SENATE | SÉNAT
CANADA

Subject matter of Bill C-7, An Act to amend the Criminal Code (medical assistance in dying)

Report of the Standing Senate Committee on Legal and Constitutional Affairs

The Honourable Mobina S. B. Jaffer, Chair

The Honourable Denise Batters, Deputy Chair

The Honourable Larry W. Campbell, Deputy Chair

The Honourable Pierre J. Dalphond, Steering committee member

February 2021

For more information please contact us:
by email: *lcjc@sen.parl.gc.ca*
by mail: The Standing Senate Committee on Legal and Constitutional Affairs
Senate, Ottawa, Ontario, Canada, K1A 0A4

This report can be downloaded at: *www.senate-senat.ca/lcjc.asp*

The Senate is on Twitter: @SenateCA,
follow the committee using the hashtag #LCJC

Ce rapport est également offert en français

TABLE OF CONTENTS

Members 1
The Committee's Pre-Study of the Subject Matter of Bill C-7: Overview 2
Background 5
What is MAiD? 5
Bill C-14 and *Carter* 5
Charter Rights and the Courts after Bill C-14 7
Bill C-7 8
Legislative Reform and Parliamentary Review 9
Responding to the *Truchon* Decision 9
Parliamentary Review 10
Expanding Eligibility for MAiD 11
Safeguards 13
Persons with Disabilities 15
Mental Illness and the Constitutionality of the Exclusion Clause 18
MAiD and Health Care 23
Accessing MAiD 24
Adequate Access to Health Care 26
The Diversity of Canadians 28
Conscience Rights and Advising Patients About MAiD 28
Indigenous Peoples 30
Faith Groups 32
Data and Research 33
Conclusion 36
Appendix I - Witnesses 37
Appendix II - Chart 43
Appendix III - GBA+ Analysis 46

MEMBERS


Mobina S. B. Jaffer, Chair


Denise Batters, Deputy-Chair


Larry W. Campbell, Deputy-Chair

The Honourable Senators


Pierre-Hugues Boisvenu


Gwen Boniface


Yvonne Boyer


Claude Carignan


Brent Cotter


Pierre J. Dalphond


Renée Dupuis


Judith Keating


Scott Tannas

Ex-officio members of the committee:

The Honourable Senators

Marc Gold, P.C. (or Raymonde Gagné)

Donald Plett (or Yonah Martin)

We would also like to thank all other Senators who participated in this study.

Parliamentary Information and Research Services, Library of Parliament:

Julian Walker and Michaela Keenan-Pelletier, analysts

Senate Committees Directorate:

Mark Palmer, Clerk of the Committee

The Committee's Pre-Study of the Subject Matter of Bill C-7: Overview

Medical Assistance in Dying (MAiD) raises fundamental constitutional, legal, moral and ethical questions about how to assist those who are suffering and wish to choose the moment of their death.

In 2015, the Supreme Court of Canada in *Carter v. Canada (Attorney General)*("*Carter*") recognized that the criminalization of providing medically assisted death for competent adults "who (1) clearly [consent] to the termination of life and (2) [have] a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to [them]"[1] violated section 7 of the *Canadian Charter of Rights and Freedoms*[2] ("Charter"). In doing so, the Supreme Court struck down the *Criminal Code*[3] prohibition on providing assistance in terminating another person's life. It suspended its declaration of invalidity for one year to give Parliament the opportunity to put in place the appropriate regulatory regimes.

In 2016, Parliament adopted amendments to the *Criminal Code* to regulate access to MAiD for individuals whose natural death is reasonably foreseeable. However, questions about how to regulate MAiD have continued to be discussed among Canadians - in particular: under what circumstances it should be made available and whether it should be expanded; what procedural safeguards are appropriate; and what supports are needed in our health care system to ensure MAiD is truly a last resort for those who have given free, prior and informed consent.

On November 3, 2020, the Senate adopted an order of reference authorizing the Standing Senate Committee on Legal and Constitutional Affairs (the "committee") to examine the subject matter of Bill C-7, An Act to amend the Criminal Code (medical assistance in dying).[4] Bill C-7 proposes amendments to Canada's MAiD regime. The *Criminal Code* currently limits eligibility for MAiD to those for whom a natural death is reasonably foreseeable and who meet certain other criteria. The bill would expand access to MAiD to include individuals whose death is not reasonably foreseeable, while also amending other aspects of the safeguards included in the law. It had been introduced to respond to *Truchon v. Attorney General of Canada* ("*Truchon*"), a decision of a trial judge of the Quebec Superior Court, which imposed a deadline of December 18, 2020. The deadline has since been extended to February 26, 2021. Consequently, the committee undertook a pre-study of this subject matter prior to the bill arriving in the Senate.

---

[1] *Carter v. Canada (Attorney General)*, 2015 SCC 5, para 4. This decision overturned the Court's 1993 ruling in *Rodriguez v. British Columbia (AG)*, [1993] 3 SCR 519, which had denied a right to assisted suicide.

[2] *The Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c.11.

[3] R.S.C., 1985, c. C-46.

[4] LEGIS*info*, Bill C-7, An Act to amend the Criminal Code (medical assistance in dying), 2nd Session, 43rd Parliament.

The committee engaged in discussions of important MAiD issues with 81 witnesses over five full days of hearings, including the Ministers of Justice, Health, and Employment, Workforce Development and Disability Inclusion; regulatory authorities; professional organizations; advocacy groups; people living with disabilities; academics, legal and medical practitioners and experts; Indigenous representatives; faith groups; caregivers; and other stakeholders. The committee also received over 80 written submissions.[5] A full list of witnesses and the meetings they attended is included in Appendix A.[6]

Compassion and autonomy are at the heart of this debate. Both those opposed and those in support of the proposed changes are concerned about how to respect the lives of those who are suffering. Witnesses shared informed, compelling, and heartfelt testimonies about whether or not MAiD access should be expanded to include those whose suffering is intolerable and irremediable, but who are not at the end of life. Some witnesses were very much opposed to the proposed expansion, others supported some elements of the bill but not all, and some witnesses urged Parliament to pass the bill. Most witnesses who testified before the committee suggested various changes to the bill, and some said it should not proceed at all.

Witnesses shared their views regarding the processes and safeguards that should be in place to protect vulnerable people if access is to be expanded, to ensure MAiD is only provided to those who meet the appropriate eligibility criteria and have freely consented.

Witnesses offered a wealth of perspectives on the many complex issues involved with expanding access to MAiD. Their insights and recommendations included: ensuring Canadians have equal and sufficient access to adequate health and palliative care; addressing stigma and discrimination against people with mental illnesses or disabilities; developing a MAiD framework that respects the diverse backgrounds of Canadians through sufficient consultation with Indigenous Peoples, people with disabilities, racialized groups, and other relevant impacted groups; the need for better data collection, research and oversight of MAiD; and, ensuring that Canada's MAiD legislative framework respects the Charter and includes safeguards that protect the most vulnerable, among many other important topics.

[5] Standing Senate Committee on Legal and Constitutional Affairs, *Briefs and Other Documents*.

[6] All quotations from witnesses contained in this report are taken from oral testimonies during committee meetings, unless otherwise stated.

The Charter guarantees the rights to life, liberty, and the security of the person in section 7 and to equality in section 15. Both Bill C-7 and the 2016 changes toCanada's *Criminal Code* that decriminalized MAiD resulted from court decisions which found that legislation at the time violated Charter rights and was therefore unconstitutional.

Witnesses presented differing opinions on whether the changes proposed in Bill C-7 respect these Charter rights, and whether further court challenges are likely to follow if Bill C-7 is passed in its current form. Some witnesses noted that passing legislation that does not conform with the Charter would impose a burden on Canadians impacted by these provisions by forcing them to contest the law in court.[7]

Two chief concerns were raised by witnesses about how the changes proposed in Bill C-7 could violate Charter rights.

Witnesses from disability organizations and several others stated that expanding MAiD to include individuals whose natural death is not reasonably foreseeable would effectively single out disability as an acceptable reason to allow MAiD and would violate the equality rights of persons with disabilities.[8]

Several witnesses expressed concerns about the exclusion from MAiD of people suffering with mental illness as their sole underlying condition, and whether excluding these individuals would respect their rights to personal autonomy and equality.[9]

[7] See for example the testimony of Dr. Georges L'Espérance (Association québécoise pour le droit de mourir dans la dignité).
[8] See for example the testimonies of Krista Carr (Inclusion Canada), Bonnie Brayton (DisAbled Women's Network of Canada), Amy Hasbrouck (Toujours Vivant-Not Dead Yet), and Professor Catherine Frazee.
[9] See for example the testimonies of Grainne Neilson (Canadian Psychiatric Association), Dr. Georges l'Espérance, Helen Long (Dying with Dignity), Professor Jocelyn Downie, Dr. Justine Dembo, Jean-Pierre Ménard, and Dr. James Downar.

Background

What is MAiD?

The *Criminal Code* makes it a criminal offence to counsel, abet, or aid a person to die by suicide.[10] It also contains exemptions from criminal liability for medical and nurse practitioners and those who assist them, such as pharmacists, if they provide a person with MAiD in accordance with other provisions in the law.[11] The *Criminal Code* allows MAiD provided that the person requesting it meets the established eligibility criteria and the required safeguards are followed. To meet the criteria, individuals must be competent adults whose natural death is reasonably foreseeable and who have a grievous and irremediable medical condition, defined as a serious and incurable illness, disease, or disability causing them enduring physical or psychological suffering that is intolerable to them.

The *Criminal Code* defines medical assistance in dying as:

(a) the administering by a medical practitioner or nurse practitioner of a substance to a person, at their request, that causes their death; or
(b) the prescribing or providing by a medical practitioner or nurse practitioner of a substance to a person, at their request, so that they may self-administer the substance and in doing so cause their own death.[12]

Information about MAiD can be found in Health Canada's *First Annual Report on Medical Assistance in Dying in Canada, 2019*. The report reviews Maid's evolution and implementation across Canada, as well as statistics regarding MAiD cases and MAiD recipients.[13]

Bill C-14 and Carter

The current MAiD regime became law on June 17, 2016, when Bill C-14, An Act to amend the Criminal Code and to amend other related Acts (medical assistance in dying) received royal assent.[14] The bill was introduced in response to the Supreme Court of Canada's decision in *Carter.*

The Supreme Court held that the prohibition against assistance in dying had the effect of forcing some individuals to take their own lives prematurely, as they might be incapable of taking their own life when they reached the point where their suffering was intolerable. It added, among other things, that an individual's response to a grievous and irremediable medical condition is a matter critical to his or her dignity and autonomy (as per section 7 of the Charter).

[10] Section 241. Section 14 also states that no person may consent to have death inflicted upon them.
[11] Sections 241.1 to 241.4.
[12] Section 241.1.
[13] Health Canada, *First Annual Report on Medical Assistance in Dying in Canada, 2019*, July 2020.

The Supreme Court suspended its declaration of invalidity of the relevant *Criminal Code* provisions for one year to provide Parliament the time to respond to the court's decision.[15] Prior to the drafting and tabling of Bill C-14, the government considered a number of reports. The federal government established the External Panel on Options for a Legislative Response to *Carter v. Canada,* which carried out consultations and reported its key findings.[16] The Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying released a report in 2015 with 43 recommendations, most of which related to provincial jurisdiction.[17] The parliamentary Special Joint Committee on Physician-Assisted Dying conducted a study beginning in 2015, reviewed the External Panel report and other studies, engaged in consultations with experts, stakeholders and Canadians, and made recommendations for a legislative response to *Carter*.[18]

After Bill C-14 was introduced in the House of Commons, the Senate Legal and Constitutional Affairs Committee completed a pre-study of the subject matter of Bill C-14 and issued a report on May 17, 2016, which included recommendations and observations.[19] After additional hearings and study of the bill, the committee reported Bill C-14 back to the Senate without amendment on June 7, 2016.[20] An extensive third reading debate followed, in which various amendments were proposed and adopted. Several of these amendments were accepted by the House of Commons[21] and the bill received royal assent on June 17, 2016. The *Regulations for the Monitoring of Medical Assistance in Dying*, which outline the reporting requirements relating to MAiD requests, came into force in November 2018.[22]

---

[14] LEGIS*info*, Bill C-14, An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying), 1st Session, 42nd Parliament.

[15] Extensions to the initial deadline were granted at the request of the Attorney General of Canada.

[16] External Panel on Options for a Legislative Response to *Carter v. Canada*, *Consultations on Physician-Assisted Dying – Summary of Results and Key Findings*, 15 December 2015.

[17] Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying, *Final Report*, 30 November 2015. Quebec did not participate, and British Columbia had observer status.

[18] Senate and House of Commons, Special Joint Committee on Physician-Assisted Dying, *Medical Assistance in Dying: A Patient-Centred Approach*, 1st Session, 42nd Parliament, February 2016.

[19] Senate, Standing Committee on Legal and Constitutional Affairs, *Third Report*, 17 May 2016.

[20] Senate, Standing Committee on Legal and Constitutional Affairs, *Fourth Report*, 7 June 2016.

[21] See: LEGIS*info*, "Status of the Bill," Bill C-14, An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying), 1st Session, 42nd Parliament (S.C. 2016, c. 3). Amendments included requiring patients to be informed of palliative care and treatment options prior to receiving MAiD; creating regulations, including for the collection of information for monitoring purposes; and, reporting requirements.

[22] *Regulations for the Monitoring of Medical Assistance in Dying*, SOR/2018-166.

Bill C-14 included a requirement for a parliamentary review of the bill's provisions within five years and for the Ministers of Justice and of Health to initiate independent reviews on three scenarios under which MAiD is currently prohibited or restricted: MAiD for "mature minors"; advance requests for MAiD; and, requests for MAiD where mental illness is the sole underlying condition.[23] These reviews were completed by three separate working groups of the Council of Canadian Academies[24], which released reports in December 2018.[25] The parliamentary review is discussed further below.

Charter Rights and the Courts after Bill C-14

Two cases challenged the MAiD regime established under Bill C-14 and sought to open access to individuals who were not in an advanced state of irreversible decline and whose death was not reasonably foreseeable. The first challenge was brought in British Columbia by Julia Lamb, who claimed the law was too restrictive in requiring that her death be reasonably foreseeable. She has a severe neurodegenerative disease that will likely get progressively worse. Her case was adjourned when the Attorney General of Canada submitted evidence that she would likely already meet the criterion of having a reasonably foreseeable natural death.[26]

The second challenge was brought in Quebec by Jean Truchon and Nicole Gladu, who were seeking access to MAiD. They had met all of the criteria to receive MAiD except the requirements for: a "reasonably foreseeable natural death" in the *Criminal Code*; and for a person to be "at the end of life" under Quebec's *Act respecting end- of-life care.*[27] In *Truchon*, a trial judge of the Quebec Superior Court declared that these provisions were unconstitutional and infringed upon the rights to life, liberty, and security of the person, and the right to equality, for individuals who want to access MAiD.[28] It held that the *Criminal Code* provision in question was contrary to section 7 of the Charter, and both laws violated the equality rights contained in section 15. The court struck down the relevant provisions but suspended the declaration of invalidity for six months. The suspension has since been extended three times, with a current end date of February 26, 2021.[29]

Both the federal government and the Quebec government decided against appealing the judgment, choosing instead to comply with the decision.

---

[23] Bill C-14, Clause 9, "Independent Review".
[24] Council of Canadian Academies is an independent non-profit organization that convenes experts to assess the evidence on topics of public interest to inform decision-making in Canada.
[25] Expert Panel Working Group on MAID for Mature Minors, *The State of Knowledge on Medical Assistance in Dying for Mature Minors*, Council of Canadian Academies, 2018; Expert Panel Working Group on Advance Requests for MAID, *The State of Knowledge on Advance Requests for Medical Assistance in Dying*, Council of Canadian Academies, 2018; and, Expert Panel Working Group on MAID Where a Mental Disorder Is the Sole Underlying Medical Condition, *The State of Knowledge on Medical Assistance in Dying Where a Mental Disorder Is the Sole Underlying Medical Condition*, 2018.
[26] See: British Columbia Civil Liberties Association [BCCLA], *Lamb v. Canada: the Death with Dignity Case Continues*; Joseph J. Arvay, Letter to the Supreme Court of British Columbia (Re: *Lamb and BCCLA v. AGC*), 6 September 2019.
[27] Quebec, *Act respecting end-of-life care*, R.S.Q., c. S-32.0001.
[28] Truchon v. Attorney General of Canada, 2019 QCCS 3792.
[29] See: Department of Justice Canada, *Joint Statement by Ministers Lametti and Hajdu on motion seeking additional extension of Superior Court of Québec's Truchon ruling*, 11 December 2020.

Bill C-7

Bill C-7 was introduced in the House of Commons on October 5, 2020, by the Honourable David Lametti, Minister of Justice and Attorney General of Canada. An identical bill had been introduced in the previous parliamentary session on February 24, 2020, though it died on the *Order Paper* upon prorogation in August 2020.

The bill responds to the *Truchon* decision by amending the *Criminal Code* to eliminate the requirement that an individual's natural death be reasonably foreseeable in order to qualify for MAiD. The bill also amends some of the existing safeguards that apply in the case of an individual whose death is reasonably foreseeable. This would include the removal of the 10-day reflection period for individuals approved to receive MAiD, the waiver of final consent in certain circumstances, and changes to who can formally witness a request for MAiD and the number of witnesses required. It establishes two separate sets of procedural safeguards: one for individuals whose natural death is reasonably foreseeable, and one for individuals who are not at the end of life. Bill C-7 also specifies that mental illness is not considered an illness, disease or disability for the purpose of determining eligibility for MAID; therefore, individuals whose sole underlying condition is a mental illness would be ineligible for MAiD.

Minister of Justice David Lametti and the Minister of Health, the Honourable Patty Hajdu, informed the committee that in preparing the bill, the federal government received over 300,000 responses to online consultations. The government also held ten expert roundtables in eight cities over the course of two weeks in January 2020, meeting with over 125 people that included medical practitioners, as well as organizations representing persons with disabilities and some Indigenous health professionals. As a result, Minister Lametti concluded that:

> The vast majority of Canadians want what is in this bill. I think there's quite a societal consensus to move forward. Society has changed since 2016, since the first MAiD legislation was adopted, and we're moving forward with it. We're moving with Canadian society.

During the committee's pre-study, Bill C-7 was concurrently studied by the House of Commons Standing Committee on Justice and Human Rights.[30] The House of Commons passed the bill on December 10, 2020. That same day, Bill C-7 received first reading in the Senate and the committee tabled its interim report for this pre- study.[31] The bill passed second reading in the Senate and was referred to the committee for study on December 17, 2020. The committee will hear from additional witnesses as part of its study of Bill C-7.

During the committee's pre-study, Bill C-7 was concurrently studied by the House of Commons Standing Committee on Justice and Human Rights.[30] The House of Commons passed the bill on December 10, 2020. That same day, Bill C-7 received first reading in the Senate and the committee tabled its interim report for this pre- study.[31] The bill passed second reading in the Senate and was referred to the committee for study on December 17, 2020. The committee will hear from additional witnesses as part of its study of Bill C-7.

[30] House of Commons Committee on Justice and Human Rights, *Recent Business: Bill C-7, An Act to amend the Criminal Code (medical assistance in dying)*; *Report 4*, 25 November 2020.
[31] Standing Senate Committee on Legal and Constitutional Affairs, *Second Report: Examine the subject matter of Bill C- 7, An Act to amend the Criminal Code (medical assistance in dying)*, 10 December 2020.

Legislative Reform and Parliamentary Review

Some witnesses were concerned that important changes to Canada's MAiD regime should not be rushed, and that time is needed to thoroughly review existing data and to adequately consult with all stakeholders before introducing legislation.[32] Others asked for immediate legislative reform so that individuals who are suffering can have access to MAiD.[33] Some weighed in on how the federal government should have responded to the *Truchon* decision, and some called for the anticipated parliamentary review to begin as soon as possible to assess how and whether Canada's MAiD regime might need reform.[34]

Responding to the *Truchon* Decision

When the Quebec Superior Court declared in its judgment of September 11, 2019, that the above-mentioned provisions in the *Criminal Code* and in Quebec's *Act respecting end-of-life care* were unconstitutional, it suspended the effect of the declaration of constitutional invalidity for a period of time to grant the applicants a constitutional exemption during this period.[35] At the time of the pre-study hearings, the deadline was December 18, 2020.

Some witnesses discussed different ways to approach this time limit. Professors Isabel Grant and Stéphane Beaulac said it would be appropriate in this case to allow the Court's suspension of invalidity to lapse. The *Truchon* decision would then apply only in Quebec.[36] They acknowledged that this might create some uncertainty but said that it is not uncommon for a court decision to only apply in the province in which it was rendered. As other provincial courts would therefore be called upon to hear and decide similar cases, Professor Beaulac added: "We will eventually have more judicial decisions that will eventually lead to, I would submit, a better final product when the issue comes back before Parliament."

[32] See for example the testimonies of Amy Hasbrouck, Bonnie Brayton, Professor Stéphane Beaulac, and Dr. Patrick Baillie.
[33] See for example the testimonies of Jason Leblanc and Hon. James Cowan (Dying with Dignity). Others who expressed general support on behalf of their respective organizations for the proposed changes in Bill C-7 include:
Dr. Sandy Buchman (Canadian Medical Association), Dr. Francine Lemire (College of Family Physicians of Canada), and Vyda Ng (Canadian Unitarian Council).
[34] See for example the testimonies of Hon. James Cowan, Helen Long, and Michael Villeneuve (Canadian Nurses Association).
[35] *Truchon*, Paragraph 741.
[36] See also the testimony of Isabel Grant.

Some witnesses said that the Attorney General should have appealed the *Truchon* decision to receive the judgment of an appellate court.[37]

Krista Carr, from Inclusion Canada, noted that "the national disability community pleaded with the federal government to appeal" the decision. Several witnesses discussed the benefit of having an authoritative decision on such important issues,[38] and some added that it would be more expeditious and avoid further litigation if Parliament referred a question on MAiD to the Supreme Court.[39] Others suggested that the Attorney General of Canada seek an extension to the December 18 deadline from the Quebec Superior Court, which he later did.[40]

Parliamentary Review

Bill C-14 requires a parliamentary review within five years (starting in June 2020), which has not yet been done.[41] This review is in addition to the above-noted independent reviews[42] and reports undertaken by the Canadian Council of Academies. The preamble to Bill C-7 states that this review "may include issues of advance requests and requests where mental illness is the sole underlying medical condition." It was also discussed during the pre-study hearings that the topic of mature minors should form part of the parliamentary review.[43]

Minister Lametti informed the committee that, although he could not commit on behalf of the government, it is his hope that the parliamentary review of MAiD will take place as soon as possible. He indicated that the review would examine how MAiD might be made available to those with a mental illness as their sole underlying condition. Minister Hajdu concurred that this is an area where "we need further research and further study, and that is exactly what will happen through the parliamentary review." She added that Parliament will decide the timing of the review. The Minister of Employment, Workforce Development and Disability Inclusion, the Honourable Carla Qualtrough, indicated that the review would already be underway had it not been for the coronavirus pandemic.

Witnesses encouraged Parliament to begin this review as soon as possible.[44] Some commented that the review should have taken place before this bill was introduced and some suggested delaying all changes to the MAiD regime until the review is completed.[45] As Amy Hasbrouck, from Toujours Vivant-Not Dead Yet (a project of the Council of Canadians with Disabilities), stated:

> Instead of rushing to pass overreaching legislation to meet a court-imposed deadline in the midst of a pandemic, Parliament should concentrate on performing a rigorous and balanced examination of the euthanasia program as a whole.

[37] See the testimonies of Neil Belanger (British Columbia Aboriginal Network on Disability Society), Dr. Trudo Lemmens, Krista Carr, Nicolas Rouleau, Alex Schadenberg (Euthanasia Prevention Coalition of Ontario), and Derek Ross (Christian Legal Fellowship).
[38] See the testimonies of Professor Isabel Grant, Professor Stéphane Beaulac, Derek Ross, and Vince Calderhead.
[39] See the testimonies of Professor Isabel Grant, Neil Belanger, and Professor Stéphane Beaulac.
[40] See the testimonies of Claire McNeil (Dalhousie Legal Aid Service), Dr. Harvey Schipper, Professor Catherine Frazee, and Professor Isabel Grant.
[41] Bill C-14, Clause 10, "Review of Act".
[42] Bill C-14, Clause 9.1, "Independent Review".
[43] See the testimonies of Hon. James Cowan, Professor Jocelyn Downie, and Hon. Carla Qualthrough, Minister of Employment, Workforce Development and Disability Inclusion.
[44] See the testimonies of Helen Long, Hon. James Cowan, and Vyda Ng.
[45] See the testimonies of Dr. Leonie Herx (Canadian Society of Palliative Care Physicians), Bonnie Brayton, Amy Hasbrouck, Dr. Sephora Tang, André Schutten (Association for Reformed Political Action Canada), Alexander King (Living with Dignity), and Michael Villeneuve.

In addition to parliamentary reviews and legislative responses, witnesses addressed their comments in the following substantive areas: expanding MAiD eligibility, safeguards, persons with disabilities, mental illness, and some issues affecting the health care system and communities in which MAiD is offered.

Expanding Eligibility for MAiD

Following the *Truchon* decision, the amendments proposed in Bill C-7 would broaden the scope of the law, permitting persons whose natural death is not reasonably foreseeable to access MAiD under certain circumstances. As explained above, Bill C-14 decriminalized MAiD, but only when the person requesting it met the criteria set out in the *Criminal Code*. These include that the person has a grievous and irremediable medical condition and:

- has a serious and incurable illness, disease, or disability;
- is in an advanced state of irreversible decline in capability;
- is, as a result, experiencing enduring intolerable physical or psychological suffering that cannot be relieved under conditions that the person considers acceptable; and
- natural death has become reasonably foreseeable.[46]

Bill C-7 creates a second track with additional procedural safeguards for individuals whose death is not reasonably foreseeable but who would be eligible for MAID under the bill. These two sets of safeguards are set out in Appendix B.

Whether to expand access to MAID for those who are not at the end of life was at the core of the debate during the committee's hearings. The committee heard from witnesses who supported removing the requirement that an individual's natural death be reasonably foreseeable.[47] Other witnesses objected to its removal based on concerns that this would eliminate a necessary safeguard that limits access to MAiD.[48]

Some witnesses who supported this expansion of the MAiD regime urged that Canadians should be allowed access to MAiD as a means to preserve their dignity and to protect their personal autonomy.

Jason Leblanc told the committee about the experience of his common-law partner, who is a person with a disability who has "severe, significant, chronic pain". She applied for MAiD but did not qualify because her death was not reasonably foreseeable. He said:

> Under Bill C-14, she is forced to live endless years in severe, significant, chronic pain or pursue her own means to an end. Under Bill C-7, she would likely qualify under the proposed 90-day waiting period, at which time she could have a medically assisted death. This is her choice.

[46] As per section 241.2(2) of the *Criminal Code*.
[47] See for example the testimonies of Jason LeBlanc, Dr. Sandy Buchman, Helen Long, Hon. James Cowan, and Dr. James Downar.
[48] See for example the testimonies of Professor Catherine Frazee, Bonnie Brayton, Krista Carr, Amy Hasbrouck, and Professor Isabel Grant.

Dr. Sandy Buchman, the past president of the Canadian Medical Association (CMA), also supported "respecting" the choice of Canadians who are eligible. He quoted Nicole Gladu, who has said it is up to people like her "to decide if [they] prefer the quality of life to the quantity of life."[49] Helen Long, from Dying with Dignity, warned that exempting from MAiD "those who are otherwise eligible based on the reasonable foreseeability of their death may cause an individual to end their own life prematurely by violent means or to endure intolerable suffering until their natural death. The Supreme Court has described this as a cruel choice." Lastly, Dr. Alain Nafud added: "It's not up to the physician to say, with a paternalistic attitude, thatthe patient should try harder and look at all the options. The decision is up tothe patient."

Some witnesses commented on the term "reasonably foreseeable natural death," questioning whether it was a suitable term from a medical perspective. Dr. James Downar found that it is "too vague and inconsistently interpreted." Dr. Yves Robert from the Collège des médecins du Québec called it "ill-defined". Dr. Stefanie Green, President of the Canadian Association of MAiD Assessors and Providers, said it has "created confusion." Dr. Naud supported removing the term from the law, adding that retaining the term imposes a burden on medical assessors because it "represents no medical concept or definition and appears in no medical textbook, and yet physicians are responsible for applying it."

One of the main objections to Bill C-7 is that it would expand access to MAiD to those who are not already at the end of life – potentially significantly increasing the number of people who would be eligible to receive an assisted death. According to Professor Grant, the bill removes "a profoundly important safeguard that prevents people who are not dying from choosing death because we, as a society, have failed to offer them a meaningful and dignified life."

Derek Ross, from the Christian Legal Fellowship, added that the safeguard of naturally foreseeable death helped ensure that MAiD does not "become a general solution to suffering or a substitute for suicide." For many witnesses, their objection to removing the reasonably foreseeable natural death requirement centred on the impact it would have on persons with disabilities.

Krista Carr stated:

> Our biggest fear has always been that having a disability would become an acceptable reason for state-provided suicide. Bill C-7 is our worst nightmare. Inclusion Canada stands united with all national disability organizations in calling for MAiD to be restricted to the end of life.

[49] Joan Bryden, "MAID litigant says disability doesn't make her vulnerable to pressure to end her life." *Toronto Star*, 16 December 2020; Benjamin Shingler, "Montrealers who challenged assisted dying laws see ruling as 'ray of hope'," *CBC News*, 12 September 2019.

Safeguards

The *Criminal Code* currently includes procedural requirements intended to safeguard the MAiD process by ensuring that those who receive assistance are eligible and consenting.[50] These include: a written request for MAiD that can be withdrawn at any time and must be confirmed immediately before receiving MAiD; assessment of that request by two independent physicians or authorized nurse practitioners; and a 10-day "waiting period" for reflection between the day the request is signed and the day when MAID is provided. Where a loss of capacity is imminent, the physicians or nurse practitioners may determine that a shorter waiting period is appropriate under the circumstances.[51] National data suggests that the waiting period is shortened in 34 % of MAiD cases.[52]

The proposals contained in Bill C-7 would amend some of the existing safeguards and create new ones. The applicable safeguards would depend on whether the applicant's natural death is reasonably foreseeable or not. In both situations, only one independent person would be required to witness a request being signed (instead of two). Both also require physicians or nurse practitioners to ensure that the applicant has been informed of the means available to reduce their suffering.[53]

Where natural death is foreseeable, the 10-day waiting period would be removed and a possible waiver of final consent would be added. This waiver would allow an individual who has been approved for MAiD, but has lost capacity prior to their scheduled date, to still move ahead with the procedure.[54]

For applicants whose death is not reasonably foreseeable, a 90-day waiting period would be added, and one of the two physicians or nurse practitioners assessing eligibility would be required to have expertise in the individual's condition.[55]

Witnesses expressed various opinions on proposed safeguards, including whether the 90-day waiting period for persons whose natural death is not reasonably foreseeable was appropriate, or should be longer or shorter;[56] the proposed removal of the 10-day waiting period;[57] and, the proposed change to only require one witness when a person signs a request for MAiD.[58]

[50] Sections 241.2(3) to 241.2(6).
[51] Section 241.(3)(g) of the *Criminal Code*.
[52] Dr. Stefanie Green's brief, citing Health Canada, First Annual Report on Medical Assistance in Dying in Canada, 2019.
[53] Bill C-7 would require physicians or nurse practitioners to ensure an applicant whose death is not reasonably foreseeable has seriously considered the means available to relieve their suffering.
[54] Bill C-7, Clause 7, new sections 241.2(3.2) to 241.2(3.5).
[55] Bill C-7, Clause 7, new section 241.2(3.1(e).
[56] See for example the testimonies of Dr. Leonie Herx (Canadian Society of Palliative Care Physicians), Dr. Georges L'Espérance, Dr. Trudo Lemmens, Sean Krausert (Canadian Association for Suicide Prevention), Dr. Francine Lemire (College of Family Physicians of Canada), and Dr. Katherine Ferrier (Physicians' Alliance Against Euthanasia).
[57] See the testimonies of Dr. James Downar, Dr. Alain Naud, Dr. Leonie Herx, and Dr. Harvey Chochinov.
[58] See the testimonies of Dr. Alain Naud, Dr. Stefanie Green (Canadian Association of MAiD Assessors and Providers), Professor Jocelyn Downie, Dr. Yves Robert (Collège des médecins du Québec), Michael Villeneuve, Alexander King, and Amy Hasbrouck.

Dr. Downar and Dr. Naud explained that the problem with these time periods is that they force individuals to wait while they are suffering.[59] Dr. Downar, Professor Jocelyn Downie, and Dr. Georges L'Espérance, President of the Association québécoise pour le droit de mourir dans la dignité, added that these waiting periods have caused some individuals to refuse pain medications that could impair their cognitive abilities for the duration of the waiting period out of fear that they would lose their ability to give final consent.[60] Dr. Green added that "there has been no evidence this [10-day] reflection period has safeguarded anyone from anything, but there is both subjective and objective evidence to suggest it has mandated substantial suffering." Jean-Pierre Ménard, counsel for Jean Truchon and Nicole Gladu, felt strongly that the 90-day waiting period would be excessive:

> The 90-day waiting period attached to this is unacceptable; it's as if we wanted to punish people for having requested medical assistance in dying when most of them have been thinking about it for a long time. An additional 90 days of suffering is completely useless and pointless.

In a statement read to the committee on her behalf, Julia Lamb expressed:

> I have great concern what these criteria might mean for my future if I choose MAID — the last days of life being not something of my choosing, and the drawn- out pain and suffering I may endure because it is not determined as equal to those who are more timely in their matter of dying. A bill that is supposed to be a choice, to end feeling trapped and hopeless in unbearable suffering, instead may trap me within an excruciating 90-day waiting period.

Professor Downie supported the proposed change to a single witness, saying that it removes a burden on access that she did not believe provided "a compensatory benefit of protection."

Several witnesses promoted retaining the waiting periods, final consent and two- witnesses safeguards, indicating that the data suggests that a person's desire for MAiD can fluctuate over time.[61]

Dr. Leonie Herx from the Canadian Society of Palliative Care Physicians added that: "there are sometimes cases where that desire to hasten death goes away with good care." Dr. Green noted that having a two-track system is not ideal, but it is "reasonable" as it adds extra safeguards for those whose death is not reasonably foreseeable. Dr. Herx warned, however, that if the 10-day waiting period were removed, people would be able to "request MAID and get it on the same day," meaning that "persons may have that desire for hastened death, and not really have another opportunity to have their care needs met and to change their mind." Alexander King, from Living with Dignity, said:

> We have strict safeguards to protect the vulnerable [as a condition of allowing MAiD after *Carter*]… here we are a few years later witnessing the removal of those safeguards one by one. … This new bill, if not amended, risks putting millions of vulnerable people further at risk.

[59] See the testimonies of Dr. James Downar and Dr. Alain Naud.

[60] See the testimonies of Dr. James Downar and Dr. Georges l'Espérance.

[61] See the testimonies of Dr. Leonie Herx, Derek Ross, Dr. Harvey Chochinov, and Alexander King.

Amy Hasbrouck felt that the proposed change to a single witness sets "the stage for an abusive attendant to coerce a person to ask for death and then serve as the only witness to that request." However, Minister Hajdu explained that "the only role of a witness is to confirm the identity of the person signing the request for MAiD" and that witnesses have no role in determining MAiD eligibility or whether a request was "voluntary and informed."

Witnesses also had divergent opinions on the requirement that a person give final consent immediately before MAiD is provided and the possibility of a waiver offinal consent in advance of a loss of capacity.[62] In her statement to the committee, Julia Lamb expressed her support for the waiver and stated that: "Without this waiver of final consent, Canadians like Audrey Parker have been forced to access MAID early because of the significant fear of becoming incompetent."[63] Minister Lametti acknowledged that this issue was "frequently raised during" government consultations, adding that:

> If persons whose natural death is reasonably foreseeable wish to obtain medical assistance in dying and are deemed eligible to receive such assistance, they would no longer have to choose to die earlier than they would wish or to refuse to take pain medication for fear they might lose the capacity to consent to the procedure.

Minister Lametti also explained how informed consent and a voluntary request made by a person with decision-making capacity would continue to be required under law.

Persons with Disabilities

The committee heard from experts and organizations representing persons with disabilities about how the proposed amendments could specifically affect them. Some noted that if the reasonably foreseeable natural death eligibility requirement for MAiD is removed, many Canadians could qualify simply because of their disability.[64]

As mentioned above, some witnesses emphasized personal autonomy in discussing MAiD, including for persons with disabilities. Julia Lamb's message to the committee was that: "MAID is the individual's choice to make."[65]

[62] Bill C-7, clause 7, new section 241.2(3.2); section 241.2(3)(h) of the *Criminal Code.*

[63] See the testimony of Grace Pastine. The waiver of final consent provision has been dubbed "Audrey's Amendment." Audrey Parker was diagnosed with terminal cancer and received MAiD in November 2019. Ms. Parker had wanted to wait until after Christmas but chose to receive MAiD in November due to fears that she would lose capacity to provide final consent. Other witnesses also supported this change, including Dr. Sandy Buchman, Helen Long, Hon. James Cowan, and Professor Jocelyn Downie.

[64] See for example the testimonies of Julia Beazley (Evangelical Fellowship of Canada) and Krista Carr.

[65] See the testimony of Grace Pastine.

Many witnesses who were opposed to the amendments feared that Bill C-7 would compound the existing discrimination and inequality experienced by personswith disabilities. Dr. Ewan Goligher said:

> As the father of a child with physical disabilities, this law would send a message that is exactly contrary to what I try to teach him, which is that he matters, not because of what he can do but because of who he is.

Krista Carr underscored that:

> Including disability as a condition warranting assisted suicide equates to declaring some lives not worth living… The end-of-life requirement was the only safeguard whereby disability was not the sole criterion. With having a disability, itself under Bill C-7 as a justification for the termination of life, the very essence of the *Canadian Charter of Rights and Freedoms* would be shattered. Discrimination on the basis of disability would once again be entrenched in Canadian law.

Witnesses discussed the historical disadvantages many persons with disabilities face.[66] Professor Catherine Frazee stated that persons with disabilities are "already forced to the margins of society." Dr. Ramona Coelho explained that: "As disabled people, we are conditioned to view ourselves as burdensome. … We're often shown that our lives are worth less than non-disabled lives." Bonnie Brayton, from The DisAbled Women's Network of Canada, explained that "the majority of Canadians with disabilities live in poverty. They have unemployed, violent lives with insecurity about housing and the fundamental social determinants of health." Neil Belanger, from the British Columbia Aboriginal Network on Disability Society, noted the low levels of government support provided for persons with disabilities, which amount to approximately $1,000 per month. He added: "We shouldn't be offering them, because they're living with a disability, the option of dying because we haven't provided them with options in life. It's unfathomable."[67]

Amy Hasbrouck emphasized that if people with disabilities do not have the services and supports they need to maintain a reasonable quality of life, then this can lead to them seeking MAiD. The need for adequate access to health care and support is discussed further below.

Nicolas M. Rouleau, a constitutional lawyer, explained why he considers the bill discriminatory:

> No other Canadian group, no matter the suffering of its individuals, is considered expendable, an offer made by the government because of its personal characteristics. By expanding MAID for Canadians with Tdisabilities but not for other Canadians, the government sends the powerful and discriminatory message that Canadians with disabilities, and only these Canadians, are non-essential. Singling out people with disabilities fosters stereotypes that their lives have less value than the lives of others, that they have an unacceptable quality of life without hope for improvement, and that whereas the state recognizes that all other individuals are better off alive, these individuals might just be better off dead.[68]

[66] See the testimonies of Professor Catherine Frazee, Dr. Ramona Coelho, Krista Carr, and Amy Hasbrouck.
[67] See also the testimony of Krista Carr.
[68] See also the testimony of Krista Carr.

Krista Carr shared the same argument and stated that Indigenous, racialized, or LGBTQ individuals also suffer disproportionately relative to other groups, and yet MAiD access has not been extended to them. “For those groups of individuals, we do everything we can to save their lives, as we should do, but why not for people with a disability? Are their lives not worth as much?”

Bonnie Brayton raised concerns that, prior to the tabling of Bill C-7, there was a lack of meaningful consultation on MAiD with “any people with disabilities despite how much more profoundly it could affect anyone who lives with a disability.” She added, as did Neil Belanger, that Indigenous persons with a disability were inadequately consulted, if at all.[69]

Minister Lametti acknowledged the “strong reaction of disability rights organizations” who “have viewed the requirement that death be reasonably foreseeable as the most fundamental safeguard.” He added that there are other “reasonable perspectives” on this, noting that “the late Mr. Jean Truchon, Ms. Nicole Gladu, and Ms. Julia Lamb” considered that the current MAiD regime “fails to respect their autonomy and their right to self-determination over their bodies and their lives.” He believes that the amended MAiD regime “could work safely by guarding against the overt and subtle pressures to seek MAiD that the disability community fears, while providing autonomy to a greater number of Canadians to make this most important choice for themselves.”[70]

Minister Qualtrough added that “we wanted to be clear that ensuring equality rights underpins this legislation.” She noted that the preamble to Bill C-7 refers to the Charter, as well as Canada’s obligations as a signatory to the United Nations *Convention on the Rights of Persons with Disabilities* (UNCRPD).[71] She emphasized that having a disability alone would not qualify an individual for MAiD, as only “a subset of people with disabilities” would meet the requirement of having a “grievous and irremediable medical condition…in an advanced state of irreversible decline, and…intolerable physiological or physical suffering.”

She also agreed with witnesses that: “Accessing MAID should not be easier than accessing disability supports. The new legislation makes it the responsibility of the medical practitioner to ensure that the individual is made aware of the supports that are available to them.”

[69] See the testimonies of Neil Belanger and Bonnie Brayton.
[70] Hon. David Lametti, Minister of Justice and Attorney General of Canada.
[71] United Nations, *Convention on the Rights of Persons with Disabilities*.

Several witnesses recommended that the committee take note of the findings of the United Nations Special Rapporteur on the Rights of Persons with Disabilities,[72] who reviewed Canada's implementation of the UNCRPD and concluded that "…access to assisted dying should be restricted to those who are at the end of life; having an impairment should never be a reason for assisted dying to be permitted." Minister Lametti assured the committee that the report had been considered, saying that Minister Qualtrough had brought the report to his attention: "We took care to try to make sure, in the drafting of this legislation, that we responded to those concerns. I think we have with respect to the kinds of safeguards that we have put in, in the non- end-of-life scenario."

Mental Illness and the Constitutionality of the Exclusion Clause

Mental illness was another central aspect of the pre-study. Many witnesses shared views on the proposed exclusion of individuals with a mental illness as the sole underlying condition from being eligible for MAiD. Some underscored that an exclusion and strong safeguards are needed to protect Canadians with mental illness under a MAiD regime, especially given that suicidality may often be a symptom of certain mental illnesses. Others shared reasons why, in their view, an exclusion is unnecessary or unconstitutional, or why it should only be temporary. And, some witnesses thought that further study is necessary before re-considering the exclusion, such as through the parliamentary review.

According to the bill's summary, the proposed exclusion in Bill C-7 states that "persons whose sole underlying medical condition is a mental illness are not eligible for medical assistance in dying." The bill states that, for the purposes of determining whether an individual meets the eligibility criteria for MAiD, "a mental illness isnot considered to be an illness, disease or disability."[73]

In his testimony, Minister Lametti said that, given the level of uncertainty and expert disagreement on this issue, "it is incumbent upon us to proceed with caution and prudence." He added that the exclusion was necessary but "temporary" and would be further studied during the parliamentary review of MAiD. He explained that:

> [The] exclusion is intended to capture conditions that are primarily treated by a psychiatrist that present this unpredictable disease trajectory or that have a desire to die as a possible symptom. [It] is not intended to capture neurocognitive disorders that are due to Alzheimer's or Parkinson's disease or neurodevelopmental disorders like speech or motor disorders, which also happen to affect how the brain works but don't present the same type of inherent risks that have been flagged by mental health experts. They might in some cases raise questions about decision-making capacity, but those are of a different order than the inherent risks raised by mental illness.

Minister Hajdu also noted that persons with mental disorders such as Alzheimer's and Parkinson's diseases "still need to meet the eligibility criteria, including having the capacity to consent."

[72] See the testimonies of Amy Hasbrouck, Derek Ross, Dr. Scott Kim, and Professor Laverne Jacobs. See also: Catalina Devandas-Aguilar, *Visit to Canada - Report of the Special Rapporteur on the rights of persons with disabilities*, A/HRC/43/41/Add.2, 19 December 2019.
[73] Section 241.2(2)(a) of the *Criminal Code* and proposed new section 241.2(2.1) in Bill C-7.

Dr. Green argued that Bill C-7 is even more restrictive in this regard than the current law, explaining that as Bill C-14 "does not actually exclude people who have a sole underlying condition of mental illness," the proposed amendment would be "absolutely more restrictive than what exists now." Under the current regime, an individual seeking MAiD solely for a mental illness would still have to meet every other criteria, including a reasonably foreseeable natural death. Dr. Green stated that "There are some examples of patients who have already met all the conditions under Bill C-14 and have received MAID [for a mental illness], and have done so under the law under rigorous scrutiny."

Many witnesses who supported the exclusion stated that there is a lack of consensus among experts about suitable medical definitions of mental illness and about the irremediability and predictability of many mental illnesses, which would make it difficult to objectively assess a patient's eligibility for MAiD.[74]

Minister Hajdu explained:

> I worked extensively, for example, in the area of mental health and substance use for many years. There are times, believe me, when a person feels at the worst of their illness, when they have lost everything, that there is nothing to live for and yet, with the appropriate treatment and supports, they can feel completely differently within months. That is a [remediable] condition. That is why we believe this area needs further research, study and expertise to truly understand how we would support people who were requesting MAID, to make sure that it really was in a situation where suffering was irremediable. Practitioners would also have the confidence that they were approving and administering medical assistance in dying in a situation where it truly was irremediable suffering.

Professor Brian L. Mishara emphasized that:

> Until I see some hard data showing me that psychiatrists or psychologists are able to reliably predict who is hopelessly doomed to continue suffering, who can benefit from treatment and who will be happy to continue living, I cannot accept that we end the lives of people who have a mental illness, knowing that many could have been alive and have been happy to be alive.

Mark Henick, a mental health advocate, expressed his view that "there is no evidence that any mental illness is irremediable," and shared his own experience with mental illness, suicidality, and recovery. Mr. Henick said that he "absolutely would have" chosen MAiD had it been available to him in his lowest moments, assuming he would have met the criteria, stating that mental illness "collapses around you and puts blinders on you so that even if there are other options, you can't always see them."

Professor Trudo Lemmens stated that the mental illness exclusion is not discriminatory because the difficulty in making predictions about irremediability makes it problematic to allow people with mental illness to be eligible for MAiD."

[74] See the testimonies of Dr. Andrew Galley (Canadian Mental Health Association), Dr. Trudo Lemmens, and Dr. K. Sonu Gaind.

Dr. Tarek Rajji, of the Centre for Addiction and Mental Health (CAMH), testified that "there is currently a lack of consensus in the mental health field to determine when an individual has an irremediable mental illness." He added that:

> [CAMH] strongly recommends that evidence-based criteria be developed prior to any decision to lift the temporary prohibition on MAiD for people whose only medical condition is mental illness. These criteria should establish a consensus definition for when a mental illness should be considered irremediable for the purpose of MAiD.

Fleur-Ange Lefebvre from the Federation of Medical Regulatory Authorities of Canada and Dr. Mona Gupta also explained that the term "mental illness" is not sufficiently clear or practical for medical practitioners.

Other witnesses opposed the exclusion. Professor Downie explained why, in her view, the exclusion is "inconsistent" and "indefensible," given that the bill allows for MAiD in the case of a mental illness where there is a physical co-morbidity. Dr. Gupta discussed the difficulty of "distinguishing all cases of mental illness from the other clinical problems for which MAiD is permitted." "As a result," she added, "what the exclusion clause will do is show it is acceptable to treat people with mental illnesses differently than others." Dr. Buchman recommended that the legislation should more clearly indicate that "the exclusion is for mental illness as a sole underlying medical condition, not mental illness as a co-morbidity."

Dr. Justine Dembo submitted that:

> The exclusion does not serve its intended purpose to protect the vulnerable … because anyone, including someone with a reasonably foreseeable natural death and a clear physical illness, has the potential to be vulnerable due to factors like extreme physical symptoms, pain or nausea, psychosocial stressors or poverty.

Instead of a blanket exclusion, Dr. Dembo recommended that "ongoing research and additional safeguards like oversight, appropriate training of assessors and a clearer definition of irremediability for mental disorders should be put in place." She did not think that further study was necessary before allowing MAiD for mental illness as a sole underlying condition.

Lawyer Jean-Pierre Ménard discussed the *Carter* and *Truchon* decisions, noting how the courts emphasized that "all cases require an individual evaluation" and must be assessed on their own merits, concluding that it "is misguided to collectivize the assessment of people." Grace Pastine from the British Columbia Civil Liberties Association also noted that in the *Carter* decision, the Supreme Court emphasized that it is possible for physicians to "adequately assess decisional capacity."[75]

[75] *Carter*, para 116.

Others explained that the psychiatric community has developed or can develop approaches and standards that enable accurate assessments. Some added that medical practitioners are already assessing the MAiD eligibility of individuals who have a combination of mental and physical illnesses and can do so.[76]

Dr. Robert stated that the Collège des Médecins du Quebec tasked the Association des Médecins Psychiatres du Québec (AMPQ) to provide an opinion on MAiD and mental illness. Dr. Isabelle Tardif, also from the Collège des Médecins du Quebec, added that:

> We've been interested in the mental health issue for several months. We've developed ways to address the issue in an informed way so we can eventually contribute to the discussion on [MAiD] for someone with a mental illness.

Witnesses noted that the AMPQ has been working towards guidelines, standards and training for MAiD cases involving mental illness.[77] Dr. Gupta described how the AMPQ struck an advisory committee that "produced a discussion paper laying out an approach to assessing requests for MAiD for mental disorders, which includes the consideration of the challenging issues of incurability, suicide, suffering and capacity."[78]

Some witnesses expressed concerns that the exclusion minimizes the suffering of people with mental illnesses, is discriminatory and stigmatizing.[79] Dr. Grainne Neilson from the Canadian Psychiatric Association (CPA) said that:

> The currently proposed exclusion criteria are at odds with decades of public work to destigmatize mental illness and also appear[s] to be at odds with the UN *Convention on the Rights of Persons with Disabilities*, which has the primary purpose to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities and to promote respect for their inherent dignity.

Dr. Neilson also added that the exclusion does not consider that both physical and mental illness can have unpredictable trajectories, and so the distinction drawn between them "is inconsistent with the available medical evidence."

[76] See for example the testimonies of Professor Jocelyn Downie and Dr. Justine Dembo.
[77] See for example the testimonies of Dr. Mona Gupta, Dr. Georges L'Espérance, Professor Jocelyn Downie, and Dr. Justine Dembo.
[78] The report was unanimously adopted by the board of the Association des Médecins Psychiatres du Québec,: *Access to medical assistance in dying for people with mental disorders*, November 2020.
[79] See the testimonies of Dr. Justine Dembo, Hon. James Cowan, and Jean-Pierre Ménard.

Dr. L'Espérance raised another consideration, namely that mental illness "is a real illness with real and sometimes intolerable suffering," and for some people may be resistant to treatment. According to Professor Downie:

> It is stigmatizing of mental illness, relying on the notion that every mental illness is curable and feeds the false belief that people with mental illness would get better if they just tried harder. Also, it doesn't take much imagination to see how the phrase "mental illness is not considered to be an illness, disease or disability" might perpetuate the harmful idea that mental illness is not a real illness.

Dr. Downar expressed his view that "if someone has an incurable illness, his or her suffering is intolerable and there is no realistic way to relieve that suffering in future, that person should be entitled to medical assistance in dying. The same question should be applied to mental and physical illnesses."

Dr. Gaind stated that there are significant differences between mental illness and physical illness that warrant treating them differently for the purposes of MAiD, and in fact that "failing to do so would be discriminatory":

> It is not about infantilizing anyone or removing their autonomy… It is about avoiding discrimination by ensuring we don't set evidence-free policy, exposing our loved ones to arbitrary assessments with no standards, that can lead to their premature deaths."

The Canadian Mental Health Association and the Mental Health Commission of Canada have not yet formed an official position on Bill C-7, due to significant time constraints during the pandemic.[80]

Some witnesses questioned the constitutionality of excluding mental illness from MAiD eligibility. Former Senator James Cowan, from Dying with Dignity, and Professor Downie argued that the exclusion is in breach of sections 7 and 15 of the Charter.

Minister Lametti explained that in his view the bill is constitutional:

> [This is] because of the very narrow focus … There is a very precise focus to this exclusion, and coupled with the uncertainty in the medical profession about "the parameters," if you will, or how to apply medical assistance in dying to people whose sole condition is a mental illness, we need to be careful.

In response to the recent Supreme Court judgment in *Ontario (Attorney General) v. G,*[81] on discrimination based on mental disability, Minister Lametti confirmed his view that the exclusion provision in Bill C-7 remains constitutional.

[80] See the testimonies of Dr. Andrew Galley and Dr. Patrick Baillie.

[81] 2020 SCC 38.

Professor Lemmens agreed that the mental illness exclusion would likely be found to be constitutional.

Some witnesses suggested that the mental illness exclusion is discriminatory and should be designed to automatically expire after a period of time (a sunset clause). Witnesses suggested six to twelve months as an appropriate length of time, after which individuals with a mental illness as a sole underlying condition who meet all the other criteria could be eligible for MAiD. This would allow time to review and adapt guidelines and standards to the application of MAiD to people suffering from mental illness.[82] Professor Downie stated "we have good grounds to believe this is doable as the Quebec Association of Psychiatrists has just done it."

Dr. L'Espérance suggested:

> removing this exclusion clause and observing a 12-month legal period of non- application during which the professional bodies from each province could work together and would be legally bound to delineate a common clinical framework.

Dr. Green said that this would put "the feet of the government to the fire" and compel the government "to have the discussions needed to deal with these patients."

Other witnesses opposed the idea of a sunset clause. [83] Dr. Gaind stated that such a clause "would be presupposing the outcome of our determination as to whether irremediability can be predicted, and we don't know that yet." He further explained:

> While some other physical disorders can be unpredictable, expansion advocates rarely point out the simple fact that we do not understand the pathophysiology of almost any mental disorder. It is a false equivalence to equate the unpredictability of illnesses like cancer, neurodegenerative diseases, or disorders with known underlying biology, with mental illnesses that we lack fundamental understanding of.

MAiD and Health Care

The committee discussed with witnesses how Canada's MAiD system operates, from the assessment stage to the administration of MAiD. This includes how Canada's health care system needs to provide support to persons who are suffering to ensure that they are seeking MAiD as a last resort, when all other alternatives consistent with the social determinants of health[84] have been made accessible and considered. This includes ensuring that adequate social and economic supports and sufficient and equal access to health and palliative care have been made available.

[82] See the testimonies of Dr. Justine Dembo, Dr. Georges L'Espérance, and Dr. Justine Downie, and Dr. Mona Gupta.
[83] See the testimonies of Dr. K. Sonu Gaind, Dr. Harvey Schipper and Dr. Scott Kim.
[84] For more information on the "social determinants of health," see for example: Government of Canada, *Social determinants of health and health inequalities*.

Accessing MAiD

Dr. Catherine Cervin, President of the College of Family Physicians of Canada, and Dr. Cornelia Wieman, President of the Indigenous Physicians Association of Canada, explained that some Canadians, especially in certain regions, face a lack of access to trained and qualified MAiD assessors and providers. Dr. Cervin added that it is "absolutely a concern" that "vulnerable populations in remote areas do not have adequate access even to primary care." Dr. Alika Lafontaine, from Alberta Health Services, and Dr. Wieman also highlighted the challenges in offering MAiD in remote communities in Canada. Dr. Green noted that accessing MAiD assessors will be particularly difficult for people whose death is not reasonably foreseeable living in rural and remote communities, where the availability of assessors with expertise inrare and complex conditions may be limited. Dr. Buchman and Dr. Jeffrey Kirby identified that virtual MAiD assessments can mitigate barriers to access. However, Dr. Naud believed that remote assessment has "significant limits and will never replace a consultation with the patient."

Many witnesses raised other concerns about how patients consult with medical practitioners about MAiD. Several witnesses emphasized that medical practitioners should never suggest MAiD as an option unless the patient has inquired about it of their own accord. Dr. Coelho and Dr. Herx stressed that there is a power imbalance between health practitioners and certain patients.[85] Dr. Katherine Ferrier, President of the Physicians' Alliance against Euthanasia, concurred, adding that: "What [health professionals] raise as an option is often understood as a recommendation," or an "instruction" by vulnerable or disadvantaged individuals.[86] These witnesses agreed that MAiD discussions should be exclusively patient-initiated to avoid the risk of even unintentional coercion, and that MAiD should remain an option of last resort.[87] Dr. Ferrier also recommended that it should be illegal to "to suggest MAiD to someone who hasn't requested it."

In raising concerns about patients who may feel coerced or pressured to pursue MAiD, Krista Carr, Dr. Herx and Dr. Coelho mentioned Roger Foley, who testified before the House of Commons Standing Committee on Justice and Human Rights that he was "coerced into assisted death by abuse, neglect, lack of care and threats. [88]"

Others such as Michael Villeneuve, from the Canadian Nurses Association, and Dr. Naud, said they do not see coercion in critical care as a concern. Dr. Naud explained that:

> Patients who request medical assistance in dying don't do so hastily, as an impulsive move. It's a deliberate request, the result of a long-term decision-making process, and I would say that virtually 100% of patients who make a request have already discussed it with their circle, their attending physicians and their nurses. …Consequently, there is no risk that patients are being pressed to choose medical assistance in dying; what we're seeing now is exactly the contrary.

[85] See the testimonies of Dr. Ramona Coelho, Dr. Leonie Herx, and Dr. Katherine Ferrier.
[86] See the testimonies of Dr. Leonie Herx and Dr. Katherine Ferrier.
[87] See also the testimony of Dr. Ramona Coelho.
[88] See House of Commons Committee on Justice and Human Rights, *Evidence*, 10 November 2020.

Some witnesses raised concerns that MAiD should not be administered in prisons due to the lack of treatment options, palliative care, and viable options for transferring prisoners to appropriate health care facilities.[89] André Schutten, from the Association for Reformed Political Action Canada, stated that administering MAiD in prisons is a "questionable practice at best." Dr. Patrick Baillie added that there is a risk of coercion tied to MAiD in prisons, and that a lack of available treatment options constrains prisoners' abilities to make free and informed decisions.[90]

Professor Downie felt that "we cannot deny prisoners access to MAiD", but acknowledged that the situation raises concerns. She recommended that MAiD in prisons could be studied as part of the parliamentary review and "should address the issue of compassionate release and the lack of a proper compassionate release program in Canada."

Commenting on the lack of treatment options for prisoners, Dr. Lafontaine observed:

> We know that Indigenous patients in particular suffer from a type of racism that leads to worsened health outcomes. That's a byproduct of the choices provided to patients, the cultural norms on what's tolerated for patients, and then the choices of providers who actually control resources in the system when it comes to making choices for patients.

Dr. Herx and Amy Hasbrouck noted that the annual report of the Office of the Correctional Investigator included a review of instances where MAiD issues arose in prisons. It recommended that the Government review this matter, and concluded:

> [A] review of these cases suggests that the decision to extend MAiD to federally sentenced individuals was made without adequate deliberation by the legislature. … In effect, there is no legal or administrative mechanism for ensuring accountability or transparency for MAiD in federal corrections. Surely, this exemption was an oversight that demands correction.[91]

[89] See for example the testimonies of Professor Jocelyn Downie, Dr. Trudo Lemmens, Michael Villeneuve, André Schutten, and Dr. Patrick Baillie.
[90] See also the testimony of Amy Hasbrouck.
[91] Office of the Correctional Investigator, *Office of the Correctional Investigator Annual Report 2019-2020*, 26 June 2020.

Adequate Access to Health Care

In considering the expansion of access to MAiD, witnesses emphasized the importance of ensuring that Canadians have adequate access to health care, especially palliative care. Some witnesses were concerned that individuals may choose MAiD if there are insufficient alternatives in palliative care or mental and physical health supports available to them. Witnesses emphasized that if MAiD is legally available in Canada, the government must also enhance support services and palliative care so that MAiD is not the only option.[92] Witnesses also emphasized how social determinants of health, including poverty and lack of adequate housing, significantly and negatively affect adequate access to palliative care and other forms of healthcare, and risk leaving those most marginalized without meaningful alternatives to MAiD.[93]

Dr. Neilson explained that: "equitable access to clinical services is an essential safeguard to ensure that people do not request MAiD due to a lack of available treatments, supports or services and as an alternative to life." Michael Villeneuve described MAiD as a "false decision" if people do not have access to other options.[94] Dr. Lafontaine underscored that, when discussing MAiD as a matter of personal autonomy, there needs to be choice for access to resources within communities: "Agency requires health systems to actually provide the infrastructure for other types of health and wellness."

Dr. Herx went on to describe access to palliative care for Canadians to be a "national tragedy." She discussed the lack of access, but also the lack of education among physicians to properly provide it. She added that: "MAiD should not be a solution to lack of access to care. Recent media reports have documented Canadians who requested MAiD due to loneliness, depression, social deprivation and lack of supports needed for living." Dr. Green stated that palliative care is "underfunded and under-accessed in Canada, and something we need to work toward."

Dr. Ferrier and Krista Carr noted that although Bill C-14 and Bill C-7 require that individuals receive information about other services or supports to address their needs before accessing MAiD, that support is not often accessible or available.

Dr. Chochinov expressed similar concerns about access to palliative care:

> About 25% of patients who received MAID did not get any palliative care, and 75% had some contact. We don't know what that means. Did they have a single consultation? There was a Health Canada study that reported, in an interim report, on MAID. It said that somewhere in the magnitude of 40% of patients were being referred in the last month or two. These are patients who have lived with months of suffering, physical suffering, existential and psychological suffering. So, although they have had contact with palliative care in the last month or two, it is really a failure of the system in that they were not referred to palliative care at a time when that suffering could have been averted.

[92] See the testimonies of Professor Jocelyn Downie, Dr. Leonie Herx, and Dr. Sephora Tang.
[93] Various aspects of the impacts of social determinants of health were discussed by Claire McNeil, Neil Belanger, Krista Carr, Bonnie Brayton, Mark Henick, Dr. Ramona Coelho, Dr. Sephora Tang, and Dr. Jeffery Kirby, among others. [94] See also the testimony of Vince Calderhead.

Dr. Green added that "of all the people reported to have received MAID in Ontario, 82% of them had palliative care involvement." Nationally, Health Canada reported that 82.1% of Canadians who received MAID in 2019 were reported to have received palliative care services.[95] Dr. Herx contested the reliability of these numbers.

Dr. Downar explained that there are problems with access to palliative and psychiatric care in Canada that need to be addressed. However, he said it is an "incorrect narrative" that it is a "lack of access to palliative care or support services or socio-economic vulnerability" that is leading people to seek MAiD. He explained that demographic data shows that "people who received MAiD are much wealthier, more likely to be married, less likely to be widowed and far less likely to be institutionalized."[96] Dr. Kirby added that MAiD legislation shouldn't be held up due to the lack of adequate health care and physicians cannot force or even encourage patients to undergo various treatments if they do not want to. Minister Hajdu responded that she had heard concerns expressed about people choosing MAiD in the absence of appropriate supportive care options:

> We very much understand how important these resources are in making a truly informed choice. The available evidence does not show, though, that Canadians are choosing MAiD because palliative care is not available. In fact, the findings from [Health Canada's] first annual report on medical assistance in dying, published this past summer, indicate that the overwhelming majority of people receiving medical assistance in dying have been offered and indeed have received palliative care.

She added that the Government of Canada is committed to improving access to palliative care.
Minister Qualtrough also responded to these concerns, saying that she sharesthem: "Canadians with disabilities are rightfully calling for governments to address these inequities, and we must."
Other witnesses emphasized the importance of ensuring that suicide prevention remains an important priority in Canada.

Sean Krausert from the Canadian Association for Suicide Prevention shared that:

> Finding hope and reasons to live are quintessential aspects of clinical care in mental disorders. Having MAiD as a treatment option is in fundamental conflict with this approach, is likely to have a negative impact on the effectiveness of some therapeutic interventions and may lead both patient and provider to prematurely abandon care.

Dr. Sephora Tang expressed similar views:

> My patients need to see that I remain firm in giving them hope, that I'm not going to give up on them even if, in a moment of desperation, they want to end their lives.They need to come to me and be guaranteed that I'm not going to collude in their suicidal urges and their hopelessness, because my job as a psychiatrist is to give them hope when they have lost all hope.

[95] Health Canada, *First Annual Report on Medical Assistance in Dying in Canada*, 2019.

[96] See also the testimony of Helen Long.

Amy Hasbrouck suggested that "there should be a prerequisite that the person be receiving palliative care and community supports for independent living, and be given suicide prevention intervention before they are determined eligible for MAiD."

The Diversity of Canadians

In discussing both access to MAiD and to adequate health care, some witnesses expressed concern that culturally appropriate healthcare options that respect the diverse backgrounds of Canadians have not been sufficiently integrated into the MAiD framework. Professor Laverne Jacobs discussed racial inequality and the importance of reviewing how providing MAiD can be impacted by "the stigmatization of a historically disadvantaged group," where "the stigma itself has caused harm to the group." Former Senator James Cowan also raised how palliative care needs to be more culturally sensitive, while Sean Krausert mentioned that cultural sensitivity is necessary for psychiatric and psychological supports and counselling. As noted above, several witnesses discussed the challenges of offering MAiD and adequate health care in rural and remote communities.

Minister Lametti stated that he recognizes "there is systemic discrimination in the health care system that we need to fight and correct as a country in collaboration with the provinces because health care is a provincial jurisdiction."

Concerned about the systemic racism and discrimination in Canada's health care system, the committee requested information from Minister Lametti with regard to the Gender-Based Analysis Plus that was prepared by the federal government in the preparation of Bill C-7. The committee received this information on January 18, 2021, however the information did not include any Race-Based Analysis.

Conscience Rights and Advising Patients About MAiD

Some witnesses raised concerns about whether medical practitioners should be required to advise a patient about MAiD if it is against that practitioner's conscience or beliefs to support or offer MAiD. Freedom of conscience and religion is protected by section 2(a) of the Charter. The preamble to Bill C-14 states that "nothing in this Act affects the guarantee of freedom of conscience and religion." In *Carter*, the Supreme Court emphasized that any legislative and regulatory response to its decision would have to reconcile the Charter rights of both patients and physicians.[97]

Conscience rights can be distinct from religion; some conscientious objections to MAiD referrals are based on practitioners' understanding of their duty to act in their patients' best interests and their oaths to do no harm.[98]

[97] *Carter*, at para. 132.
[98] See for example the testimonies of Dr. Stephanie Tang, Professor Brian A. Mishara, Dr. Leonie Herx, Laurence Worthen (Christian Medical and Dental Association), and Alexander King.

Dr. Coelho described the distinction between providing information and providing a referral:

> In Ontario … you can give people the Telehealth Ontario number. But a referral is something very different. A referral is when I say: This is something I think is truly good for the patient. So I am going to, because it's not part of my expertise, I am passing it on to a specialist to complete the care that I believe is good… There is an ethical implication in a referral. It is not just a piece of paper and a signing off to someone else. [99]

She also said in British Columbia, Alberta, and Manitoba, "robust" systems work well in providing information to patients, adding that:

> They have not identified conscience objectors as an obstruction to access to MAiD. I think that is important in a pluralistic society, that the system is set up in a way that respects everybody. I think it can be done.

Several witnesses felt very strongly that medical practitioners' freedom of conscience rights should mean that they are not obligated to advise a patient about MAiD, with some adding that they should not be required to refer them to another practitioner either.[100] Several witnesses stated that existing conscience protections were not sufficient for practitioners who are opposed to participating in MAiD, and called for these to be strengthened.[101]

Marilee Nowgesic of the Canadian Indigenous Nurses Association expressed concerns about meaningful protection for the conscience rights of Indigenous healthcare workers, asking: "Are they going to be punished in their workplace if they do not [provide MAiD] because they're the only nurse or nurse practitioner in that community that could do this?"

Others considered the protections to be adequate and held that "physicians who conscientiously object still need to act in the best interests of the patient."[102]

Several witnesses discussed a recent Ontario Court of Appeal ruling involving a challenge to the provincial regulator, the College of Physicians and Surgeons of Ontario's policy requiring effective referral, though they had differing views on its impact.[103] According to the Ontario Court of Appeal:

> The Policies each require physicians who object to providing certain medical procedures or pharmaceuticals on the basis of religion or conscience to provide the patient with an "effective referral". …The Policies do not require physicians to personally provide the services to which they object, except in an emergency where it is necessary to prevent imminent harm to a patient.

[99] See also the testimony of Dr. Ewan Goligher.
[100] See the testimonies of Dr. Leonie Herx, Dr. Sephora Tang, Dr. Ramona Coelho, and Dr. Thomas Bouchard (Alberta Committee for Conscience Protection).
[101] See the testimonies of Julia Beazley, Dr. Leonie Herx, Dr. Sephora Tang, Most Reverend William McGrattan , Laurence Worthen, Alexander King, Dr. Ewan Goligher, and Marilee Nowgesic (Canadian Indigenous Nurses Association).
[102] See the testimony of Fleur-Ange Lefebvre (Federation of Medical Regulatory Authorities of Canada). See also the testimonies of Professor Jocelyn Downie and Helen Long.
[103] *Christian Medical and Dental Society of Canada v. College of Physicians and Surgeons of Ontario*, 2019 ONCA 393 (CanLII).

The court held that this was an appropriate balance between a patient's interests and physicians' Charter-protected religious freedom.

Witnesses had different views on how the court decision impacts the rights of physicians who do not wish to participate in MAiD in Ontario. According to Dr. Herx, this decision requires physicians to "participate in and facilitate MAiD for someone when [they] may not think that it's indicated from a professional perspective or it may go against [their] moral integrity." Professor Downie said that the decision did not mean that a clinician would be compelled to provide MAiDor participate in it, but rather the duty is to transfer the individual to another's care or provide an effective referral.

Dr. Bouchard explained that in Alberta, a provincial system of referral for patients has been established through the Medical Assistance in Dying Care Coordination Service. Patients are able to access the service to generally discuss all end of life options available, including MAiD, without a referral.[104] While some witnesses called for a provision to be added to the *Criminal Code* to protect the conscience rights of medical practitioners,[105] other witnesses stated that conscience rights in the provision of health care fall under provincial jurisdiction.[106] The provinces then delegate that authority to the Colleges of Physicians and Surgeons and the Colleges of Nurses.

Indigenous Peoples

The committee heard from a number of witnesses from organizations representing Indigenous Peoples.[107] They discussed the Government of Canada's consultations with Indigenous Peoples and all asserted that they have been insufficient.[108] Some felt that Bill C-7 should not proceed before these consultations have taken place.[109]

Neil Belanger stated that the government's consultations and surveys in preparation for Bill C-7 lacked input from Indigenous communities and Canada's territories, as well as from Indigenous persons with disabilities. He added that without adequate involvement with Indigenous Peoples, the changes proposed in Bill C-7 are contrary to the "spirit and intent of reconciliation and self-determination" and should not be passed into law.

Professor Bourassa commented on the Council of Canadian Academies expert panel on MAiD in 2018, where she helped to organize the Indigenous elders' circle:

> When we had the circle two years ago, there was certainly some movement around, "Yes, we should have this discussion," but we have not been appropriately engaged. And if we're going to have this discussion, it has to be done in a very delicate manner. You can't just pull together three or four elders and expect that to be engagement.

[104] Alberta Health Services, *Medical Assistance in Dying Care Coordination Service*.
[105] See the testimonies of Dr. Sephora Tang and Laurence Worthen.
[106] See the testimonies of Professor Jocelyn Downie, Laurence Worthen, and Fleur-Ange Lefebvre.
[107] See the testimonies of Neil Belanger, Dr. Alika Lafontaine, Marilee Nowgesic, and Dr. Cornelia Wieman (Indigenous Physicians Association of Canada).
[108] See the testimonies of Neil Belanger and Professor Carrie Bourassa.
[109] See the testimonies of Neil Belanger, Dr. Alika Lafontaine, and Marilee Nowgesic. Dr. Cornelia Wieman did not fully concur that the legislation should not proceed and added that "at this very instant there are people who are suffering intolerably" and who are able to make informed decisions about MAiD.

The committee also heard about problems with systemic racism towards Indigenous Peoples in the health care system and a lack of equal access to services. Dr. Buchman stated that: "It's absolutely critical that access to all health services be improved for First Nations populations across the country." He added that the CMA is "working closely with groups across Canada who are focusing on providing culturally sensitive palliative care to all First Nations peoples." Marilee Nowgesic emphasized "the disparaging level of access to adequate health services" for Indigenous Peoples. Dr. Wieman and Neil Belanger noted recent reported incidents of racism and injustice towards Indigenous Peoples in the provision of health care in Canada.[110] Neil Belanger added that this problem was "so common" that the federal government was meeting with 400 Indigenous organizations and persons in relation to systemic racism toward Indigenous Peoples in health care. He emphasized that given the racism that exists in Canada's health care system, "it would be dangerously naive to suggest that … Indigenous persons living with disabilities would be adequately protected without the end-of-life criteria under MAID."

Witnesses also underscored the importance of ensuring that Indigenous Peoples in Canada are properly informed about MAiD in a culturally safe way[111] and have equal access to MAID, palliative care, and other of end-of-life care.[112]

Dr. Wieman and Professor Carrie Bourassa emphasized the importance of self- determination for Indigenous Peoples, while cautioning the committee that they are not monolithic and their views and perspectives on MAiD are diverse. Dr. Wieman emphasised that:

> It is important to continue to strive to achieve culturally safe health care for all Indigenous people, including end-of-life care. When MAID is requested, the supports required for MAID need to be in place, culturally safe, and concurrent ceremonies respected.

Professor Bourassa added that she is "quite concerned about the lack of cultural safety" with regard to MAiD and Indigenous communities. As a possible solution to these challenges, she recommended that culturally safe training should be mandatory for health professionals in MAiD and that defining culturally safe practices and understandings should be a community-led initiative. She further stated:

> [I]t is very difficult for Indigenous communities, particularly for the elders, to really understand about [MAiD] because there are so many suicides in our communities. When I've talked to elders, the response is very difficult because many hold the perspectives that we have so many people who are dying in our communities, how can we even have this conversation? How do we even talk about this?

---

[110] Neil Belanger noted the reported cases of Joyce Echaquan and Brian Sinclair, who are both Indigenous persons. Joyce Echaquan, 37, recorded racist slurs uttered by medical staff while she pleaded for someone to help her before she died in hospital. Brian Sinclair, 45, died waiting to be seen in the emergency room at Winnipeg's Health Sciences Centre. He was discovered 34 hours after he arrived. For more information, see Jorge Barrera, "Criminal investigation needed into death of Joyce Echaquan, say 2 legal experts," *CBC News*, 1 October 2020; and Aidan Geary, "Ignored to death: Brian Sinclair's death caused by racism," *CBC News*, 18 September 2017.

[111] See the testimonies of Dr. Cornelia Wieman and Marilee Nowgesic.

[112] See the testimonies of Dr. Cornelia Wieman, Dr. Alika Lafontaine, and Marilee Nowgesic.

Although the Métis were not included in the roundtable discussions, MinisterLametti discussed the "outreach" that the federal government undertook with Métis communities, including a conversation with the President of the Manitoba Métis Federation. Minister Lametti discussed how they heard from "voices" working in Métis communities that explained that the outreach "focused a lot on social determinants and on giving people a real choice, and not choosing MAiD because one felt one had to choose MAiD and there weren't any other options."

Minister Qualtrough also added that while there was consultation with Indigenous groups in the preparation of Bill C-7, she agreed there is a need to do more. She noted that:

> The rate of disability in Indigenous communities is twice that of the national average. That sets off major alarm bells for me. It means the most vulnerable people continue to be not properly included in our systems, nor to have a voice in the future of these systems.

Faith Groups

The committee also heard from representatives of leading religious organizations in Canada who shared their views concerning MAiD.[113] Most stressed the importance of protecting the sacred dignity of the human person, and expressed concerns about the possible negative impacts that broadening access to MAiD might have on people with disabilities, vulnerable individuals, the elderly, or marginalized Canadians. Imam Refaat Mohammed, the President of the Canadian Council of Imams, stated:

> We are greatly fearful that expanded MAID will lead to people with disabilities, or those who are elderly, feeling more pressure to choose death in order to avoid being a burden on others. We are deeply worried that the health care system will start to ignore long-term care and chronic disease in the elderly as MAID becomes more available.

Bishop McGrattan echoed these concerns:

> [W]e still remain deeply concerned about the provisions that are enclosed in Bill C- 7 — especially, as has been mentioned, the devastating impact it will have on many disabled and marginalized Canadians.

[113] See the testimonies of Julia Beazley, Vyda Ng, Derek Ross, Most Reverend William McGrattan (Canadian Conference of Catholic Bishops), Laurence Worthen, Imam Refaat Mohammed (Canadian Council of Imams), André Schutten (Association for Reformed Political Action Canada), Reverend Daniel Hayward (United Church of Canada), and Alexander King.

Julia Beazley, from the Evangelical Fellowship of Canada, shared that:

> We approach this issue out of respect for human life and dignity, and care for those who are vulnerable. These principles, rooted in our faith, are also reflected in Canadian law and public policy. We remain firmly opposed to hastened death but offer recommendations to minimize the harm and risk to vulnerable Canadians.

These included maintaining existing safeguards, as well as extending the proposed safeguards in Bill C-7 for those whose death is not reasonably foreseeable to all MAiD applicants.

Vyda Ng, Executive Director of the Canadian Unitarian Council, voiced approval for Canada's MAiD regime and for Bill C-7:

> We believe that living with dignity is a human right; dying with dignity is similarly a human right. There is no dignity in living with extreme pain and suffering. The [2016] legislation and the current proposed changes put Canada well on the way to ensuring that our citizens and residents have access to this basic medical assistance.

Data and Research

Witnesses agreed that there is a need for more data collection, research, and oversight of MAiD in Canada. Witnesses also shared information drawn from existing surveys, data collection, and research, though there was not always consensus on how to analyse or use this data in developing MAiD policies.

Minister Qualtrough acknowledged the need for "robust federal monitoring" and "a reliable national data set that promotes accountability and improves the transparency of implementation." She added that:

> [W]e also need to better understand who is accessing MAiD and why. This is of the utmost importance to the disability community. It is incumbent upon all of us to ensure that the regulations that flow from this legislation allow for fulsome data analysis.

Several witnesses from Quebec discussed the province's unique experience with MAiD, regulated in the province a few months prior to the adoption of Bill C-14 and following extensive public consultations conducted by a bipartisan parliamentary committee.[114] These witnesses informed the committee that work on MAiD started in Quebec in 2006, and continues to this day with the AMPQ's recent report on MAiD for mental illness. As such, it offers information on best practices, directives, patient relationships and potential changes to MAiD delivery. Quebec has a Commission on End-of-Life Care,[115] which Derek Ross said has "really provided us the most thorough information that we have about MAiD in Canada." He explained how it collects data, reviews cases, and ensures that the law is being followed. Dr. Robert concurred that it "has certainly contributed to the social debate and has made it possible to better define the reality of medical assistance in dying." Dr. Gupta also promoted how Quebec has recognized the importance of mentoring for those who provide care and assess MAiD requests to discuss best practices and review difficult cases. Dr. Kirby recommended that similar models should be created in other provinces and the territories. It should be noted that many other witnesses acknowledged their unfamiliarity with the Quebec model and studies conducted in the province.

Other witnesses stressed the importance of thorough data collection on MAiD requests and outcomes to inform future reports, reviews, and critical analysis of the regime.[116] Professor Downie underscored that "expanding the reporting requirements facilitates insight into implementation, particularly in relation to barriers to access." Dr. Neilson emphasized the need for "standards related to the assessment process and procedures so that the manner in which the eligibility criteria are being applied across the country are uniform and in keeping with the legislation's intent." Dr. Buchman advocated for "developing clinical practice guidelines that aid physicians in exercising sound clinical judgment" and highlighted the need for more oversight.[117] Professor Mishara contrasted Canada's MAiD regime with the system in the Netherlands, saying the Dutch oversight system is "public and transparent," with reports on investigations and data provided to the public.

Dr. Chochinov said that what is missing from studies is the "voice of the patient" to inform better practices and palliative care. "We need to have studies of MAiD patients," he added, "patients who are thinking of having MAiD, interviews with them, with members of their family to try to find out what the nature of their suffering is."

[114] See for example the testimonies of Geoffrey Kelley, Dr. Yves Robert, Dr. Georges L'Espérance, Dr. Alain Naud, and Dr. Mona Gupta.
[115] The Commission was created under Quebec's *Act Respecting End-of-Life Care* with a mandate to examine all matters related to end-of-life care and to oversee the application of specific requirements related to MAiD. Minister Lametti noted that Quebec is the only province that has its own provincial MAiD regime that works in harmony with the federal criminal law.
[116] See the testimonies of Dr. Alain Naud, Derek Ross, Dr. Sandy Buchman, and Dr. James Downar. Dr. James Downar expressed his approval of the federal government's *Action Plan on Palliative Care*'s emphasis on improving data collection and research.
[117] See the testimonies of Dr. Grainne Neilson, Dr. Leonie Herx, and Professor Brian A. Mishara.

Dr. Cervin also raised the importance of training family physicians about MAiD, which she said is not yet part of "core training":

> [An] educational standard is a necessary procedural safeguard both for the assessment of patients requesting medical assistance in dying and to ensure that delivery of the service is by health care providers with expertise and demonstrated competence.[118]

Many witnesses relied on information drawn from other countries' experiences with their equivalent to MAiD, which differ from Canada's MAiD regime.[119] Some witnesses, such as Dr. Naud and Dr. Kim, emphasized that the experiences in countries such as the Netherlands and Belgium, where systems similar to MAiD have been legal since 2002, provide helpful data and experiences.

For example, the Netherlands currently permits euthanasia for mental illness.[120] Dr. Kim referenced his study on Dutch cases of euthanasia for mental illness and stated:

> 70-plus per cent of people who receive [euthanasia for a mental illness] are women. This is a robust, consistent finding across countries over time. This is the same ratio as suicide attempts in people where attempts are two to three times higher inwomen in these countries.

This study reviewed 66 of the 110 reported cases of euthanasia for mental illness in the Netherlands between 2011-2014.[121] These account for less than 1% of all Dutch euthanasia cases during that time period.[122]

Professor Downie cautioned that international examples may not be analogous to the Canadian context:

> One of the cautions that the judge in *Truchon* issued for us was that we must consider all of this in the Canadian context, so look to Europe but be reflecting upon how the system will work in Canada.

A full comparative analysis of international regimes similar to MAiD and how they could inform the Canadian experience was beyond the scope of this pre-study.

---

[118] See also the testimony of Professor Carrie Bourassa.
[119] See for example the testimonies of Dr. Scott Kim, Dr. Harvey Chochinov, Dr. François Primeau (Physicians' Alliance against Euthanasia), Dr. Trudo Lemmens, Professor Brian A. Mishara, Dr. Patrick Baillie, Dr. Alain Naud, André Schutten, Reverend Daniel Hayward, Dr. Mona Gupta, Jean-Pierre Ménard, Dr. K. Sonu Gaind, and Professor Jocelyn Downie.
[120] Assisted death in the Netherlands is referred to as euthanasia.
[121] See the testimony of Dr. Scott Kim. See also: Scott Y.H. Kim et al, "Euthanasia and Assisted Suicide of Patients with Psychiatric Disorders in the Netherlands 2011 to 2014," *JAMA Psychiatry*, 2016.
[122] This percentage is drawn from the Netherlands Regional Euthanasia Review Committees Annual Report 2014.

Conclusion

The committee is very grateful to the witnesses who shared their expert knowledge and their valuable experiences for this pre-study. Their testimony and written submissions were informed and compassionate and have highlighted the need for legislation that fully respects the lives of those who are suffering. MAiD is a challenging topic, but it is vital that these discussions take place, that all voices and perspectives are heard, and that thorough research and reliable evidence inform the legislation for Canada's MAiD regime.

APPENDIX I: Witnesses

23 November 2020

The Honourable David Lametti, P.C., M.P., Minister of Justice and Attorney General of Canada (Department of Justice Canada) (23 November 2020)

Bonnie Brayton, National Executive Director (The DisAbled Women's Network of Canada) (23 November 2020)

Dr. Sandy Buchman, Past President (Canadian Medical Association) (23 November 2020)

Krista Carr, Executive Vice-President (Inclusion Canada) (23 November 2020)

James S. Cowan, Chair, Board of Directors and former senator (Dying With Dignity Canada) (23 November 2020)

François Daigle, Associate Deputy Minister (Department of Justice Canada) (23 November 2020)

Dr. Alison Freeland, Chair, Professional Standards and Practice Committee (Canadian Psychiatric Association) (23 November 2020)

Andrew Galley, National Research and Policy Analyst (Canadian Mental Health Association) (23 November 2020)

Dr. Stefanie Green, President (Canadian Association of MAiD Assessors and Providers) (23 November 2020)

Amy E. Hasbrouck, Executive Director, Toujours Vivant-Not Dead Yet a project of the Council of Canadians with Disabilities (Council of Canadians with Disabilities) (23 November 2020)

Dr. Leonie Herx, Palliative Medicine Consultant, Immediate Past-President and Executive Board Member (Canadian Society of Palliative Care Physicians)(23 November 2020)

Dr. Georges L'Espérance, President, Neurosurgeon (Association québécoise pour le droit de mourir dans la dignité) (23 November 2020)

Helen Long, Chief Executive Officer (Dying With Dignity Canada) (23 November 2020)

Dr. Grainne E. Neilson, President (Canadian Psychiatric Association) (23 November 2020)

Dr. Tarek Rajji, Chief of Adult Neurodevelopment and Geriatric Psychiatry, Professor of Psychiatry, University of Toronto (Centre for Addiction and Mental Health)
(23 November 2020)

Laurie Wright, Senior Assistant Deputy Minister (Department of Justice Canada)
(23 November 2020)

24 November 2020

Dr. Patrick Baillie, Psychologist and Lawyer (Mental Health Commission of Canada)
(24 November 2020)

Dr. Catherine Cervin, President (College of Family Physicians of Canada)
(24 November 2020)

Dr. Harvey Max Chochinov, Distinguished Professor, University of Manitoba
(24 November 2020)

Dr. Justine Dembo, Psychiatrist, Sunnybrook Health Sciences Centre, Lecturer, University of Toronto
(24 November 2020)

Dr. James Downar, Head and Associate Professor, Division of Palliative Care, University of Ottawa (24 November 2020)

Jocelyn Downie, Professor, Health Law Institute, Dalhousie University
(24 November 2020)

Dr. Catherine Ferrier, President (Physicians' Alliance against Euthanasia)
(24 November 2020)

Mark Henick, Mental Health Advocate (24 November 2020)

Sean Krausert, Executive Director (Canadian Association for Suicide Prevention)
(24 November 2020)

Dr. Francine Lemire, Chief Executive Officer (College of Family Physicians of Canada)
(24 November 2020)

Trudo Lemmens, Professor and Scholl Chair in Health Law and Policy, Faculty of Law, University of Toronto (24 November 2020)

Brian L. Mishara, Director, Centre for Research and Intervention on Suicide, Ethical Issues and End of Life Practices, and Professor, Psychology Department, University of Quebec at (24 November 2020)

Dr. Susan Moffatt-Bruce, Chief Executive Officer (Royal College of Physician and Surgeons of Canada) (24 November 2020)

Dr. Alain Naud, Clinical Professor, Department of Family and Emergency Medicine (Laval University) (24 November 2020)

Alex Schadenberg, Executive Director (Euthanasia Prevention Coalition of Ontario) (24 November 2020)

Dr. Sephora Tang, Psychiatrist, The Ottawa Hospital, Clinical Lecturer, University of Ottawa (24 November 2020)

Michael Villeneuve, Chief Executive Officer (Canadian Nurses Association) (24 November 2020)

25 November 2020

The Honourable Patty Hajdu, P.C., M.P., Minister of Health (Health Canada) (25 November 2020)

Louise A. Auger, Director, Professional Affairs (Federation of Medical Regulatory Authorities of Canada) (25 November 2020)

Julia Beazley, Director, Public Policy (Evangelical Fellowship of Canada) (25 November 2020)

Dr. Mona Gupta, Psychiatrist and Researcher, Associate Professor, Department of Psychiatry and Addictions, Université de Montréal (25 November 2020)

Sharon Harper, Director General, Strategic Policy Branch (Health Canada) (25 November 2020)

Daniel Hayward, Chair, Theology and Inter-Church Inter-Faith Committee (The United Church of Canada) (25 November 2020)

Abby Hoffman, Senior Policy Advisor (Health Canada) (25 November 2020)

Alexander King, Chair of the Board (Interim) (Living with Dignity)(25 November 2020)

Karen Kusch, Senior Policy Analyst, Strategic Policy Branch (Health Canada) (25 November 2020)

Fleur-Ange Lefebvre, Executive Director and Chief Executive Officer (Federation of Medical Regulatory Authorities of Canada) (25 November 2020)

Jean-François Leroux, Lawyer (25 November 2020)

Stephen Lucas, Deputy Minister (Health Canada) (25 November 2020)

The Most Reverend William McGrattan, Roman Catholic Bishop of Calgaryand Member of the Canadian Conference of Catholic Bishops' Executive Committee (Canadian Conference of Catholic Bishops) (25 November 2020)

Jean-Pierre Ménard, Lawyer (25 November 2020)

Refaat Mohamed, President (Canadian Council of Imams) (25 November 2020)

Vyda Ng, Executive Director (Canadian Unitarian Council) (25 November 2020)

Derek Ross, Executive Director and General Counsel (Christian Legal Fellowship) (25 November 2020)

André Schutten, Director of Law and Public Policy (Association for Reformed Political Action Canada) (25 November 2020)

Laurence Worthen, Executive Director (Christian Medical and Dental Association of Canada) (25 November 2020)

26 November 2020

The Honourable Carla Qualtrough, P.C., M.P., Minister of Employment, Workforce Development and Disability Inclusion (Employment, Workforce Development and Labour) (26 November 2020)

Neil Belanger, Executive Director (British Columbia Aboriginal Network on Disability Society) (26 November 2020)

Dr. Thomas Bouchard, Family physician (Alberta Committee for Conscience Protection) (26 November 2020)

Robyn Boucher, Intern, University of Toronto (26 November 2020)

Dr. Carrie Bourassa, Professor, Community Health and Epidemiology, College of Medicine, University of Saskatchewan (26 November 2020)

Vince Calderhead, Lawyer, Pink Larkin (26 November 2020)

Dr. Ewan Goligher, Assistant Professor of Medicine, University of Toronto (26 November 2020)

Dr. Alika Lafontaine, Physician and Medical Lead, Aboriginal Health Program, North Zone (Alberta Health Services) (26 November 2020)

Claire McNeil, Lawyer, Dalhousie Legal Aid Service (Disability Rights Coalition of Nova Scotia) (26 November 2020)

Marilee Nowgesic, Executive Director (Canadian Indigenous NursesAssociation) (26 November 2020)

Grace Pastine, Litigation Director (British Columbia Civil Liberties Association) (26 November 2020)

Dr. François Primeau, Clinical Professor, Psychiatry and Neurosciences, Physicians' Alliance against Euthanasia (26 November 2020)

Dr. Yves Robert, Secretary of the Order (Collège des médecins du Québec) (26 November 2020)

Dr. Harvey Schipper, Professor of Medicine and Adjunct Professor of Law, University of Toronto (26 November 2020)

Dr. Isabelle Tardif, Deputy Director General and Assistant Secretary (Collège des médecins du Québec) (26 November 2020)

Dr. Cornelia Wieman, President (Indigenous Physicians Association of Canada) (26 November 2020)

Krista Wilcox, Director General, Office for Disability Issues (Employment and Social Development Canada) (26 November 2020)

27 November 2020

Stéphane Beaulac, professor, University of Montreal (27 November 2020)

Dr. Ramona Coelho, Family Physician (27 November 2020)

Catherine Frazee, Professor Emerita in the School of Disability Studies, Ryerson University (27 November 2020)

Dr. K. Sonu Gaind, Associate Professor, University of Toronto (27 November 2020)

Isabel Grant, Professor, University of British Columbia (27 November 2020)

Laverne Jacobs, Associate Professor and Associate Dean, Research and Graduate Studies, Faculty of Law, University of Windsor (27 November 2020)

Geoffrey Kelley, Former Member of the National Assembly of Quebec
(27 November 2020)

Dr. Scott Kim, Senior Investigator, Department of Bioethics, National Institute of Health
(27 November 2020)

Dr. Jeffrey Kirby, Professor, Bioethics Department, Faculty of Medicine, Dalhousie University
(27 November 2020)

Jason LeBlanc, Caregiver and Researcher (27 November 2020)

Nicolas M. Rouleau, Constitutional Lawyer (27 November 2020)

APPENDIX II: Chart

The following chart was prepared by the Library of Parliament for its *Legislative Summary* of Bill C-7.[123]

Table 1 – Comparison of the Current Safeguards with the Safeguards Provided for in Bill C-7

Current Safeguards: Section 241.2(3) of the *Criminal Code*	Safeguards in Bill C-7 When Natural Death Is Foreseeable: Amended Section 241.2(3) and New Sections 241.2(3.2) to 241.2(3.5) of the *Criminal Code*	Safeguards in Bill C-7 When Natural Death Is Not Foreseeable: New Section 241.2(3.1) of the *Criminal Code*
The physician or nurse practitioner (NP) is of the opinion that the person meets all the criteria set out in section 241.2(1).	No change	No change
The request for medical assistance in dying (MAID) is made in writing, and signed and dated by the person after they were informed that they have a grievous or irremediable medical condition.	No change	No change
The request is signed and dated before two independent witnesses.	The request is signed and dated before one independent witness.[a]	The request is signed and dated before one independent witness.[a]
The person is informed that they may, at any time and in any manner, withdraw their request.	No change	No change
A second physician or NP provides a written opinion confirming that the person meets the criteria.	No change	A second physician or NP provides a written opinion confirming that the person meets the criteria. If the first physician or NP does not have expertise in the condition that is causing the person's suffering, the written opinion must be provided by a physician or NP with that expertise or a third physician or NP with such expertise must be consulted.
The second physician or NP is independent from the first.	No change	No change

[123] Julia Nicol and Marlisa Tiedemann, *Legislative Summary of Bill C-7: An Act to amend the Criminal Code (medical assistance in dying)*, Library of Parliament, Publication No. 43-2-C7-E, updated 21 January 2021. Please note this chart reflects the version of Bill C-7 as passed by the House of Commons on 25 November 2020. It contains amendments to Bill C-7 made after the committee was given its pre-study order of reference; the committee studied the first reading version of Bill C-7.

Current Safeguards: Section 241.2(3) of the *Criminal Code*	Safeguards in Bill C-7 When Natural Death Is Foreseeable: Amended Section 241.2(3) and New Sections 241.2(3.2) to 241.2(3.5) of the *Criminal Code*	Safeguards in Bill C-7 When Natural Death Is Not Foreseeable: New Section 241.2(3.1) of the *Criminal Code*
There are at least 10 clear days between the day that the request is signed and the day that MAID is provided (unless the person's death or loss of capacity to provide informed consent is imminent).	Section repealed	There are at least 90 clear days between the day on which the first assessment begins and the day MAID is provided, or – if the assessments have been completed and both of the physicians or NPs are of the opinion that the loss of the person's capacity to provide consent to receive medical assistance in dying is imminent – any shorter period that the physician or NP who is to provide MAID considers appropriate in the circumstances.
Immediately before providing MAID, the person is given the opportunity to withdraw the request, and the physician or NP ensures that the person is giving their express consent.	Immediately before providing MAID, the person is given the opportunity to withdraw the request, and the physician or NP ensures that the person is giving their express consent. However, this verification of final consent may be waived if certain criteria are met (see section 2.4 of this Legislative Summary for details).	Immediately before providing MAID, the person is given the opportunity to withdraw the request, and the physician or NP ensures that the person is giving their express consent. However, this verification of final consent may be waived if certain criteria are met. The scenarios in which a waiver of the verification can occur are more limited than when natural death is reasonably foreseeable (see section 2.4 of this Legislative Summary for details).
If the person has difficulty communicating, reasonable measures must be taken to provide a reliable means by which the person may understand the information that is provided to them and communicate their decision.	No change	No change

Current Safeguards: Section 241.2(3) of the *Criminal Code*	Safeguards in Bill C-7 When Natural Death Is Foreseeable: Amended Section 241.2(3) and New Sections 241.2(3.2) to 241.2(3.5) of the *Criminal Code*	Safeguards in Bill C-7 When Natural Death Is Not Foreseeable: New Section 241.2(3.1) of the *Criminal Code*
No equivalent, but the eligibility requirement outlined in section 241.2(1)(e) includes being "informed of the means that are available to relieve their suffering, including palliative care."	No change	The person has been informed of the means available to relieve their suffering, including, where appropriate, counselling services, mental health and disability support services, community services and palliative care, and has been offered consultations with relevant professionals who provide those services or that care.
No equivalent	No equivalent	Both of the physicians or NPs have discussed with the person the reasonable and available means to relieve the person's suffering and agree with the person that the person has given serious consideration to those means.

Note: a. The provision regarding who can be a witness is changed by clause 1(8) of the bill as well. See section 2.5 of this Legislative Summary for further details.

Sources: Table created by authors based on a comparison of the existing law with Bill C-7. See *Criminal Code*, R.S.C. 1985, c. C-46, s. 241.2(3); and Bill C-7, An Act to amend the Criminal Code (medical assistance in dying), 2nd Session, 43rd Parliament.

APPENDIX III: GBA+ Analysis

Gender-based Analysis +

Bill C-7, *An Act to amend the Criminal Code (medical assistance in dying)*

Gender-based Analysis (GBA) + is carried out to assess the potential impacts of law reform on diverse groups of women, men and people with other gender identities, as well as other factors such as age, sexual orientation, disability, race, education, language, geography, culture and income. This document provides a summary of information considered in the development of Bill C-7 and the anticipated impacts on women and other vulnerable/marginalized groups.[1]

Demographics of Medical Assistance in Dying – Canada and International

There are two types of MAID regimes worldwide, those limited to dying persons (US states, Colombia, Victoria (Australia), New Zealand) and those without such a limit (Belgium, Netherlands and Luxembourg (otherwise known as the Benelux countries)). MAID legislation was passed in Quebec in 2015 and federally in 2016, both of which are end of life regimes. From that time to December 31, 2019, Health Canada reports that there have been 13,946 MAID deaths in Canada of persons whose natural death was reasonably foreseeable.[2] The average age of individuals receiving MAID in Canada is 75.2 years old, and there is no significant difference in the proportion of Canadian men and women who are receiving MAID.[3] The federal monitoring regime does not collect information about individuals' income, education level, ethnicity, and gender diversity.

These characteristics appear to be consistent with what has been reported in other permissive regimes. For instance, the Oregon Health Authority reports that during 2019, 290 Oregonians died from ingesting lethal medications, a slight majority of whom were male (59%) and most of whom were over the age of 65 (75%).[4] The state of Washington reports that 267 people were prescribed lethal medication in 2018, resulting in 251 deaths, the majority of whom were over the age of 65 (79%).[5] In Washington, there were more women who ingested a prescribed lethal medication (56%) than men. In both Oregon and Washington, the vast majority of individuals who received MAID in the most recently reported year were white (96% in Oregon and 96% in Washington) and a substantial proportion of them had completed at least some college-level education (78% in Oregon and 70% in Washington). Neither state collects data on whether or not MAID patients identified as having a disability. It is worth noting that, in U.S. states (which only allow for self-administration), the proportion of deaths attributed to MAID is lower than that of other permissive countries (less than 1% of total deaths).

[1] The data presented in this document were considered in the original gender-based analysis undertaken in preparation for the introduction of Bill C-7, and updated, where possible, for the purpose of the study ofBillC-7 by the Standing Senate Committee on Legal and Constitutional Affairs.
[2] Health Canada (2020). *First Annual Report on Medical Assistance in Dying in Canada, 2019.* (https://www.canada.ca/en/health-canada/services/medical-assistance-dying-annual-report-2019.html#a3.0, retrieved on November 26, 2020).
[3] *Ibid.*
[4] Oregon Health Authority (2020). *Death with Dignity Act, 2019 Data Summary.* (https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWIT HDIGNITYACT/Documents/year22.pdf, retrieved November 26, 2020)
[5] Washington State Department of Health (2019). *2018 Death with Dignity Act Report.* (https://www.doh.wa.gov/Portals/1/Documents/Pubs/422-109-DeathWithDignityAct2018.pdf, retrieved November 26, 2020)

In Belgium, which by contrast does not have an end of life requirement for eligibility, in 2016-2017, a total of 4,337 euthanasia were reported to the Federal Commission of Control and Evaluation of Euthanasia[6.] (this represents roughly 2% of total deaths in that country). Of these, a slightly larger proportion were male (51%) and 64% were over the age of 70. Over these two years, 173 patients received euthanasia for psychological suffering only (4% of all euthanasia deaths).

In the Netherlands, where medical assistance in dying is also not limited to those at the end of their life, there were 6,361 notifications of euthanasia or assisted suicide to the Regional Euthanasia Review Committees (RTEs) in 2019.[7.] The RTEs reported that approximately 1% involved patients with a psychiatric disorder. Statistics on the number of patients who identified as having a disability were not reported. The numbers of male and female patients were almost the same: 3,309 men (52%) and 2,935 women (46%). Similar to Belgium, 66% of patients were over the age of 70. Data on mental illness in the Netherlands have been collected since 2012.

Early data demonstrate that MAID deaths where mental illness was the sole underlying condition are increasing (14 cases were reported in 2012 and 41 cases were reported in 2014). Euthanasia deaths represents 4% of all deaths in the country.

Medical assistance in dying and Canadians living with disabilities

There is a possibility that permitting MAID for persons on the basis of severe physical disability alone will be perceived as re-enforcing negative and erroneous stereotypes that such lives are full of suffering and are of poor quality. This could leave some individuals with disabilities vulnerable to being pressured into requesting MAID, either by societal or medical community attitudes and behaviour, or by internalized self-stigmatization.

It has been argued by non-governmental organizations (NGOs) representing Canadians with lived experience of disability that removing the RFND criteria will only act to entrench stigma about disabilities. In fact, disability organizations all over the world oppose MAID laws for this reason. To the degree that these organizations allow room for MAID, it is only ever for end of life situations.

Statistics Canada found in 2006 that women with disabilities aged 25 to 54 expressed a very high degree of satisfaction with the quality of their relationships with family and friends and general satisfaction arising from their daily activities.[8.] Research has found that generally speaking, it is not a person's condition that causes the most difficulty in terms of being satisfied with their life, but rather their response to their condition that affects quality of life; being able to adapt effectively and learning practical coping skills for dealing with everyday tasks are generally associated with better quality of life. For this and other reasons, disability advocates have argued for increased supports for people with disabilities, rather than extending the availability of MAID.

[6] Belgium Federal Commission of Control and Evaluation of Euthanasia (2018). *Eighth Report to the Legislative Chambers 2016-2017.* (https://dyingforchoice.com/docs/Belgium_Annual_Report_2016-2017_En.pdf,retrieved November 26,2020)
[7] Regional Euthanasia Review Committees (2020). *Annual Report 2019.* (https://english.euthanasiecommissie.nl/the-committees/documents/publications/annual-reports/2002/annual- reports/annual-reports, retrieved November 26, 2020)
[8] Crompton, S. (2010). *Life satisfaction of working-age women with disabilities.* Statistics Canada, Catalogue No: 11-008-X201000111124.

During her visit to Canada in 2019, the United Nations Special Rapporteur on the Rights of Persons with Disabilities voiced her concern about the implementation of MAID legislation from a disability perspective. She noted that she had heard worrisome claims about persons with disabilities in institutions being pressured to seek MAID. Further, she stated that the *Truchon* decision might put additional pressure on persons with disabilities who are in a vulnerable situation due to the lack of sufficient community support. She recommended that Canada establish adequate safeguards to ensure that persons with disabilities do not request MAID simply because of the absence of community-based alternatives and palliative care.

There are exceptions to the belief that allowing MAID only for those suffering from physical conditions and physical disabilities will have adverse impacts on the disability community. There are experts and physicians who argue that some people living with disabilities feel that allowing them to obtain MAID demonstrates that society values their autonomy.

In 2017, one in five (22%) of the Canadian population aged 15 years and over – or about 6.2 million individuals – had one or more disabilities.[9] The prevalence of disability increased with age, from 13% for those aged 15 to 24 years to 47% for those aged 75 years and over. Overall, women (24%) were slightly more likely to have a disability than men (20%). Disabilities related to pain, flexibility, mobility, and mental health were the most common disability types.

Persons with more severe disabilities (28%) aged 25 to 64 years were more likely to be living in poverty than their counterparts without disabilities (10%) or with milder disabilities (14%). Research has shown that "poverty-and the material and social deprivation associated with it-is a primary cause of poor health among Canadians,"[10] which can negatively affect resilience and mental health. This relationship between disability, poverty and mental health could make individuals even more vulnerable to feel pressure to request MAID as a way to end their physical suffering. This could be compounded by an uneven access to services, thereby potentially increasing negative impacts for certain groups of Canadians, such as those living in remote or rural areas.

Medical assistance in dying and Canadians living with mental illness

Many Canadians have had or do have a mental illness. In 2012, a total of 2.8 million Canadians aged 15 and older, or 10.1% of the population, reported symptoms consistent with at least one of the following mental or substance use disorders: major depressive episode, bipolar disorder, generalized anxiety disorder, and abuse of or dependence on alcohol, cannabis or other drugs.[11] Women have higher rates of mood disorders and generalized anxiety disorder than men, while men have higher rates of substance use disorders.

[9] Morris, S. *et al.* (2018). *A demographic, employment and income profile of Canadians with disabilities aged15 years and over, 2017.* Statistics Canada, Catalogue No:89-654-X

[10] Raphael, D. (2007). *Poverty and Policy in Canada: Implications for Health and Quality of Life.* Toronto: Canadian Scholars' Press Inc.

[11] Pearson, C. *et al.* (2013) *Mental and substance use disorders in Canada.* Statistics Canada, Catalogue No:82- 624-X

It is important to note that the Statistics Canada study that drew these conclusions is likely underestimating the rates of mental illness, as it did not include persons living on reserves and other Indigenous settlements, full-time members of the Canadian Forces, and the institutionalized population, many of whom are extremely vulnerable. Canadians in the lowest income group are 3 to 4 times more likely than those in the highest income group to report poor to fair mental health. In addition, studies in various Canadian cities indicate that between 23% and 67% of homeless people report having a mental illness.

The World Health Organization (WHO) notes that gender determines the differential power and control that men and women have over the socioeconomic determinants of their mental health and lives, their social position, status and treatment in society and their susceptibility and exposure to specific mental health risks.[12.] There are gender-specific risk factors for common mental illness that disproportionately affect women, such as gender-based violence, socioeconomic disadvantage, low income and income inequality, low or subordinate social status and rank and unremitting responsibility for the care of others. The high prevalence of sexual violence to which women are exposed and the correspondingly high rate of Post-Traumatic Stress Disorder (PTSD) following such violence, renders women the largest single group of people affected by this disorder.

The WHO has also noted that gender stereotypes regarding proneness to psychiatric problems in women and alcohol problems in men appear to reinforce social stigma and constrain help-seeking along stereotypical lines.[13.] They are a barrier to the accurate identification and treatment of psychological disorders. This could explain the gender bias that is observed in the treatment of psychological disorders. Doctors are more likely to diagnose depression in women compared with men, even when they have similar scores on standardized measures of depression or present with identical symptoms. In addition, female gender has been found to be a significant predictor of being prescribed mood altering psychotropic drugs.

Gender differences also exist in patterns of help seeking for psychological disorders. Women are more likely to seek help from and disclose mental health problems to their primary health care physician and seek more health care in response to both physical and mental health concerns.

Men are more likely than women to disclose problems with alcohol use to their health care provider. These gender differences may help to explain why women with psychiatric conditions are more likely than men to request MAID in the Benelux countries.[14.] It can be expected that should MAID be made available in Canada for individuals whose sole underlying condition is mental illness, we would see an increase in women seeking MAID for psychiatric suffering, and at younger ages.

[12] World Health Organization. *Gender and Women's Health.* (https://www.who.int/teams/mental-health-and- substance-use/gender-and-women-s-mental-health, retrieved November 26, 2020).
[13] *Ibid.*
[14] Kim, S. *et al.* (2016) *Euthanasia and assisted suicide of patients with psychiatric disorders in the Netherlands 2011 to 2014.* JAMA Psychiatry, 73(4), 362-368.

The greater likelihood of women seeking help for their mental health concerns from their primary health care physician may also partially explain the reason why men are three times more likely to die by suicide than women.[15.] Canadians who are most at risk of dying by suicide include: men and boys, people serving federal sentences, survivors of suicide loss and survivors of a suicide attempt, youth (15 to 24 year olds), some First Nation and Métis communities, especially among youth, and all Inuit regions in Canada.[16.] Thoughts of suicide and suicide- related behaviours are more frequent among LGBTQ2S+ youth in comparison to their non- LGBTQ2S+ peers. This refers to those who identify as lesbian, gay, bisexual, trans, Two-Spirit or queer / questioning youth. Persons with disabilities experience higher than average suicidality in large measure because of how they are not wholly included in some aspects of society.

Expert evidence presented by Dr. Mark Sinyor during the *Truchon* case noted that the phenomenon of suicide contagion has been repeatedly and consistently demonstrated by research.[17.] Contagion in this context means social influence; it refers to the propensity for certain behavior exhibited by one person to be copied by others. There is a very real risk in suicide contagion amongst vulnerable groups following a MAID death, especially if members of the vulnerable group identify with the person who received MAID. In addition, the Chief Psychiatrist at Veterans Affairs Canada has indicated that veterans are affected by suicide more than the general population. Male veterans are 1.4 times more likely to die by suicide than the general population (2.4 times more for those under 25), and female veterans are 1.8 times more likely to die by suicide than the general population. She also noted that the strong degree of identification with each other among veterans places them at risk of imitating suicidal behaviour when they see or become aware of it in other veterans.

In the Benelux countries, where eligibility for MAID is not limited to those suffering physically, there have been controversial MAID deaths that have occurred, and it can be expected that similar cases would emerge in Canada under this option. For example, in the Netherlands, MAID was provided to a patient in her twenties who had been sexually abused as a child because of the emotional suffering she endured following the trauma. There have also been cases of transgender individuals and people who identify as gay obtaining MAID due to the suffering associated with those aspects of their conditions.

It should be noted, however, that there are experts who believe that knowing MAID is an option can provide psychiatric patients with the peace of mind to continue living, and examples of this were presented to the Canadian Council of Academies during their study of MAID in cases where mental illness is the sole underlying condition.

[15] Navaneelan, T. (2010). *Suicide rates: An overview*. Statistics Canada. Catalogue No: 82-624-X

[16] Public Health Agency of Canada and the Mental Health Commission of Canada (2018). *Research on Suicide and its Prevention: What the current evidence reveals and topics for future research.* (https://www.mentalhealthcommission.ca/sites/default/files/2018-12/Research_on_suicide_prevention_dec_2018_eng.pdf,retrieved November26,2020)

[17] Sinyor,Mark.(2018) *Report on the Impact of Expanding Medical Assistance in Dying(MAID) Legislation on Suicide Messaging, Contagion and Prevention.*