, all re-

plete with the stories of death of friends, roommates, fellow inmates and disabled people who died by suicide, who hanged themselves from the rafters or died by suicide years after they had escaped the institution but were still haunted by their experiences inside it.

For many years these suicides were a catalyst for great social change, resulting in government commissions and inquiries into these deaths. Last week Minister David Lametti expressed the intention of track two MAID being necessary because disabled people are unable to complete suicides.

As a researcher of institutions, I find the fallacy of this argument troubling.

For the last century and a half, disabled people have been trapped in institutions away from their communities, reduced to a point of efficiency, a mere practicality. These institutions, which were used as tools for eugenics, removed disabled people from society and prevented their reproduction.

Today the same logic is maintained in institutions, where access to pleasure, leisure or pain management is seemingly non-existent. Instead, these institutions, such as prisons, long-term care homes and psychiatric institutions, maintain conditions of neglect, isolation and such disregard for individual autonomy that it produces depression and suicidality both in people inside the institution and in those who fear it in their future. People are very clear in their discussions with me: They would rather die than live in an institution.

Historically, deaths have been one of the few windows into institutions—sometimes murky windows, as in the case of the Huronia Regional Centre, where the deaths were hidden away in mass graves without markers or names. The view into institutions, no matter how murky, is a view into austerity and privatization that yield bedsores, neglect and forced feeding.

We had a view inside the institutions where people use MAID, such as Chris Gladders' retirement home, before you passed track two changes. There, feces stain the floor. Instead of cleaning it up, you made changes to expand track two. Now the deaths have become so frequent that we are haunted by the possibility of loss at all times.

Because of track two MAID, disabled people are dying en masse in institutions they had been fighting to leave. These were beautiful lives. As disabled persons, we look into the windows of these institutions and we fight as hard as we can for a way out for all of us, not just for an individual through an individual death.

You ask us for the protections of disabled people. It is clear that track two MAID must be ended.

When you look inside these windows smashed open by dead bodies, you see people suffering from the conditions that you yourself created. Instead of offering a solution, a help out the door through provisions of accessible housing, home care and pain management, you offer people death.

Do not be mistaken: This provision of death for disabled people under track two MAID is eugenics, and it must be repealed as soon as possible.

We must look at the political economy for the timing of these decisions. Why now, with the increase of pandemics and incurable illnesses, such as COVID and long COVID? Why now, with pandemic health care rationing and with health care under the budget axe?

The expansion of MAID must be viewed within the context of the economic order we live under that is eviscerating the social contract by encouraging government to retreat from its responsibilities for the public's welfare and to instead kill us. You feel generous providing mercy from the austerity that you have designed.

• (0910)

To all of you, disabled people do not need your help to die. You have been killing us for years. We need your help to get out of the institution you trapped us in. The only safeguard against MAID is foreseeable death.

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

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

We'll go into our first round of questions.

We begin with Mr. Cooper, who will share the five minutes with Ms. Vien, so it will be three minutes followed by two minutes.

Mr. Cooper, the floor is yours.

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

Thank you to the witnesses for your compelling testimony.

Dr. Frazee, I'm going to ask you two questions, and I'll ask you to just answer them both, because I have only three minutes.

You spoke about the shoring up of existing requirements under track one. Could you elaborate upon what you mean by shoring up and what recommendations you would have?

Speaking of shoring up with respect to track one, do you have any recommendations on additional safeguards for track two, recognizing of course that the requirement of death being reasonably foreseeable should never have been removed?

Finally, you spoke of the discriminatory effects that MAID is having on the kinds of things that ordinary citizens say about it. Can you provide the committee with examples of that?

Dr. Catherine Frazee: Thank you, through the chair.

I'll tackle the first question first and quite briefly. I can say more in writing if you wish.

There are some very significant phrases in our existing MAID law that are being overlooked. Perhaps I can give two examples. One is the meaning of the word "natural" and the phrase "natural death is reasonably foreseeable". Reasonably foreseeable natural death is not the same thing as reasonably foreseeable death. A plain reading of the phrase signalled to me that behaviours such as voluntary starvation and other self-destructive acts do not fall within the category of reasonably foreseeable natural death. That is a distinction that is unfortunately moving people into the track one situation incorrectly and, I would suggest, unlawfully.

The other very important phrase—and this would affect both track one and track two—is the phrase "is caused by" in paragraph 241.2(2)(c). The intolerable suffering that is at the heart of MAID eligibility has to be tied directly to a medical condition. It excludes suffering, such as Professor Grant and Ms. Linton have described, that is predominantly socio-economic in nature. That is the major factor in many cases.

I believe that is contrary to paragraph 241.2(2)(c). I think clarifying these intended meanings in the way the law is drafted would go a long way towards preventing unlawful deaths and enforcing—

• (0915)

The Joint Chair (Hon. Yonah Martin): Dr. Frazee, I will interrupt you to say that if you wish to send us further details, you could do that in writing. We've come to the end of this time, so now I'll turn it over to Ms. Vien.

[*Translation*]

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

Ms. Frazee, I don't have much time left and I'd appreciate a brief answer.

In your preliminary remarks, you said that the carnage of track two had to be stopped. What's your basis for saying that track two is a form of carnage?

[English]

Dr. Catherine Frazee: That is on the basis of the number of cases of concern that we have been documenting and referring to in our testimony over the past three meetings of people who clearly wanted to live being induced to access MAID as a form of escape from deplorable conditions of life.

The Joint Chair (Hon. Yonah Martin): There's one minute left.

Mr. Michael Cooper: Could you elaborate on shoring up track one?

Dr. Catherine Frazee: I'm sorry—is this directed to me?

Mr. Michael Cooper: Yes. I'm sorry, Dr. Frazee. Could you elaborate on shoring up track one?

Dr. Catherine Frazee: I've given you the primary two examples. Clarify the issue of causation, of what must be the cause of suffering. A person's medical condition is the only cause of suffering for which MAID was designed and intended. It's the only exemption to the Criminal Code, and that really needs to be clarified, as does the definition of reasonably foreseeable and natural death.

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

Next I will turn to Madam Brière for five minutes.

[Translation]

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

My question is for this morning's three witnesses.

Over the decades, we've seen that one of the fundamental principles of the modern movement on behalf of persons with disabilities has been to ensure equality in terms of access to programs and services that every member of society ought to be able to expect.

Given that the decision-making process for people considering medical assistance in dying is extremely personal and unique to their own particular situation, irrespective of the circumstances surrounding their status and their perspective, whether or not they identify as having a disability, and assuming that all the guarantees, safeguards and protocols are in place and working properly, what would you say to a person who is disabled and who has decided in a clear and well-informed manner to request medical assistance in dying in collaboration with medical teams?

[English]

Prof. Isabel Grant: Can I respond to that?

The Joint Chair (Hon. Yonah Martin): Professor Grant, go ahead.

● (0920)

Prof. Isabel Grant: I think we're saying that MAID is available to everyone, and why do we deny that to people with disabilities? I think the disability community feels that only track two MAID is available to them, and that we would like the government to be focusing on finding ways to make people's lives manageable and to alleviate suffering, rather than alleviating the people who are doing the suffering, because we think that this has been targeting people with disabilities.

As Ms. Linton said earlier, they don't need help dying; they need help living.

Ms. Megan Linton: I would respond to an individual who might make a well-informed decision to access MAID.

I'm 27 and I'm disabled. Most of my classmates don't have disabilities, and they don't have access to MAID because they don't have disabilities. I have access to it, and they don't. What is the equal access there? That doesn't really make sense to me.

However, the problem here is not the individual. It's not about one person making a decision. It's about the collective impacts. If one person is making a decision about MAID, as was the case with Jean Truchon, it's an individual choice and an individual response to a situation of social harms. For them it might be the worst possible situation.

I have been supporting people who have experienced suicidal ideation since I was 16, and I can assure you that people can make that decision and do make that decision. I have had so many disabled friends who have died by suicide, and I don't think I look at them badly for dying, but I am here to say we don't need help with that. We have access to that. We're dying en masse and we don't need that support. That's not what equal access to programs looks like. Equal access to programs would look like access to supports for the living community, not access to supports for dying.

I was a little bit confused by that question, because you said in your introduction the intention about there not being equal access to programs. We have special access to this one program only. The rest of systems in society we don't have equal access to.

We still have a segregated education system. People are unable to graduate from high school with a diploma. How is that equal access? Do you care about that equal access?

I'm not—

The Joint Chair (Hon. Yonah Martin): There's one minute left. Go ahead.

Dr. Catherine Frazee: I will just quickly endorse what my fellow panellists have said.

With respect, again, through the chair, the premise of the question is flawed. This is not a matter that challenges the notion that disabled people should have equal access and opportunity. Absolutely, we agree with you 100% on that, but track one is not available to non-disabled persons. That begs this question: Why is it made specially available to us, given its very substantial implications and harmful consequences?

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

Next we'll go to Mr. Thériault for five minutes.

[Translation]

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

I would describe all three instances of evidence we heard this morning as ad hoc evidence, in every sense of the term. I think that since the beginning of the hearings on protecting persons with disabilities, all committee members were in agreement that more needed to be done for them.

I have frequently put forward the idea that impairment is individual and that disability is always, at the outset, social. It is accordingly clear that more must be done. Persons with disabilities experience discrimination and stigmatization. They don't have equal access to care and programs. It's difficult for them. That makes them victims once.

Further to what I've heard from the witnesses, it appears that you would like them to become victims a second time, this time of the state. In other words, at the most personal and private moment in life, after experiencing what they found to be beyond tolerable, that the state should deny them access to medical assistance in dying, thereby taking away their freedom to be able to decide for themselves what's acceptable to them in their own lives.

No one should be able to decide on someone else's quality of life. Only they themselves should be able to make that decision. By acting in this way, the state would be discriminating against them, making them victims for a second time.

Let's follow through on this line of argument. It says that the track one issue, meaning the foreseeable death criterion, should be strictly reintroduced. In keeping with the logic you described this morning, should these people also be denied the right to refuse care, even if that right is, from the ethical standpoint, considered to be a good medical practice? What would most likely happen is that these people would have no options other than refusing to eat, for example, which would lead to dehydration until they reach the point of imminent death, and when death is only a few hours away, to have medical assistance in dying administered. That has something to do with the distress you were talking about today.

Saying that the solution for people who are being discriminated against, and who do not have equal access to a full and meaningful life in society, is to take away their right to receive medical assistance in dying following an assessment, implies that their only option is suicide when their suffering becomes irreversibly intolerable.

Is it up to the state to decide what the tolerable threshold of suffering is for another human being?

Would anyone like to take this question? Ms. Grant?

• (0925)

[English]

Prof. Isabel Grant: Sure. I'll make a couple of comments.

None of us have spoken to you today about getting rid of track one. Dr. Frazee mentioned the importance of the word “natural” and that stopping eating is not a natural death.

I think the flaw here is that track one is available to everybody at the end of their lives. Limiting MAID to track one does not discriminate against people with disabilities. They too, at the end of their lives, will have access to track one.

What discriminates against people with disabilities is saying, “The law of murder, the law against aiding suicide doesn't apply to you because your deaths are a benefit to you. When you die, that's a good thing.” We're saying you cannot say to people with disabilities that their deaths are a social good that their government should promote when their deaths are not reasonably foreseeable.

We agree that people with disabilities should have access to track one MAID as other Canadians do—I believe that—but not when they are not at the end of their lives. It's not the state's job to kill people with disabilities because they're suffering; it's the state's job to try, to the best extent possible, to alleviate that suffering in some way, or to mitigate it.

The Joint Chair (Hon. Yonah Martin): Thank you. It's near the end.

Lastly, we have Mr. MacGregor. You have the floor for five minutes.

Mr. Alistair MacGregor (Cowichan—Malahat—Langford, NDP): Thank you very much, Madam Co-Chair, and thank you to all of our witnesses for joining us today.

I too am joining you from British Columbia, so I appreciate how early it is.

This has absolutely been a very difficult subject for this committee to grapple with, and we certainly have heard some heart-wrenching testimony. We know that far too many persons with disabilities in Canada are living below the poverty line.

I have a constituent who's a very real activist in this field. He coined a term, “legislated poverty”, and has repeatedly urged the federal government to do more, especially with economic supports because of that disability level. We know that it exists.

Ms. Linton, I'd like to start with you because of the research field you've been involved in.

For clarification, do you have some statistics to share with the committee on how many disabled people are living in institutions? What percentage of the larger disability community is that?

• (0930)

Ms. Megan Linton: Thank you for that question.

One of the challenges is that the government has not conducted a census on the institutional population since 1991 when it did the HALS institutional survey, the Health and Activity Limitation Survey. At that point it was beneficial to do that survey, following a committee hearing much like this, which revealed the significant impacts of institutions and particularly disability obstacles in Canada.

Since that time, we haven't had up-to-date information on the size of the institutionalized population. Right now we know that over 100,000 people are living in institutions. If we include long-term care facilities, it's around 190,000. Those are numbers pulled from the Stats Canada survey on residential care facilities.

A challenging part of understanding what is happening in institutions is that the Canadian disabilities survey doesn't actually go to institutionalized people. As a result, we don't know what's happening inside institutions. We also don't know how specific government bills targeting ending disability poverty are going to impact institutionalized people, because in institutions you receive a different level of legislated poverty. In Ontario that is about \$149 a month, and across Canada it peaks at \$300. Imagine living on \$300 a month.

We don't have a lot of numbers, and I think that's one of the most concerning aspects of this. We don't know the size of the population afflicted by institutionalization, and we also don't know the size of the population, particularly the population of people labelled with mental disorders that will be expanded under the changes to track two.

Mr. Alistair MacGregor: I'm sorry to interrupt. I only have a minute and a half left and I want to add one more question for you to consider.

We know from the pandemic that the conditions in long-term care homes became very widely publicized. It certainly sparked talk about instituting national standards in long-term care homes. Could you also add to your answer what the conditions are like?

I know that some institutions must be very well staffed and have incredible support services. There must be a whole continuum. Can you add a bit on that in your answer as well, please?

Ms. Megan Linton: Yes. While we learned a little bit about what was happening in long-term care facilities through reporting through COVID-19, the other types of institutions for disabled people, particularly unregulated congregate settings like domiciliary hospitals, homes for special care and other residential care facilities, were not exposed to the same level.

What we do know is that in the many unregulated institutions where, in Ontario alone, tens of thousands of disabled people live, the conditions include cockroaches and four people to a room. During COVID, they were told to sleep head to foot to prevent the spread of infection. In those institutions, it's about 100% that there are going to be pests—cockroaches, bedbugs—rotten food and levels of staffing that are one poor person who is paid about minimum wage. The conditions inside these institutions are really horrifying, and we continue to see fires and deaths en masse due to COVID and other infections.

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

We will go into our next round of questions.

I'll turn this over to my co-chair, Mr. Garneau, for questions from senators.

• (0935)

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

We will begin with Senator Mégie.

[*Translation*]

Senator, you have the floor for three minutes.

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

First of all, Ms. Frazee, what would you say to the disabled people who came here and told us that they did not want to be considered vulnerable and unable to make their own decisions, and did not want to be treated paternalistically?

There is a whole network of disabled people who are often encountered. Some may think like you, but what would you say to those who are demanding that they be allowed to decide for themselves?

Secondly, Ms. Linton or Ms. Grant, if the government were to introduce a guaranteed minimum income program for disabled people, do you think that would deter them from requesting medical assistance in dying?

[*English*]

Dr. Catherine Frazee: Thank you.

If I may speak to the member's question very briefly, to a disabled person who says to me, "I am not vulnerable and I am entitled to make my own decisions", I say, "I agree 100%. That is why I am working very hard to make it clear that our entitlements extend to the full protection of the Criminal Code, and if we could take more than 60 seconds to have a conversation, let's talk." That would be my answer.

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

There's about one minute left, Dr. Grant, if you would like to answer the second question.

Prof. Isabel Grant: I think there are a number of levels to that.

I think that with the harms that Dr. Frazee has outlined and that Ms. Linton has shown us, no, I don't think a guaranteed minimum income would mean that it was okay to kill disabled people who are not at the end of their lives. I think the inequalities and the harms of track two MAID that Dr. Frazee has outlined are ongoing, and they are ongoing not only for the people who are choosing MAID therapy but for all the people who feel their lives have been devalued by this committee and by the legislation passed by this government, so I do not think—

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

Prof. Isabel Grant: I'm sorry. Go ahead.

The Joint Chair (Hon. Marc Garneau): Next is Ms. Linton. Be very quick, please.

Ms. Megan Linton: I do not think that a guaranteed income program would lessen the likelihood to request MAID. I think it could improve many people's lives, but I don't think it would result in the changes to the care system that would allow for people to live in communities or live the way they want, so no.

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

We'll now go to Senator Kutcher.

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

I have questions for Dr. Linton and Dr. Grant. There are two questions, so I'd like to try to get to both of them.

None of us want persons with disabilities to seek MAID because of a lack of resources. We all support living with dignity. However, I'd like you to consider a different scenario. Should a competent person with a disability who is socio-economically secure and has no need for additional services be allowed to request and receive MAID?

The Joint Chair (Hon. Marc Garneau): We'll go to Dr. Grant first.

Prof. Isabel Grant: I would say no, not if they are not at the end of their life. A competent non-disabled person does not have a right to receive MAID. I don't see why a competent disabled person would have a right to receive MAID.

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

Ms. Linton, go ahead.

Ms. Megan Linton: I don't think that someone being competent or having socio-economic supports means that they should kill themselves or let the state kill them.

Hon. Stanley Kutcher: What about a disabled person in the same situation who has severe and chronic unremitting pain and has been intolerably suffering for decades? Should that person be denied access to MAID because they have a disability?

Prof. Isabel Grant: We deny that person access to effective pain management. We've seen with the opioid crisis that pain patients are the people who have been hurt a great deal by the denial of effective pain medications.

If we're really worried about their unremitting pain, then we should be doing more to treat that pain. We're offering them death when we won't offer them medication to treat the pain. There are people accessing MAID for that reason, because they have been cut off of pain medications. That is track two of MAID.

• (0940)

Ms. Megan Linton: I'm a person who lives with chronic unremitting pain. I live a really wonderful, fantastic life that's made more difficult by the lack of access to pain management. No, I don't think that I should die because I have pain. I think I live a really great life.

I think that disabled people have the opportunity and should have the opportunity to live wonderful, beautiful lives, with pain or without. I don't know about many people, but—

Hon. Stanley Kutcher: Just so that I understand, the presence of severe, unremitting, intolerable pain to someone—not you, but another person—should not ever be a consideration for MAID.

Ms. Megan Linton: If they're not at the end of their life, then no. It seems like this is an issue of pain management and access to pain medication.

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

[*Translation*]

We will now go to Senator Dalphond.

[*English*]

Hon. Pierre Dalphond (Senator, Quebec (De Lorimier), PSG): Thank you to the witnesses for their appearances today.

It's not the first time that I've heard from some of them. Their positions are very clear. I understand their desire to prevent any deterioration in the situations of disabled people, in that we need more support and we need to provide more resources to help disabled people. It's certainly a pressing issue.

However, I certainly doubt that we should oppose the right to choose for somebody who wants to choose, like Mrs. Gladu. She was socially and economically in a good situation but decided at one point that she wanted to die on her own terms and conditions and she asked for MAID. She died from natural causes in the year that followed.

I understand that you would deny her the right to apply to have MAID. Your position is very clear, and I thank you for that.

My question is for Dr. Linton.

You said that disabled people are dying en masse because of track two. Would you have any data to support that affirmation? You're a researcher, so I'm sure you're speaking about the findings of your research.

We have had track two in place for the last two years. You said that a lot of people had access to MAID en masse. Would you provide numbers about that?

Ms. Megan Linton: We don't have access to the numbers because the MAID committee didn't look specifically at the use of institutionalization. That's despite my recommendation, in data collection stages, that they count those numbers.

We are seeing that Canada is the number one global provider of MAID. You can just turn to the front page of many newspapers, or even the back page of the obituary section, and it's quite clear that disabled people are dying significantly through MAID. There are many, many stories. There's also the report on MAID that came out and the statistics that are included there.

No, we don't have clear numbers of the number of people in institutions. As I was saying earlier—

Hon. Pierre Dalphond: Is it fair to say that you don't have numbers except in stories in the papers of some people, and some we've met with previously, where there is more nuance than what we read in the papers?

Ms. Megan Linton: I would say the report that was provided statutorily is a really great place to look for numbers.

I also think that the stories we hear from people and that are reported in papers are important to read, because, as I was saying in my presentation—

Hon. Pierre Dalphond: I assume you also surveyed the results of Belgium and the Netherlands.

Ms. Megan Linton: Yes.

Hon. Pierre Dalphond: You saw that en masse, disabled people are asking for MAID.

Ms. Megan Linton: Yes.

Hon. Pierre Dalphond: That's your affirmation.

Ms. Megan Linton: Yes.

Hon. Pierre Dalphond: Thank you.

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

[*Translation*]

Thank you, Senator Dalphond.

[*English*]

We'll go to Senator Wallin for six minutes.

Senator Wallin, are you with us?

• (0945)

The Joint Chair (Hon. Yonah Martin): Senator Wallin had some technical issues, so she is not present at this time.

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

Therefore, we'll go over to you for three minutes.

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

I have some questions for Professor Grant.

Are there any possible safeguards we could implement under track two that would make it so that it doesn't discriminate against persons with disabilities?

Prof. Isabel Grant: Thank you.

No, I don't think there are. I think the only safeguard is to make sure that people are at the end of their lives when they are accessing MAID. Death can't become a solution for the suffering of people with disabilities.

The Joint Chair (Hon. Yonah Martin): You characterized the fast-approaching implementation of MAID for mental illness as an "impending...catastrophe". Could you further elaborate on your thoughts on MAID for sole mental illness and perhaps offer your thoughts on the expert panel's report?

Prof. Isabel Grant: I had a lot of concerns with the expert panel report, which I'm sure doesn't surprise you. I think the evidence that we don't know whether mental illness is irremediable, and that we cannot identify that condition, was ignored. I think the data showing that that in Belgium and the Netherlands up to 70% of the people accessing it are women, many of them women who've lived through trauma, is deeply troubling.

For me personally, as someone who has done a lot of work in civil commitment in British Columbia, that report recommends that people who are detained by the state, forcibly treated against their will and have lost all their rights and liberties are going to have access to MAID. I think that's an impending human rights disaster. The conditions in our psychiatric hospitals are abysmal, and death might feel like it's preferable to living. The fact that someone could be hospitalized because they are suicidal and could be detained against their will because they are suicidal but then be given access to MAID is deeply, deeply troubling.

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

Mr. Co-Chair, do I have more time?

The Joint Chair (Hon. Marc Garneau): You have another minute, Senator Martin.

The Joint Chair (Hon. Yonah Martin): Okay. I'll be brief.

I want to direct my last question to Dr. Frazee.

How can a law such as MAID affect people who aren't directly involved in seeking or receiving MAID, in your opinion?

Dr. Catherine Frazee: I think one of the best ways I could illustrate this is by an example from another realm of law.

Laws and courts are among the most powerful cultural influences in our society. Last month, in the Munk lecture by Harvard sociologist Michèle Lamont, she observed that following the adoption of same-sex marriage laws in 32 American states, there was a significant decrease of suicide attempts among LGBTQ college students. Those students weren't ready to make wedding plans; that wasn't what was going on. They were hungry for validation, and that simple but monumental legislative change was enough to give them hope.

That's how law works. That's how culture works. What you are doing is going to powerfully affect whether people with disabilities in this country see ourselves as welcomed and valued citizens.

Thank you for your question.

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

I'm turning it back to you now, Senator Martin.

The Joint Chair (Hon. Yonah Martin): Senator Wallin is now online. Would you kindly go to her at this time?

The Joint Chair (Hon. Marc Garneau): That's good to hear.

Senator Wallin, you have three minutes.

Hon. Pamela Wallin (Senator, Saskatchewan, CSG): I have unmutted and I hope you can hear me. As you can see, there were technical issues.

I'm sorry, but because of that, I am not sure exactly who said this. However, I think the message is the same: Disabled persons “are dying en masse” because of track two MAID.

Again, one of these things, as we are taking testimony here in front of a committee, is that it's very important that we have actual sources and references to support such a claim. That's a very, very serious one: “dying en masse” because of track two MAID.

I need to clarify this issue.

MAID is the law of the land. If it is not offered to either abled persons or disabled persons, it would be in violation of the law. You must have the same choice. Everyone must have the same choice when it is the law of the land. It is a choice that any individual can access.

I am not sure what the supporting evidence is for disabled persons dying en masse because of track two MAID. Is there anyone who wants to answer that?

• (0950)

The Joint Chair (Hon. Marc Garneau): That would go to Ms. Linton, who made that statement.

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

Ms. Megan Linton: I'm happy to provide the evidence in writing afterwards, if that is helpful.

What I was intending to say is that disabled people are dying en masse in institutions they had been fighting to leave. What I meant in saying that was that through the last century and a half, we've had disabled people dying, ongoing, in a significant capacity, in institutions. Institutions rapidly shorten people's lives and bring them closer to death. Track two has expedited the death in institutions. We have seen this through multiple cases. We can bring those cases forward, and I can send them over email.

It is important to recognize that disabled people are dying because of track two in institutions.

Hon. Pamela Wallin: I'm sorry, but I have to ask you to clarify.

You said, “because of track two”. They're dying because of track two. They must qualify for MAID; otherwise, you can't access MAID.

Ms. Megan Linton: Yes, but as Catherine was saying, there's a ripple effect. Not only are people dying because they qualify—yes, because they are disabled, and as a result they qualify—but also because of the ripple of the changes—

Hon. Pamela Wallin: Okay. I guess this is the thing. When giving testimony at a Senate-House of Commons committee, we have to be very careful of the language that is used.

If you can provide evidence that people are dying in institutional settings, that's one thing, but we cannot have on the record that disabled persons are dying en masse because of track two MAID. I just don't think that's a factual statement, and it makes it difficult for us when we have to consider testimony.

Ms. Megan Linton: Is the—?

The Joint Chair (Hon. Marc Garneau): Thank you. This is the end of the testimony.

We'll go back to Senator Martin to close things off.

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

As requested, Ms. Linton, and I think earlier, Dr. Frazee, if there are additional comments and support material that you can present to the committee, that would be very helpful.

Thank you to our witnesses once again. We will suspend momentarily to prepare for our second panel.

• (0950)

(Pause)

• (0955)

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

If I may just make a few comments for the benefit of the new witnesses who are joining us....

Before speaking, please wait until you are recognized by name. I will remind you that all comments should be addressed through the joint chairs. When speaking, please speak slowly and clearly. Interpretation in this video conference will work like in an in-person committee meeting. Those of you online have the choice, at the bottom of your screens, of either floor, English or French. When you're not speaking, please ensure that your microphone is on mute.

With that, this is our final panel in our study before we go into our work plan and the drafting of the report.

Thank you to the witnesses, Jennifer and Mike Schouten, who are here in person, and thank you also to our online witness, Mr. Kevin Liu. Your testimony will be very important to our study as we conclude, so thank you for being here.

We'll begin with opening remarks by Mr. Kevin Liu, followed by Mr. and Mrs. Schouten.

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

Mr. Kevin Liu (As an Individual): Good morning. It's an honour to have this opportunity to appear as a witness for this committee.

I'm speaking to you as a young person who has conducted a study with other young people aged 16 to 24 about their views on MAID in general and also on MAID for minors. Specifically, we conducted five focus groups, each consisting of three to five participants. I began working on this project when I was 18 years old in my last year of high school, and I conducted this research with the VOICE childhood ethics research program at McGill University. We recently completed the project, and an article is currently under review for publication.

I'm currently 23 years old. I'm a youth adviser as part of the youth advisory council for the VOICE childhood ethics program. The VOICE youth advisory council also contributed a statement in a report on this topic that was commissioned by the Quebec health ministry's end-of-life commission, which Franco Carnevale submitted to this committee as part of his testimony in a previous meeting.

I was given 48 hours to prepare for this testimony, and I'm also a full-time student in dental school, so I tried to prepare as best I could with the time that was available.

My comments this morning are drawn from the results of the project regarding youth perspectives on MAID and MAID for mature minors. Please note that neither I nor the participants in this study are living with life-limiting illnesses and are otherwise from the general population.

Some pertinent results of the study include the following—

• (1000)

The Joint Chair (Hon. Yonah Martin): Mr. Liu, I'm sorry to interrupt. Would you kindly slow down?

Mr. Kevin Liu: Yes, of course.

The Joint Chair (Hon. Yonah Martin): It's because of our interpreters. Also, there's no sound.

Okay, if you could slow down just a little bit.... Also, we have a slight technical issue, so if you wouldn't mind, you could perhaps go back and begin your sentence from where I interrupted you.

Thank you.

Mr. Kevin Liu: Okay, for sure.

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

Thank you.

[*Translation*]

Mr. René Arseneault (Madawaska—Restigouche, Lib.): Madam Chair, if I may, it's true that the interpretation was fast, but we heard it here, and didn't miss anything.

Mr. Luc Thériault: The sound in the room was too loud.

[*English*]

The Joint Chair (Hon. Yonah Martin): I see. It was loud.

Mr. Liu, could you just slow it down slightly? Otherwise, we have been able to hear you.

I'm sorry about the interruption. Go ahead.

Mr. Kevin Liu: No worries.

My comments this morning are drawn from the results of the project regarding youth perspectives on MAID and MAID for mature minors. Please note that neither I nor the participants in the study live with life-limiting illnesses and that we are from an otherwise general population.

Some pertinent results of the study include the following.

Young people are capable of understanding, articulating and empathising with elements of MAID. They're capable and keen to re-

flect on high-stakes matters and to contribute towards difficult decisions that may affect them.

Participants in our study expressed aspirations and concerns about how MAID should be implemented. They demonstrated a capacity and a willingness to explore and navigate, imagine and understand multiple dimensions of MAID. They demonstrated a marked sense of responsibility for others, expressing concerns for the bereaved and considerations for the interactions and the relationships between different stakeholders at the end of life.

They articulated clear understandings of what they felt might be at stake. They understood and expressed how each MAID case is nuanced, recognizing that all individuals are unique, with different values and motivations for MAID.

They explored their understandings of what they thought “maturity” meant in the context of MAID for mature minors and how maturity may or may not be relevant in extending MAID legislation to minors.

Further, they demonstrated an interest and desire to articulate the perspectives, and they seemed frustrated with their lack of opportunities to do so. They were aware that adults can exclude young people because they underestimate their abilities to contribute towards high-stakes decisions such as MAID and end-of-life issues generally. They spoke against this exclusion.

In conclusion, young people want to be meaningfully engaged with difficult conversations about MAID, and they're capable of doing so. I imagine that this is also the case for young people with life-limiting conditions, who may be eligible for MAID if it's extended to include mature minors.

The participants in our study genuinely appreciated the opportunity to speak on a matter they felt was important and in which they felt they had a stake yet never had an opportunity to discuss.

I'm extremely grateful that I was invited to testify as a witness today. I hope that there are more opportunities for other young people to provide their perspectives on this matter, particularly those who are minors, those with life-limiting illnesses, those who could be eligible for MAID, and other vulnerablized young people. Finding out what's important to these young people regarding MAID and end of life can help inform and ensure that future policies align with the interests of the people whom they are meant to serve.

Thank you.

The Joint Chair (Hon. Yonah Martin): Thank you very much. You're representing your generation very effectively today, very articulately.

We will now go to Mr. and Mrs. Schouten. I believe you will share your time, so you will have the floor for five minutes.

Thank you very much for being here.

Also, we have two photographs that you have circulated to members of our committee, which include photos of your late son.

Mr. and Mrs. Schouten, the floor is yours.

Mr. Mike Schouten (As an Individual): We thank you very much for inviting us here to share our lived experience of walking alongside a child with a terminal illness. It's our hope that through our testimony today you'll receive some insight into how to deliberate and what to recommend to Parliament.

My wife will begin, and then I will conclude.

Ms. Jennifer Schouten (As an Individual): This is our dear son Markus. On February 26, 2021, he was diagnosed with Ewing sarcoma, an aggressive form of bone cancer. After 20 rounds of chemotherapy, 25 rounds of radiation and numerous surgeries, including the replacement of his entire upper right arm with an internal prosthetic, we made the decision with Markus and his doctors to end treatment for cure and focus on quality of life.

Markus' care was then transferred from BC Children's Hospital to Canuck Place Children's Hospice. The palliative and hospice care Markus received at our home was focused on addressing his suffering and valuing his dignity. The doctors and nurses knew his days would be short, and their efforts ensured that the days he had left were lived well.

Markus wanted to die at home, surrounded by his family, but he also didn't want to experience the intense pain and suffering that he knew would come as his lungs filled with tumours.

On what turned out to be his last Friday, nurse Shana assessed Markus and said, "His time is short." She advised us to take the window we still had for Markus to be transported to Canuck Place Hospice in Vancouver. With the increased intensity of his care, we agreed. Our whole family was together at the hospice, and as we entered the evening, it appeared that Markus would last only a few more hours. As each of his siblings said goodnight to Markus, he told them he loved them and said, "See you in paradise."

Mike and I didn't sleep at all but took turns sitting beside Markus. The nurses maintained his medication, and Markus assured us that he was very comfortable and not in any pain. At one point he said to me, "This is how I hoped it would be."

As dawn arrived, we realized that God had another day in store for Markus. Early that morning Markus' friends arrived at the hospice, and together they cried, laughed and prayed. That afternoon both of Markus' sets of grandparents also came to say goodbye. By early Sunday morning, Markus was non-responsive and his breathing had become a lot more shallow. Just before 2:30 that afternoon, Markus' breathing slowed and with all of us around his bedside, he took his final, peaceful breaths.

• (1005)

Mr. Mike Schouten: Markus died just six short months ago, on May 29, 2022, only 15 months after his diagnosis. If he were here today, his appeal to you would be to not expand euthanasia to minors, for two reasons.

First, earlier this month, it was reported in the news that CAMAP, the Canadian Association of MAiD Assessors and Providers, is recommending that physicians have an obligation to bring up medical assistance in dying with patients who meet eligibility requirements.

As Jennifer just outlined, Markus met all the eligibility requirements. This means that if euthanasia is extended to minors, the day will come when families just like ours, with their dying children, will feel an obligation to end the suffering of their child by having a doctor euthanize him or her.

Dear committee members, we recommend against the expansion of euthanasia, because by giving some minors the right to request, you put all minors and their families in a position where they are obliged to consider it. If that had happened to Markus, the message he would have heard would have been clear: "We don't value your life; we don't think it is worth living, and if you want, we can end it for you." It would have said to him, "We are giving up on you."

Honourable members, we should never give up on our children.

The second reason we recommend you not extend MAiD to minors is that by doing so, you eliminate unimaginably beautiful experiences.

When we went to the Canuck Place Children's Hospice, we didn't know how long Markus would live. We hadn't even wanted to go the hospice initially, but being there allowed us to embrace each moment we had with him, and him with us. If euthanasia becomes available to minors then that Friday night when we thought Markus was going to go, after we'd all had our time with him to say our goodbyes, it would have seemed like the thing to do, right? "It's time," the nurse would say. "It's the compassionate thing to do. He doesn't have to suffer anymore."

But then we would not have had Saturday, a most beautiful day shared with our son, our brother and our friend. We suffered much with Markus, and we miss him terribly, but Markus showed us how to find meaning in suffering, and he was thankful for each day that God gave to him.

Therefore, it is our heartfelt recommendation to this committee, on behalf of Markus and our family, that you not extend MAID to minors and instead focus on providing the necessary, robust palliative and hospice care resources to ensure the best quality of living, even when someone is dying.

Thank you.

• (1010)

The Joint Chair (Hon. Yonah Martin): Mr. and Mrs. Schouten, thank you very much for your courageous testimony this morning. I cannot imagine being in your shoes. The fact that you were able to share this testimony with us was very powerful.

We'll now go into our first round of questions.

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

Mr. Michael Cooper: Thank you, Madam Co-Chair.

Thank you to the witnesses.

In particular, thank you, Mr. and Mrs. Schouten, for your powerful and heartfelt testimony. I wish to express my condolences on your loss of your son.

I want to start with a general question. It sounds like your son Markus had no desire to die. He wanted to live.

However, we also heard testimony from a mother whose son was 16. MAID was not available to him. She gave powerful testimony before the committee that if he'd had the option of MAID, it would have resulted in his ending his suffering just a little sooner before he passed on.

What would you say in a situation like that? What would you say in response to that mother's very powerful testimony before this committee?

Mr. Mike Schouten: Thank you for the question.

I think we need to remember that perspective is everything. We also need to acknowledge the influence and ability of parents, of government and of health care providers to influence children in our country. If the perspective through suffering is that this suffering is going to get worse, and that unimaginable things might or could happen to you, and that your life might be very short, then that leads to despair. As Viktor Frankl once said, "Despair is suffering without meaning."

If that's the perspective we're portraying to children who are suffering from terminal illness, then I can agree with you that this might lead to despair, which could include a request for medical assistance in dying, but then there's the perspective we experienced right from the very day Markus's oncologist told him there was nothing more they could do. When Markus asked him how long he had, the doctor gave him this answer: "We don't know. We're not going to focus on that. We're going to focus on you living every day that you have well. We're going to do everything we can to ensure that you can live every day you have well."

That perspective does not lead to despair. That perspective does not lead to someone's request to ask a doctor to euthanize him or her.

Mr. Michael Cooper: Thank you for that.

Mr. Schouten, you mentioned in your testimony that the Canadian Association of MAiD Assessors and Providers has come up with a recommendation that medical doctors have an obligation to mention or bring up MAID when their patients meet the eligibility requirements. Can you speak to what impact you think that may have in terms of end-of-life care, and in particular to mature minors if MAID would be expanded to mature minors?

Mr. Mike Schouten: I think as we've seen in other demographics in our country, that obligation to consider is happening more and more. While we were at Canuck Place hospice, on more than one occasion we expressed gratitude that euthanasia for children was not legal in Canada and that it was not part of the suite of options the doctors and health care providers had in order to treat our son.

All of his treatment, all of his care, was focused on his living well. In the end, it wasn't day by day; it was hour by hour, moment by moment. When those resources are there, the request for someone to die and to ask a doctor to end that suffering by euthanizing them doesn't happen.

• (1015)

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

Can you speak to Markus's experience in the end-of-life care he received and how that measures up against the palliative care and long-term care that most adults receive?

Mr. Mike Schouten: About six months before Markus was diagnosed, I had an uncle who was 69 and was diagnosed with stomach cancer. He did not have his first appointment with an oncologist until after he passed away.

Our doctors, through the child system, were always ahead of us. My uncle's wife had to run around all over the place trying to find treatment for him, trying to find the right medication, trying to address every symptom that came up.

In our case, through BC Children's Hospital and the Canuck Place Children's Hospice, they were always ahead of us, so much so that, as my wife said, that Friday morning, they knew this was the time. They knew that Markus wanted to stay home, but they said that if we had a window to get to Canuck Place Children's Hospice, this was now.

That made us able, as a family, to spend every living moment we had yet with Markus living well, enjoying each moment we had with him, sharing laughs, sharing memories, with him telling us over and over that he loved us. When he was in the hospice and said—as Jennifer indicated in her testimony—this is how I hoped it would be, that's how he hoped it would be, surrounded by his family, surrounded by health care professionals who didn't give up on him, who didn't say, "Your life is not worth living. You might want to request us to end it." They considered his life worth living right up to the moment that he passed away at the hospice.

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

Next we're going to go to Monsieur Arseneault.

You have the floor for five minutes.

[*Translation*]

Mr. René Arseneault: Thank you, Madam Chair.

I'll begin by thanking the witnesses here today.

Mr. and Mrs. Schouten, I'd like particularly to pay tribute to your courage. You've suffered the worst thing that can ever happen to parents. It happened to me somewhat indirectly, because my parents lost their daughter, meaning my sister. We held her hand until she drew her final breath. So I can only imagine what it's like and I saw the extent to which it could have destroyed my parents. You're very brave. It's a difficult ordeal, but there's always light at the end of the tunnel.

Mr. Liu, you told us that young people wanted to have their say and have people to listen to them. Could you briefly summarize the position of the young people you heard from and consulted on medical assistance in dying? Are they in favour of or opposed to medical assistance in dying for minors?

[*English*]

Mr. Kevin Liu: Hi. Thank you for your question.

It's a bit of a difficult question to answer because, like adults, young people also have a wide variety of perspectives, opinions and preferences for the topic. To say blankly that youth are in favour or that youth are not in favour is difficult. It is a difficult question to answer.

Importantly, the lack of a consensus doesn't mean that it's wishy-washy per se, just that there's nuance. That's more of a reason to elicit more youth perspectives, to understand more about their preferences, their visions, so that, again, we're able to advance policy in a way that is aligned with what's important to them.

However, generally in our focus groups, what we saw was that by the end of them, more participants were in favour of or sensitive to the benefits of medical assistance in dying and felt more comfortable with the ability of young people to make difficult decisions like this.

[*Translation*]

Mr. René Arseneault: Thank you, Mr. Liu. I'll get back to our discussion if I have enough time.

Mr. and Mrs. Schouten, could you remind me how old your son was when he died?

• (1020)

[*English*]

Mr. Mike Schouten: When Markus was diagnosed with Ewing sarcoma, he was 17 years old, and when we buried him in the ground, he was 18 years old.

[*Translation*]

Mr. René Arseneault: Thank you very much.

According to *Carter v. Canada*, which led us into the era of medical assistance in dying in Canada, people have to be adult within the meaning of the Criminal Code, which is 18 years of age.

We've heard many witnesses tell us that in other countries where medical assistance in dying is available, children, even though there are not many of them, who are extremely ill and who gained in maturity because of their illness and their lengthy stays in hospital, are allowed to request medical assistance in dying. These witnesses also said that the parents definitely had to be consulted, but that the final say was given to the child in matters of medical assistance in dying.

You've just had a painful experience. In any event, your son was about to turn 18 and become an adult. If medical assistance in dying were available to young people in Canada one day, at what age do you think it should be? Also, what safeguards do you think should be in place for a mature minor?

It's still not entirely clear to me.

[*English*]

The Joint Chair (Hon. Yonah Martin): Would you mind being brief in your response? There is less than a minute remaining.

Mr. Mike Schouten: Sure. I will just speak about the experience we had, because that's our lived experience.

Friday evening, Markus thought that he was going to go, and he called us all to his bedside and told us that he loved us. Saturday morning, when he was still with us and I said to him, "Markus, should I see if your buddies are able to come to the hospice?"—these friends that you see in the picture right in front of you—his eyes lit up, and he said "If you could, that would be so good." He had 90 minutes of time with them, and he wouldn't have had that time if the decision for medical assistance in dying had happened.

He had that time because everyone around him, from his parents to his health care providers, valued his dignity, valued his life and did everything they could to ensure that he lived well even though he was dying, even though, over the course of two months, he drowned to death as his lungs filled with tumours.

There is not a much more terrible way you can go, but in our country—and our experience is proof of that—we can care for each other and give each other that dignity so that the request for MAID doesn't have to be there.

The Joint Chair (Hon. Yonah Martin): Next we'll go to—

[*Translation*]

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

[*English*]

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

Mr. Thériault, you have five minutes at this time.

[*Translation*]

Mr. Luc Thériault: First, Mr. and Mrs. Schouten, I'd like to express my sincere condolences. I was deeply moved by your testimony.

I understand that you are probably still grieving, and hope that what you are experiencing now will ease your pain and help you through the mourning process.

There is a woman who, like you, testified before the committee recently. My colleague Mr. Cooper spoke about it. This was Ms. Caroline Marcoux, the mother of Charles Gignac. Her son was 17 years and nine months old when he died. He too had aggressive bone cancer. Two years to the day after the diagnosis, he died under palliative sedation in palliative care. He had fought the disease—he was tough—in all its phases, but never had any respite or remission and kept losing the battle.

In his memory, his mother decided to come and testify to tell us that free choice was important. For Charles, medical assistance in dying would have been his way of winning the war with the disease by preventing it from deciding when he was going to die. He wanted to choose the time to die peacefully, surrounded by his loved ones.

Before hearing your testimony, when I looked at the photographs of your son surrounded by his loved ones, I thought we might be about to hear something completely different from you. It's true that medical assistance in dying can also occur in a palliative care setting.

Mr. Liu's presentation got me thinking. I understand now that young people are just like adults, in that some are in favour of medical assistance in dying and others are against it. Isn't the role of the state precisely to guarantee the conditions needed to exercise free choice in such a personal human decision as one's own death and how it is to be experienced?

• (1025)

[English]

Mr. Mike Schouten: As I said earlier, I think perspective is everything. Two weeks before Markus passed away, someone gifted us with funds to use an Airbnb on Vancouver Island. We almost didn't make it because, on the way, we had to stop at BC Children's Hospital to empty Markus' lungs of two litres of liquid. That's how sick he was. However, because that precious time had been given to us, he wanted to use it. He recognized, as I said in my testimony, that when you unnaturally interrupt life through medical assistance in dying, you miss out on beautiful experiences that you can have.

It's one thing to ask healthy, able-bodied minors in our country "If you receive this diagnosis and life looked this terrible, would you want medical assistance in dying?" They say, "Yes, I think so." It's an entirely other thing to actually experience it yourself or with your child and have available the palliative and hospice resources to care for that illness.

[Translation]

Mr. Luc Thériault: But then Mr. Liu just told us otherwise, and that there doesn't appear to be consensus among healthy young people.

Ms. Marcoux told us that she would have supported Charles if he had chosen to die at a specific time, or instead decided to continue living until the very end notwithstanding his suffering, which is what happened after all.

If your Markus had told you that he had wanted to end it now, with medical assistance in dying, would you have supported him in his decision?

The role of parents is another factor we need to consider in the decision about whether or not medical assistance in dying should be extended.

[English]

The Joint Chair (Hon. Yonah Martin): Please answer very briefly.

Mr. Mike Schouten: Again, just to reiterate, that Friday night, Markus wanted to die. He was ready to die. He was ready to go and meet Jesus—he was a Christian—and he didn't die, and then that Saturday he had beautiful experiences with his best friends, with his family and with his grandparents.

Markus wanted to die. He was ready to die, but by asking a doctor on Friday night to end his life, he would have missed out on those beautiful opportunities.

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

Lastly, we'll have Mr. MacGregor, who has the floor for five minutes.

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

Thank you to all of our witnesses.

I would like to start with the Schoutens. First of all, echoing my colleagues, I'd like to thank both of you for having the courage to appear before our committee and to share your personal experiences with your son Marcus.

What we're struggling with here is respecting a person's autonomy. There's a question I want to pose to you.

Under B.C. law—I'm also a resident of British Columbia—we have a provincial law, the Infants Act, which defines what mature minor consent is. Essentially, under provincial law, children can refuse health care if the health care provider assesses them and determines they have the necessary understanding to give that consent.

For example, if a child is living with a terminal illness and the health care provider has the understanding that they can give consent, that child can say, "I don't want you to resuscitate me; I want to refuse feeding and I want to refuse all kinds of life-saving measures should my body fail."

Perhaps I could ask you for your perspective on that, because that is a way for a child under the age of 18 to essentially give consent, to say that they don't want to be resuscitated.

Can you maybe frame your answer? That's a child making a decision on their end-of-life care. How, in your mind, does that differentiate from a child using that same autonomy to say, "I want to choose the time and space of my passing and maybe I want to do it so that I can have my family members and friends come at a pre-determined time and I can then go out the way I want to"?

• (1030)

Mr. Mike Schouten: Two things come to mind as you ask your question.

One is that our experience is that all throughout Markus's treatment, he was very involved, right from the first bad scan that showed that before the cancer had even been gone, it was back and into his lungs. Marcus was consulted. It was his decision to continue to proceed with treatment. It was his decision that day that my wife referenced when our oncologist said, "There's nothing more we can do." It was his decision, along with us, to say, "I want treatment so that my quality of life is as good as it can be in the days that I have left."

The other thought I had as you asked your question is that I want to emphasize the point that when you make it available to minors, then people like Markus and families like ours will be in a position where they're obliged to consider this. That doesn't sound like autonomy to me.

Mr. Alistair MacGregor: Okay. Thank you for that answer and perspective. I respect that.

Mr. Liu, I'd like to turn to you. I do appreciate the testimony you gave, because we did have another witness who did say there is a lack of consultation among minors in this country, and I appreciate the first steps you've taken.

Our committee is tasked with tabling a report in February of next year. We do want this to be reflective of the witness testimony, but we also want to have some solid recommendations.

From your perspective, what would you like to see the federal government do to build on what you've already done? If you could, just take the remaining time that I have—a minute—to speak about the kinds of recommendations you would like to see in our report for the federal government, to build on what you've already started.

Mr. Kevin Liu: Yes, of course. It's a big question. Is it okay if I take a few moments to consider? I won't be too long. I know that time is limited.

The Joint Chair (Hon. Yonah Martin): Okay. There is about one minute remaining, so go ahead.

Mr. Kevin Liu: I think it would definitely be important to consult vulnerabilized young people who wouldn't normally be in an otherwise general population—people who could have different perspectives and be affected by this: indigenous young people; again, minors; people who have terminal illnesses and might be eligible for medical assistance in dying. I think there is tremendous value in that.

A good place to start would be youth advisory councils and also proactively seeking youth input. I think it's very hard to find a young person who will approach you and say, "Yes, we're young people, and we want to talk about medical assistance in dying." I

think being proactive and actively approaching young people is definitely the way to go.

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

Now I will turn this over to my co-chair for the next round of questions.

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

We'll begin with Senator Mégie for three minutes.

[*Translation*]

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

Some witnesses asked us about the standpoint of young people on this issue. I am therefore pleased to have heard what you told us today. I'd like to clarify a number of points about the study you conducted.

First, could the study be sent to the committee if this has not yet been done? Next, what's the demographic breakdown of the young people you consulted? Are they mainly from Montreal, urban or rural? Overall, how many young people took part in your study?

• (1035)

[*English*]

Mr. Kevin Liu: Yes, of course. Thank you for your question.

I'm not sure whether I am allowed to submit the study, because it's currently under review by a journal, but I can double-check with my research supervisors. If I am allowed to, I would be very happy to share the manuscript.

In terms of demographic information, we conducted five focus groups, among ages ranging from 16 to 24. The study was conducted in Montreal.

Would you like specific demographics for each of the five focus groups?

[*Translation*]

Hon. Marie-Françoise Mégie: When you send us your study, I assume that this information will be in it. Thank you.

Good afternoon, Mr. and Mrs. Schouten. I think that what you experienced was the worst thing that has ever happened to you. Earlier in my life, I worked in palliative care as a family doctor. After having cared for their loved ones, no matter what their age might have been, the families always told us that what they had just experienced—that very short 24-to 48-hour period before death—had been the most powerful time of their life.

After after seeing the photographs and having heard you, I agree that you're right.

I wanted to ask you a few questions. If medical assistance in dying were offered to young people, do you think they would be required to accept it? Everyone is saying that it should be available to them. Do you think young people should be required to accept medical assistance in dying? As parents, would you feel obligated to encourage your son to opt for medical assistance in dying if it was offered to him?

[English]

Mr. Mike Schouten: You mentioned palliative care and how important that is. When the palliative care is focused on—

[Translation]

Hon. Marie-Françoise Mégie: Excuse me for interrupting.

I mentioned palliative care just to let you know that I understood what you had gone through.

However, here's what I would like to know now. If medical assistance in dying were offered to certain young people, would they be obliged to accept? As a parent, would you feel guilty, as you said, for not having suggested to your son the option of ending his suffering by requesting medical assistance in dying? If medical assistance in dying were ever available to mature young people, would you feel obliged to do that?

[English]

Mr. Mike Schouten: If we would have suggested to our son to consider medical assistance in dying, or if his health care providers had said to him, “Would you like to consider medical assistance in dying?”, the message he would have heard is “We're giving up on you.” That would have led to despair, and that would further entrench the desire to have medical assistance in dying.

We are incredibly grateful and thankful that our health care providers and that we, as parents, were given the strength to ensure for Markus that every day was going to be a day worth living, no matter how much suffering came.

[Translation]

Hon. Marie-Françoise Mégie: Thank you.

[English]

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

We'll now go to Senator Kutcher.

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

Thank you to the witnesses for being here.

My first question is for Mr. Liu, and then I will ask the Schoutens a question as well.

Mr. Liu, could you be relatively brief, because of the time we have?

In your focus groups, is there a message to us that young people want us to respect their wishes about end-of-life decisions?

Mr. Kevin Liu: Yes. I think there's a resounding yes to that. They categorically agreed that young people are the best experts on their own experiences and that those experiences inform their end-of-life decisions.

• (1040)

Hon. Stanley Kutcher: Thank you very much for that.

To the Schoutens, as a parent myself, a grandparent and a physician who has sat with many people who have lost their children, I know that it's the most difficult thing, and I'm so sorry for your loss.

Our challenge is to try to understand this in a much more complex way. You help us think about important issues. This is going to be a difficult question, but I want you to grapple with it, please.

Your son chose to die in a specific way. We respect that. We respect his choice of how to do it, surrounded by his family and the support that you gave him. We also know that all of those in similar circumstances would necessarily make the same choice. We also know that not all families in the same circumstances would also make the same choice. Do you respect that others in similar circumstances may choose a different path for their end of life, one that might be different from your son's, and might have a perspective that is different from yours?

Maybe they have different values, different ways of understanding the world. Would you respect it if their choice and their family's choice was MAID, or should they be denied access to MAID?

Mr. Mike Schouten: It wasn't Markus's choice to die, just to clarify. Markus wanted to live. He didn't want to die. He was given a terminal illness, outside of our control, that we were responsible for deciding how to respond to, how to live with. We've shared with you this morning how we did that.

I can acknowledge that other families, as I indicated earlier, might focus on the suffering and on despair and on how terrible life is going to get, and that can and will lead to a request to die. There were times in Markus's illness when he wanted to die. The pain was a lot. He wanted to die, but immediately the health care providers found ways to address that pain, but not by suggesting to him, “You're right. We're going to give up on you. Here's the option now.” If that would have happened, he very likely would have died way sooner than he did.

Hon. Stanley Kutcher: I hear what you're saying, but people may have a perspective that is different from yours. If they have a different perspective and if they may not agree with your statement, would you respect their ability to make that decision?

Mr. Mike Schouten: I respect that people may have a different viewpoint on this and may approach it with a different world view, but our appeal to you is that if you open up euthanasia for minors, then even families like ours that would not support that decision will feel obliged to consider it. That's what's problematic here.

As has been recently revealed by CAMAP, it's happening already in our country. To have that happening to families sitting in places like the Canuck Place Children's Hospice would be an incredibly negative experience for them.

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

[*Translation*]

Senator Dalphond, you have the floor.

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

[*English*]

Since I have limited time, I'll ask my questions to Mike and Jennifer Schouten, whom I thank very much for being present with us today. I offer my deepest condolences.

If I understand well from the letter you sent to us in April and from the other letters you've published on various media, whether about abortion or MAID, you, as Christian political activists, are of the view that a life is always worth living. That's your main philosophy.

I respect your views. They are entrenched in the political stance that you took, but in your letter from April—you said in that letter that the “rapid pace of expansion has recently become very poignant for our family”—about the cancer of your son—“in particular for our [18-year-old] son”. When you wrote to us, your son was already 18 years old. I think he was born in March or April...?

Mr. Mike Schouten: It was July.

Hon. Pierre Dalphond: It was July, so he was close to being 18. He was already 18 years and seven months, so he had been eligible for MAID for about seven months before he decided to stop the treatment. Despite his admissibility for MAID, he never asked for it, and it was never part of your discussions.

Why are you so fearful, if we extend MAID to mature minors, that it's going to change your situation? For your son and your family, because of your beliefs and your values, it was not an option you would consider, but you were mindful that it was available. He was over 18. He could have received it if he had applied for it because obviously, once he stopped treatment, unfortunately, natural death was imminent in a matter of months or weeks. It did not prevent you from doing so, but, as my colleague said, some other families believe differently. We heard another mother who said that her son, who was 17 and a half, was going through unbearable suffering and wanted to have access to MAID.

Why would we deny access to MAID to that 17-and-a-half-year-old? It would not force you to apply for MAID, which you did not apply for and your son did not apply for. Why should we deprive others of the choice?

● (1045)

Mr. Mike Schouten: Again, we were grateful to be invited here by you to share our experience with the suffering and death of a child.

When Markus was 17 and diagnosed on February 26, we were driving back to our home from the Vancouver, B.C., children's hospital. He said to us, “Mom and dad, this cancer sounds really bad. If they don't get it the first time, I might as well just go home to die, because there's no chance.” He understood from day one that this was terminal, yet all of his treatment was focused, first of all, on a cure, yes, and then, when it morphed into treatment for quality of life, it all emphasized the value of his life, no matter how sick he

got and no matter how incapacitated he became. That is our experience. We're grateful to share that.

I would suggest that if you would like to hear from people who have different experiences, you need to talk to them.

Hon. Pierre Dalphond: We did. That's why the opposition is denying access for these people. That's what I understand. Thank you.

[*Translation*]

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

[*English*]

We will now go to Senator Wallin for three minutes.

Hon. Pamela Wallin: Thank you very much.

My questions are for Jennifer and Mike, and obviously about their son Markus.

You have used the word “obliged” on several occasions. Did any medical professional—a doctor, a nurse or a MAID provider—come in and say to you that you must do this, you should do this or you have an obligation to do this? What exactly occurred in the final stages?

Mr. Mike Schouten: The word “obliged”, Senator, comes directly out of the CAMAP document, where they recommend that physicians have an obligation to bring up medical assistance in dying with people who—

Hon. Pamela Wallin: Right, as they do with the other options. They have to lay out for patients all of the options to consider.

Beyond that, did somebody come in and say, “You are doing the wrong thing; we don't think your personal or religious views are acceptable; we think that the best course of action is MAID, and right now?”

Mr. Mike Schouten: As you would have heard in our testimony, Markus halted his treatment at the BC Children's Hospital. His palliative and hospice care was provided through Canuck Place Children's Hospice. It was not part of the conversation at those institutions.

Hon. Pamela Wallin: Right. That's what my colleagues and I are trying to establish here. It's a very, very important principle that MAID is about choice. If you choose not to access MAID, nobody will ever challenge you on that as parents or from the point of view of your son Markus. Nobody can force you to do this because, in fact, you'd have to go through an assessment process. If you were not interested in that or if it offended your views, nobody could force you to do that.

Mr. Mike Schouten: I think we have to be very careful here. You would recognize, as we do, that the news this week is filled with people who have been led to despair because medical assistance in dying was offered to them.

When you do the same to minors, children who have not the same capacity as adults and their families, who are simply trying to live each day well, that will lead to despair.

• (1050)

Hon. Pamela Wallin: I don't have your experience, obviously, but having gone through this with people with whom I'm extremely close, I watched them choose to have MAID as an option. I watched them change their mind about the date, in one case to push it out and in one case to bring it closer, and they had that choice. I think that's just what we're trying to say.

We're all very sad about the circumstances you were in. I just wanted to reassure people that in no way can MAID be forced on someone against their will, or on someone with the religious views of your son or the personal views that you may have. Even if they are suffering, I think offering palliative care or MAID, or whatever the options may be, is not saying you are not worth living. That is not the message that I hear.

Mr. Mike Schouten: I would implore you to try to be open to that message. We were sitting in the first panel this morning listening in, just to emphasize with what was said there, and the impact of the law is far greater than you might think it is.

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

We'll now conclude with Senator Martin for three minutes.

The Joint Chair (Hon. Yonah Martin): Again, thank you to our witnesses this morning.

Mr. Liu, I want to commend you on the work you undertook and the fact that you're doing some very important work to hear the voices of the mature minors.

My question is focusing on the importance of the specialized palliative care or palliative care. We heard from previous witnesses about the state of palliative care here in Canada and the fact that it's not the same across the country.

In your case, you had this very incredible experience of receiving hospice care and palliative care for your son. That care is important in addressing these end-of-life issues or, in the case of your son, to live well right to the end.

I'd love to get your perspective on the importance of palliative care, hospice care and specialized palliative care in the time that remains for me.

Mr. Mike Schouten: When Markus had his first negative scan, it was six months into his treatment, and at that meeting with his oncology team, the Canuck Place Children's Hospice nurses and doctors were already part of that meeting. His palliative care was already engaged at that point. They knew Markus. They knew our family. They knew how to care for him when it came time to transfer all of his care into the Canuck Place Children's Hospice from BC Children's Hospital.

As I said earlier, it was incredibly comforting to know that they were always one step ahead of us. The resources that are allocated to the care for children who have terminal illness in a palliative condition appear to be far superior than those allocated to people in the adult world.

As I shared, my uncle and his family spent the last few months of his life scrambling around trying to find the right medications, the right treatment, what to do when, how to do it, whereas every day when they would come to our house, the Canuck Place hospice nurses would assess Markus and say, "I think we need this type of medication" or "We need an extra dose of this type of medication to treat this" or "Let's bring in some more bedding", or pillows or oxygen. Whatever it had to be, they were always ahead of us.

That allowed Markus to enjoy—as you see in the pictures even the very day before he passed away—every moment he had that he was alive and to not miss out on those unnaturally interrupted beautiful experiences that would not have happened if he had chosen medical assistance in dying far earlier.

The Joint Chair (Hon. Marc Garneau): Senator, you have about 20 seconds.

The Joint Chair (Hon. Yonah Martin): Okay, I'll just conclude.

What I'm hearing, as a result of what happened in your case, is that it's important that the timing of the palliative care is not just attached to the end, but rather that it overlaps the early care so that care can be seamless.

Again, thank you very much.

I will conclude, Mr. Chair, so I'm not in my question mode but going back to co-chair.

The Joint Chair (Hon. Marc Garneau): Yes, please.

The Joint Chair (Hon. Yonah Martin): Again, thank you very much for your testimonies as we conclude our time with our witnesses. I think it was very eye-opening and compelling, and I want to thank each of you for taking the time to share your lived experience with us, as well as your insights among the young people you studied in your report, Mr. Liu. Thank you for sharing that as well.

I am told by the analyst that because we are going into draft instruction on Tuesday of next week, in order for you to submit your report, it would have to be very quick. I just wanted to let you know the timeline.

To my colleagues, this concludes our study with our witnesses. On Tuesday we begin drafting instructions for our final report. If you recall, there was an email on November 22 from our analyst. Could you review the instructions on that so that we can begin our drafting instructions on Tuesday?

With that, thank you so much to everyone. I bring this meeting to a close.

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