



HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

44th PARLIAMENT, 1st SESSION

Special Joint Committee on Medical Assistance in Dying

EVIDENCE

NUMBER 016

Friday, September 23, 2022

Joint Chairs:
The Honourable Marc GarneauThe Honourable Yonah Martin



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• (0845)

[English]

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

Good morning, everyone, and welcome to the meeting of the Special Joint Committee on Medical Assistance in Dying.

I would like to begin by welcoming the members of the committee, the witnesses, and those watching this meeting on the web. My name is Yonah Martin, and I am the Senate joint chair of this committee. I'm joined by the Honourable Marc Garneau, the House of Commons joint chair.

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

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

With that, I would like to welcome our first panel of witnesses who are here to discuss MAID when a mental disorder is the sole underlying medical condition.

We have, as an individual, Ellen Cohen, national coordinator, National Mental Health Inclusion Network. We also have Dr. Cornelia Wieman, deputy chief medical officer. Lastly, from Association des médecins psychiatres du Québec, we have Dr. Guillaume Barbès-Morin, psychiatrist.

Thank you to the witnesses for joining us. We will begin with opening remarks. Each will be five minutes in length, which I will try to carefully time. We will begin with Ms. Cohen, followed by Dr. Wieman and then Dr. Barbès-Morin.

Ms. Cohen, you have five minutes.

Ms. Ellen Cohen (National Coordinator Advocate, National Mental Health Inclusion Network, As an Individual): Thank you, Madam Chair.

Good morning. I hope everyone is well.

My name is Ellen Cohen, and I'm here today as an independent witness willing to share my expertise that is built from my professional and personal experiences.

For over 30 years, I have worked in the mental health consumer sector. I'm a person with mental health challenges and two chronic health conditions, and a family member. I need you to know that there is a lot on the line for me today, and I'm nervous. This is so much larger than all of us. The recommendations that you make to the government can make a big difference for people I support, persons with disabilities and people with mental health conditions living in Canada.

Who is not touched by mental illness? Mental illness affects everyone. People with disabilities make up 22% of the population, and that represents 6.2 million people living in Canada. Among youth aged 15-24 with disabilities, 60% claim to have mental health-related disabilities. All too often, some professionals do not understand that people with intellectual, physical and sensory disabilities can also have mental health conditions that are not related to any disability they may have.

I know that some of the problems where MAID is a major concern for our communities include poverty and lack of food security, safe housing, access to health care, mental health care and addiction services. There is also systemic discrimination—to mention a few.

I was invited onto the panel representing mental health from a disability perspective, which I did. The disability community is diverse, and I know that mental health consumer survivors are divided on the issue of MAID. Despite what was said by Dr. Gupta in her testimony to the members of this committee, I came onto the expert panel with an open mind. As a member of the panel, I was responsible to voice my opinion and to make recommendations for safeguards where mental illness was the sole underlying medical condition in applying for MAID.

Since the beginning of the process, there were challenges, including the composition of the expert panel. It was made up of seven doctors, five or six of whom provided assessments, one palliative care family doctor working with marginalized people, two doctors from the indigenous community, a psychiatric ethicist, two lawyers, two community members from the mental health community, and myself, a member of the disability/mental health community.

From the beginning of the panel, those who were assessors talked about the difficulties they were experiencing with [*Technical difficulty—Editor*] patients in general. They shared about the complications and difficulties of assessment. Those difficulties were not clear to me, nor were they transparent. The assessors also shared about the amount of time needed for each assessment and talked about the fair compensation for the work that is expected of MAID assessors. There was no space made for meaningful discussions on seriously complicated issues concerning decision-making, consent and capacity, accountability, monitoring, privilege, vulnerability. That just did not happen in the context of people suffering with mental health disorders.

When the discussion of mental illness came up, the discussion was shut down, or we moved on. When suggestions were brought forward, panel members were discouraged due to time constraints. When I did suggest something, I was shamed by the only other peer on the panel, stating that having specific safeguards for those suffering from mental disorders was discrimination.

Under Bill C-7, I believe there's a big difference between people requesting MAID for incurable and disabling conditions and those who are requesting MAID for mental illness as the sole medical condition. I ask you this: Is this a lack of resources or bureaucracy? I believe the outcome of the panel was a foregone conclusion. It became clear that some of the expert panellists had very little appetite to make any attempt at recommendations regarding the addition of legislative safeguards for any amendments to Bill C-7 with regard to mental health disability.

● (0850)

After reading the Quebec decision and giving it some thought, it became obvious to me that there were too many unanswered questions and issues in determining and assessing requests for track two patients without adding to it the request from people with mental illness, which will be available come March 2023, so I left the panel.

Through this whole process, there was limited discussion about mental illness as the sole mental condition for requiring MAID. The process was rushed. Seven months from our first meeting was not enough time to decide about life and death. It was not enough time to consult with the community that Bill C-7 is endangering. I would like to point out that this parliamentary process is also being rushed.

Thank you for allowing me to share my story.

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

Next we will hear from Dr. Cornelia Wieman.

● (0855)

[*Translation*]

Dr. Cornelia Wieman (Psychiatrist, As an Individual): *Boozhoo, aaniin*, good morning, bonjour.

[*English*]

I would like to thank the joint chairs, vice-chairs, members, honourable senators and members of Parliament for the invitation to appear before you.

My name is Dr. Cornelia “Nel” Wieman. I'm originally from Little Grand Rapids First Nation in Treaty 5 territory, Manitoba, part of the Anishinabe nation. I now live, work and play in the traditional, unceded, ancestral and continually occupied territories of the Coast Salish people, including the Musqueam, the Squamish and the Tsleil-Waututh nations.

I'm the first indigenous woman in Canada to train as a psychiatrist, and I have over 20 years of experience in clinical practice in a variety of settings, including rural, on reserve, urban and in tertiary care emergency psychiatry departments. It would be difficult to quantify how many psychiatric assessments I have conducted over more than two decades, though I would estimate, at a minimum, several thousand.

I most recently completed a six-year term as the president of the Indigenous Physicians Association of Canada and currently serve as the deputy chief medical officer at the First Nations Health Authority in British Columbia. However, I'm not speaking to you today in either of those leadership capacities. I am providing my testimony as an individual, as a psychiatrist and as a member of the expert panel on MAID and mental illness that tabled our final report in May of this year.

I will highlight a few key messages in these opening remarks and then look forward to further discussion in the Q and A period to follow. Section 1.5 of the final report of the expert panel says:

Indigenous peoples in Canada have unique perspectives on death which need to be considered in the context of the emergence of MAiD including MAiD MD-SUMC. However, engagement with Indigenous peoples in Canada concerning MAiD has yet to occur.

Hearing from additional witnesses, including myself, cannot be considered to be a fulsome consultation with first nations, Métis or Inuit. Perspectives on MAID are on a spectrum. I have heard of medically assisted deaths occurring in first nations communities that are grounded in ceremony, where the whole community is aware of what is happening and the dying person is drummed into the next world. On the other end of the spectrum are those who are still acutely distressed by their individual experiences of historical, intergenerational and contemporary traumas. Their view of MAID is that it essentially amounts to genocide.

This becomes even more complicated when we consider MAID in the MD-SUMC category. There is the potential for the spread of misinformation, as we have seen during the COVID pandemic, to the extent that some people believe indigenous youth who are suicidal will be able to access MAID. We all know that would not be allowed to happen, but these are reasons why broader engagement is necessary.

Last, I will note the fatigue of first nations communities associated with engagement and consultation, speaking from my experience in British Columbia. There has been so much going on over the past several years that communities have had to contend with that asking for further consultation at this time on a highly charged topic such as MAID in general, and MAID MD-SUMC specifically, is daunting. First nations communities are more likely to want to discuss the youth suicide crisis than MAID MD-SUMC, and yet they must be consulted.

This committee has no doubt heard from other witnesses or is aware of some of the challenges that many indigenous people face in terms of the social determinants of health placing them in situations of vulnerability. Having a mental illness, living in inadequate or unstable housing, being underemployed or unemployed, and experiencing food insecurity can all contribute to physical and mental suffering, and assessments for MAID MD-SUMC will have to grapple with trying to tease out this type of suffering from that related to an incurable, irreversible mental disorder. How can the suffering be alleviated, especially in rural and remote settings where health and social services programs and resources are already scarce and inadequate?

Some of these issues are summarized in a statement from the expert panel's final report:

As a result of the creation of laws that provide access to MAiD, concerns have been raised by Indigenous leaders and communities that it is easier for people in their communities to access a way to die than to access the resources they need to live well.

● (0900)

In the interim report of the special joint committee from June 2022, I note some discussion on the issue of access to health services, in reference to all Canadians, including indigenous people in Canada, having equitable access both to MAID assessments if requested and to the health care services and programs they may need to prevent irremediable suffering. However, we must expand our understanding of “access” to mean not just having a health care professional team or services available to provide care in a reasonable amount of time. Medical care and attention can be impeded by people choosing not to access services because of, in this instance, anti-indigenous racism and discriminatory treatment. Indigenous people choose not to access health services out of a fear of how they will be treated. It will be imperative that cultural safety is assured in clinical care related to MAID and MAID MD-SUMC. This would include having access to both western medical and traditional healing and supports.

I thank you again for the opportunity to participate in the session today. I look forward to our discussion and encourage you to continue to seek out the perspectives of first nations, Métis and Inuit peoples and organizations in the work of this committee.

Thank you. *Meegwetch.*

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

Lastly, we'll have Dr. Barbès-Morin.

[*Translation*]

Dr. Guillaume Barbès-Morin (Psychiatrist, Association des médecins psychiatres du Québec): Good morning, members of the committee.

I think it is appropriate for me to address you in French.

My name is Guillaume Barbès-Morin and I am a psychiatric physician. I appear before you today as a representative of the Advisory Committee on Medical Assistance in Dying of the Association des médecins psychiatres du Québec. I have been working for 16 years as a general psychiatrist in a small community in north-western Quebec near the Ontario border, called Rouyn-Noranda. It is a small community of 45,000 people, far from Montreal, Toronto and Ottawa.

I work with a general clientele consisting of both adolescents and people at the end of life, in a variety of clinical settings such as emergency rooms, hospitals and outpatient offices. I assess, at the request of their primary care physician, people with simple problems, as well as people experiencing extremely serious problems and who need support, medical follow-up, and lifelong care.

I am also asked to sometimes act as a consultant in situations where people request medical assistance in dying and we're trying to determine if their mental state is interfering with their ability to make decisions. That's a clientele I'm familiar with as well.

I would like to present to you the position of our association's Advisory Committee on Medical Assistance in Dying.

First, it is essential for us that all stakeholders understand our role, which is not to promote medical assistance in dying in general, or when a mental health problem is the only medical problem at issue. As a matter of fact, we emphasize that there is no clinical justification for routinely refusing all requests for medical assistance in dying from individuals whose only medical condition is a mental health problem. In our opinion, people with such problems deserve to have their suffering heard and assessed, even in the context of medical assistance in dying. At the same time, we are very sensitive to the fact that this must be done properly, as all the committee's work demonstrates.

It is also fundamental for us to make clear that medical assistance in dying should never be considered an alternative to accessible and adequate mental health services.

On the other hand, I would like to mention one important element. In our view, the complexity inherent in such problems is not new. It is already well known to physicians who currently evaluate situations involving medical assistance in dying. These situations involve people who are often already very vulnerable in social and other ways. The vulnerability of people with mental health problems is not something new. Mechanisms already exist to take this into consideration, and clinicians already surround themselves with multidisciplinary teams to try and best assess all of the relevant factors.

It is also very important for our committee to make it clear that the mental health issues targeted by requests for medical assistance in dying are in fact very serious mental illness issues. For us, it is important to make a clear distinction between psychological and mental suffering, which is very present everywhere in our society, and serious mental illness. The latter is a very specific and fortunately very rare thing. In our opinion, it is important to make a clear distinction in all this.

I went through the exercise of trying to determine what proportion of my patients, in the course of my personal practice, might have been eligible for medical assistance in dying under recognized criteria. Of the hundreds of patients I've assessed in my 16 years of practice, I would say that only three or four could have been eligible. We are talking about people who were suffering from extremely serious problems. Unfortunately, they couldn't find relief in all the treatments we had to offer that were available to them. I remind you that we are talking about very serious cases here, which are fortunately very rare.

That is the point I was trying to make. I'll be happy to answer your questions.

• (0905)

[English]

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

Thanks to all of our witnesses for lending us their important recommendations and insights on a very complex and difficult matter such as MAID.

We'll go to our first round of questions. I remind members that each of you will have five minutes, unless you're sharing your time.

For the first round, we have Mr. Barrett for five minutes.

Mr. Michael Barrett (Leeds—Grenville—Thousand Islands and Rideau Lakes, CPC): Thanks very much, Madam Chair.

Thank you to the witnesses for joining us this morning and for providing us with their testimony.

I'd like to ask Ms. Cohen some questions.

Good morning, Ms. Cohen. How are you doing?

Ms. Ellen Cohen: Good morning. I'm very nervous.

Mr. Michael Barrett: I appreciate that it can get one's nerves up when speaking with a joint committee of Canada's Parliament, but you're here as our guest and we're very interested in what you have to say.

I'd like to zero in on your comments about safeguards. During your time on the expert panel, what were the safeguards you recommended?

Ms. Ellen Cohen: One thing I felt strongly about is the fact that mental health legislation across Canada varies. In Canada, our mental health legislation allows for people to be legally held against their will and treated because of their illness. I think this needs to be looked at. I understand that you're the federal government, but I believe that, if the intention is to move forward with MAID as a treatment for mental illness, we really need to, as a country, look into the mental health legislation to ensure that the coercive situations and behaviours implied in the legislation are dealt with. We are people, and we need to be treated as such. We need to have laws that protect us, not laws that harm us.

I repeatedly raised concerns about MAID in this context, and I was not at all satisfied with the answers I received. There was really no space for any discussion about it.

Mr. Michael Barrett: What were the answers you received? That is to say, why were your recommendations rejected?

Ms. Ellen Cohen: I understood it's because there are jurisdictional issues. I understand it's not Canada's responsibility; however, Canada does have the wherewithal to move forward to do something.

In B.C., there's an organization funded by the B.C. law society to look into the mental health legislation in British Columbia. This came about as a result of the UN rapporteur for persons with disabilities' scathing report on Canada's MAID regime, as well as mental health situations occurring in B.C.

• (0910)

Mr. Michael Barrett: What were the safeguards recommended by the expert panel?

Ms. Ellen Cohen: There were none. I don't believe there were any safeguards recommended. They—

Mr. Michael Barrett: Why do you think that is?

Ms. Ellen Cohen: The expert panel ultimately ended up recommending that, if a person is in a situation of involuntary confinement, it would be okay if, after six months, they wanted to apply for medical assistance in dying. They could do so. On one hand, we have the provincial government saying you cannot choose to be free, and, on the other hand, we have the federal government offering medical assistance in dying as a treatment.

Mr. Michael Barrett: The last thing I want to touch on, quickly, is your resignation from the panel. Dr. Gupta told our committee that, despite your initial willingness to participate, you realized that, given your public opposition, you couldn't reconcile your personal position with the work of the panel.

Is that accurate?

Ms. Ellen Cohen: No, it's not at all.

From my first conversation with Abby Hoffman and Karen Kusch, I came into this saying that I do have problems with it; however, my community, the mental health community, the consumer movement, is very split by this. I have friends and family members who definitely believe that medical assistance in dying should be allowed for people who are prepared and who are ready to do it.

I've never said that I'm against medical assistance in dying for people with mental illness; however, that being said, vulnerable people, the majority of people with mental illness, live in poverty. We're talking about the upper-middle class and privileged people who may be applying for medical assistance in dying because of their mental illness.

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

We are a little bit over on that. Thank you very much.

Mr. Michael Barrett: Thank you.

The Joint Chair (Hon. Yonah Martin): Next we will have Monsieur Arseneault.

[*Translation*]

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

Ms. Cohen, you said at the outset that testifying before us today made you very nervous. I can assure you that everyone here around the table is relatively nervous at the prospect of raising this sensitive subject before witnesses with so much experience. So I congratulate all the witnesses for being here today.

My first question is for Dr. Wieman.

[*English*]

Dr. Wieman, can you speak about the experience of the B.C. First Nations Health Authority in the area of MAID? Are you able to share any best practices or guidelines that the First Nations Health Authority has adopted with respect to MAID?

Dr. Cornelia Wieman: I should probably clarify that the First Nations Health Authority, in many cases, is not a direct medical service provider; however, we work in partnership with our regional health authorities.

We have most recently formed an internal steering committee to examine, look at and monitor the provision of MAID assessments and MAID itself in our province, although that work is just in the early stages. We have a couple of clinical nurse specialists who work for us in the office of the chief nursing officer, and they have liaised with MAID service providers to first nations people in British Columbia. That's, for example, where I have heard of several first nations people in British Columbia accessing MAID who met the eligibility criteria. The safeguards were in place, and they did receive a medically assisted death.

These are the positive examples, and, as I mentioned, of course that must be balanced with other people's hesitation and perhaps not being aware of medically assisted death in general, particularly when it comes to a mental disorder as the sole underlying medical condition coming up in terms of seeking a medically assisted death. That work really is ongoing.

I would say, from my experience on the panel, however, that one of my fellow panel members, also an indigenous physician, Dr. Sara Goulet, a MAID assessor and provider, described quite a terrific team—I can't think of a better word than “multidisciplinary”—that does not just provide MAID assessments in larger urban centres, but in fact travels to remote places to conduct MAID assessments and provision.

• (0915)

[*Translation*]

Mr. René Arseneault: Thank you very much.

My next question is for Dr. Barbès-Morin.

Paragraph 241.2(1)(c) of the Criminal Code stipulates that to be eligible for medical assistance in dying, a person must “have a grievous and irremediable medical condition.” This means “enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable”, as the Code further states.

Are there treatments for some illnesses or mental health problems that the patient may consider unacceptable, but that could relieve intolerable suffering?

Dr. Guillaume Barbès-Morin: That's an excellent question. It's one of the points we tried to clarify in our paper.

There are indeed some extremely invasive types of treatments in psychiatry. One example is implanting a vagus nerve stimulator. This is a device implanted in the brain. Some people might decide that it's too invasive for them. That should be clarified.

We have access to a fairly broad set of psychiatric treatments in Canada. I would say that in general, people hesitate because of a misunderstanding or misinformation. Take the example of electroshock, also known as sismotherapy. This treatment is extremely effective for major depression and is used regularly, but it carries significant social stigma. Often, people who are misinformed will refuse it. Personally, I offer this treatment to certain patients. When you take the time to sit down with them and adequately explain its usefulness, they usually understand it well.

Sometimes, an individual refuses treatments like those because they deem them unacceptable. Generally, however, it is possible to walk them through it, thoroughly illustrate the benefits these treatments can provide, and explain how tolerable they are compared to all the treatments available in physical medicine, which are often very invasive as well.

Mr. René Arseneault: That's all the time I have.

Thank you.

[English]

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

Next we'll have Mr. Thériault for five minutes.

[Translation]

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

I'll start with Ms. Cohen.

Good morning, Ms. Cohen. Welcome to the committee.

I am somewhat perplexed. I understand that you left the Expert Panel on Medical Assistance in Dying and Mental Illness. However, I'm sure you read the final report.

On page 10, assessing the capacity to consent to care, it reads: “[W]hen the assessment is so difficult or uncertain that the clinicians involved cannot establish that a specific individual is capable of giving informed consent, the intervention is not provided to that individual.”

Further, on page 11, the report examines crises involving suicidality: “In any situation where suicidality is a concern, the clinician must adopt three complementary perspectives: consider a person's capacity to give informed consent or refusal of care, determine whether suicide prevention interventions—including involuntary ones—should be activated, and offer other types of interventions which may be helpful to the person.”

When reading this report, it's very clear that anyone with mental disorders or personality disorders, who is suicidal and in their 20s, for instance, would have to wait several decades before someday having access to medical assistance in dying, after having tried the entire range of possible therapies. Indeed, an assessment would be needed at that time to determine if they could have access.

What do you think of this part in the report? Are you for or against what it says?

• (0920)

[English]

Ms. Ellen Cohen: I'm not really understanding the question. The report talks about alternative supports and alternative therapies and young people. I think that's good, and I think people should be offered supports, but it's not always just mental health supports and services. Any access to those services doesn't come that quickly. There are waiting lists. There are a million reasons why people don't access services and supports.

I didn't really understand your question. I understand that there were a lot of suggestions about offering people supports and services. However—

[Translation]

Mr. Luc Thériault: Excuse me for interrupting, but I'd like to move on to another witness. It's not a problem if you didn't understand my question.

Dr. Barbès-Morin, some members of your association claim there's always a treatment to relieve suffering. Many oppose offering medical assistance in dying, since incurability is not necessarily a foregone conclusion in many cases.

In your opinion, does claiming that there's always a treatment to relieve suffering and asserting that there's no need for medical assistance in dying amount to medical paternalism, or a kind of therapeutic obstinacy in psychiatric practice? This was said in Quebec.

[English]

The Joint Chair (Hon. Yonah Martin): Answer very briefly, Dr. Barbès-Morin.

[Translation]

Dr. Guillaume Barbès-Morin: I would answer that the same concern exists in physical medicine. This might be the perception among doctors treating various neurological conditions and different disorders. I don't want to pass any judgment on their level of paternalism.

From my personal clinical experience, I can tell you about situations where people had appropriate and sustained access to an array of incredible treatments and, unfortunately, they continued to perceive their suffering as intolerable.

I think we should recognize their autonomy and their capacity to judge their situation. Of course, I am not talking about cases of suicidality. However, in general, people who are suffering are capable of assessing it and deciding what they want for their lives. We have to listen to them.

This is not unique to mental illness; it is the same in physical medicine.

[English]

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

Next I have Mr. MacGregor for five minutes.

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

Thank you to our witnesses for helping guide this committee through a very serious subject matter. It's one that I know many Canadians are paying attention to.

Ms. Cohen, I'll start with you. I appreciate that you are nervous appearing before a parliamentary committee, but I can assure you that all members around this table do appreciate your being here. We want to make this as comfortable as possible for you.

When you were talking in your opening statement about how this process has been rushed, I can understand the fears that you have with the timeline. This joint committee did exist in the previous Parliament, but it had to be reconstituted in the 44th Parliament. We've really only been under way since April. We've been working with less than a year, until March of next year, when the law will be changed and mental disorder as a sole underlying condition will be allowed under our Criminal Code.

You also made it very clear that you are not opposed to medical assistance in dying, but that you had very real concerns that there were no meaningful discussions on capacity, on vulnerabilities and on specific safeguards. Therefore, given that our committee is ultimately tailoring a report with recommendations to the federal government, do you have any comments specifically on...? Should we recommend that the March deadline be pushed back? What additional steps would you specifically like to see the federal government take in addressing the concerns that you have so clearly outlined in your testimony?

• (0925)

Ms. Ellen Cohen: First, I would like to see the government push the deadline back because it's unrealistic. I signed on in June and we didn't start our first meeting until the end of August, so it was rushed. I understand that your panel and this process is being rushed as well. I'm not sure what the hurry is.

I know that we made many recommendations. Dr. Wieman remarked on Dr. Goulet's experience in Manitoba as a MAID assessor. We talked about teams. She talked about having a great team. I think there needs to be some kind of thought into how people....

It's difficult for doctors, as I understand, as well. I clearly understood that as I was sitting at the panel. I understand the difficulties, but I think that if the government is going to move forward, they need to help support the medical community to develop the processes collectively. There needs to be a standard across the country so that things don't go off course.

Mental health legislation went off course. Every province does it differently. What I witnessed in Bill C-14 was that every province monitored differently and some of the provinces had "unknown" categories. Way too many people were dying from unknown—

Mr. Alistair MacGregor: Thank you for that.

I'm terribly sorry to interrupt.

Ms. Ellen Cohen: That's okay.

Mr. Alistair MacGregor: I think you gave some great points there, but I do have limited time and I want to get one question in to Dr. Wieman.

Dr. Wieman, thank you for joining our committee. I also hail from British Columbia. My riding of Cowichan—Malahat—Langford has a very large indigenous population. I very much understand the intergenerational trauma that exists among indigenous nations in my riding.

You have very clearly identified that broader engagement is necessary. Again, under the theme of us working with this March date that is rapidly approaching us, what, in your mind, does adequate consultation look like? What concrete steps should the federal government start with in this engagement process?

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

Dr. Cornelia Wieman: Thank you for your question. I think a large part of what needs to be done in terms of engagement is listening to first nations, Métis and Inuit groups. I know that you've had some representation here at these committee hearings, but in my opinion, that probably is not sufficient.

I think a large part of it, as I referred to in my opening remarks, has to do with communications. Indigenous people in Canada deserve equal access to medical services. That includes having access to MAID assessment and provision. But as I mentioned, those misunderstandings and misperceptions need to be clarified for people. That, I think, would go a long way toward alleviating some of the concerns that come out of those misperceptions.

• (0930)

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

I will turn this over to my co-chair so that we can go to our round of questions from the senators.

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

[*Translation*]

We will now start with senators' questions.

As Senator Kutcher is not here, his speaking time has been given to Senator Mégie. She has six minutes and I give her the floor.

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

I thank all the witnesses who came today to enlighten us about their work.

My first question is from Senator Kutcher, and it is for Dr. Barbès-Morin.

Does your association agree with the expert panel's conclusion?

Dr. Guillaume Barbès-Morin: Could you specify which expert panel conclusion you are referring to? I am sorry, I don't follow exactly what this is about.

Hon. Marie-Françoise Mégie: Senator Kutcher did not specify the exact conclusion. Could you speak generally about the conclusions and recommendations made by the expert panel and the direction of the report?

Dr. Guillaume Barbès-Morin: I am sorry, but I cannot answer that question on behalf of my association, as we have not discussed it specifically.

Hon. Marie-Françoise Mégie: In that case, I will focus on a specific point. According to the expert panel, there's no need for measures to safeguard people whose request for medical assistance in dying stems solely from a mental health problem. Does your association agree?

Dr. Guillaume Barbès-Morin: In our report, we did propose a process to follow, a way of setting up safeguards to make sure that the assessment is done appropriately. I imagine it would vary somewhat from province to province, as there are some differences. In our view, two psychiatrists must be involved in that assessment, for example. We've also defined minimum timeframes and guidelines to apply to proposed treatment.

I cannot tell you to what extent these protections or safeguards will ensure appropriate assessment. Regardless, we suggested a structured approach for assessment to make sure that things are done appropriately.

Hon. Marie-Françoise Mégie: You're a psychiatrist in Rouyn-Noranda. In similar regions, do you think there's sufficient access to psychiatrists?

Dr. Guillaume Barbès-Morin: That depends on the region we're talking about. Whether or not there are enough psychiatrists is a constant issue as people come and go. I'm sure it's the same throughout Canada.

I think that access to services and care is an extremely important issue which must not be resolved at the expense of medical assistance in dying. All of Canada's health systems should prioritize access to services and care. We must make sure that people with needs have access to services. That's true in every region. Speaking from what I know, I would say that in some sectors of Montréal, it is currently very difficult to get access.

Medical assistance in dying is for people who, in general, have had very serious and chronic disorders for quite some time. They've often had access to many quality services throughout their lives. This should not change. People with a serious mental illness must continue to have access to quality services throughout their lifetime, so that they can get the fastest and best relief possible.

Although related, this issue is different. It transcends medical assistance in dying, in my opinion, and remains fundamental.

● (0935)

Hon. Marie-Françoise Mégie: My next questions are for Dr. Wieman.

You mentioned medical assistance in dying being grounded in ceremony. As time grows short, could you speak briefly about some of those ceremonial aspects?

You also said that indigenous communities perceived medical assistance in dying as genocide. If someone were to express these thoughts in your office, as part of the doctor-patient relationship, how would you discuss it with them? Would you let them leave with this perception of genocide, or would you try to further inform them about medical assistance in dying?

[English]

Dr. Cornelia Wieman: Thank you for those questions. I will try to be brief.

For example, for first nations individuals who are accessing a medically assisted death, it is up to them to decide how they would like that to proceed. For some people, that may involve including part of their culture and ceremony into that process. As I spoke to in my opening remarks, I have heard some case studies of MAID being delivered to first nations individuals in British Columbia where the person did want aspects of ceremony included. In fact, the community was aware, since many of our communities in British Columbia are quite small, that this was happening on that particular day. It is one example I gave that gives some idea of what a medically assisted death could look like for a first nations person.

Additionally, to the second question, I have spent most of my career working with indigenous patients, as I mentioned, in a variety of settings. The first thing I try to do when I meet patients is hear where they're coming from. I think that's part of delivering culturally safe care. Of course, I would hear a concern such as a worry that someone would not be considered to be eligible for accessing a MAID assessment or provision. I would hear out their concerns, because their concerns are valid. They're coming from their point of view. Then I would obviously be able to spend some amount of time trying to provide the correct information or to correct misperceptions: Medical assistance in dying, particularly for those with mental disorders, is not a form of genocide.

There are people who are truly suffering and whose conditions, as Dr. Barbès-Morin mentioned... Both of us, I think, have similar experiences. In my decades of working in psychiatry, there are very few individuals I can think of, probably fewer than 10, who I would think, based on my knowledge, would qualify for a medically assisted death under the MD-SUMC category.

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

[Translation]

We will continue with Senator Dalphond for three minutes.

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

I thank the witnesses for being here.

Since I only have three minutes, I will address my questions to Dr. Barbès-Morin.

Reports from officials in the Netherlands and in Belgium show that medical assistance in dying is granted in at most 1% of cases of mental illness. They are therefore exceptional cases.

You spoke of your 16 years of experience [*technical difficulties*] are, however, worried...

The Joint Chair (Hon. Marc Garneau): Senator Dalphond, we lost sound for a moment. Could you ask your question again please?

Hon. Pierre Dalphond: Reports from officials in the Netherlands and Belgium show that medical assistance in dying is granted in at most 1% of cases of mental disorders.

You estimated that three or four of the patients you've treated during your 16 years of practice could have been eligible for medical assistance in dying, based on current Criminal Code criteria.

However, others who testified before our committee said that they had concerns about it. In their view, medical assistance in dying would be too readily available to someone who is depressed or going through a difficult time, who has lost their job, who is unemployed, or who is experiencing economic hardship.

Do you think that federal standards are required to ensure consistency in this area and ensure that medical assistance in dying is only provided in the most serious cases? Or do you think that medical and professional practice is sufficiently structured to ensure such an outcome?

• (0940)

Dr. Guillaume Barbès-Morin: With respect to the federal-provincial challenge of managing uniform standards across the country, I am sorry, but I do not have the expertise to judge which standards are preferable and whether it is better to respect the provinces' views.

Originally, medical assistance in dying was implemented in Quebec. The rest of Canada then followed, but things evolved differently, which explains the disparities that exist today. I don't want to comment too much on that.

I think a framework is needed to set some fairly clear parameters, particularly in terms of assessment. We need to know what to assess, what we are assessing, what parameters to use and what values are assigned to those parameters, including initiation and duration of treatment.

To the best of my knowledge, this framework already exists in some form in the current legislation. As suggested, however, it needs to be adjusted somewhat to take into account certain characteristics related to mental health issues.

Hon. Pierre Dalphond: If I understand correctly, psychiatric medical practice is capable of setting these standards.

Dr. Guillaume Barbès-Morin: Indeed, psychiatric practice is capable of assessing the presence of a mental disorder and its severity, as well as establishing if this is an isolated moment of crisis or not. In general, we work with multidisciplinary teams.

That is already the case, and it should remain so for this type of situation. Assessing capability is already something that we are able to do in cases of grievous mental disorder. Psychiatric medical practice is therefore able of doing so.

Hon. Pierre Dalphond: Thank you.

The Joint Chair (Hon. Marc Garneau): Thank you, Dr. Barbès-Morin and Senator Dalphond.

[English]

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

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

On my first question, I think I'll go to Dr. Wieman.

We've had, I would say, conflicting testimony over the months, perhaps even years, on this issue, with some parts of the indigenous community thinking that medical assistance in dying is an attempt at genocide.

You're presenting another case, on how we need the ability to incorporate traditional practices or rituals into the process for indigenous individuals. Can you give us some sense...? I know this is a hard one to do, but from the indigenous population in general, would you say there is cultural resistance or not? Could you quantify whether it's fifty-fifty, or sixty-forty?

Dr. Cornelia Wieman: Thank you for the question, Senator.

I'm not able to quantify.

What I believe, in a couple of short statements, is that first nations, Métis and Inuit people deserve equal access to any medical treatments and procedures that are available to any other Canadians in this country, including MAID, and for those suffering from mental disorders.

However, I think the issue, the conflict, comes from people's understanding of what that is and the pathway that someone must undertake to access a medically assisted death, for MAID in general and MD-SUMC specifically. I think people misunderstand, for example, the ease with which a medically assisted death might be obtained. That is clearly not the case. There are existing safeguards in the legislation.

I think that balance needs to somehow be found. That is why I was saying it's going to be found by having an engagement strategy and a communications strategy, probably nationally and provincially, so that people understand, because my concern—

• (0945)

Hon. Pamela Wallin: Do you mean something specific to the indigenous community?

Dr. Cornelia Wieman: That's correct. My worry is that there are people who are suffering in our communities and who have a right to access a medically assisted death but are not able to, because of the level of misunderstanding and misperception in some communities.

Hon. Pamela Wallin: Thank you.

So this is—

The Joint Chair (Hon. Marc Garneau): Thank you, Senator Wallin. I'm sorry. Time flies.

Senator Martin, you have three minutes.

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

Thank you to all the witnesses once more.

Ms. Cohen, I wanted to come back to your experience on the expert panel and the fact that you felt it was definitely rushed and the deliberations were restricted.

Your voice is missing from that report, since you stepped down, but what are some of the recommendations around monitoring and accountability that you would have liked to see in the report?

Ms. Ellen Cohen: As for monitoring, ultimately we need to make sure that people's experiences are being documented correctly. We need to understand and make sure that people who are choosing MAID because they have no other choice have their stories told, and that we don't skip over those kinds of stories. It's really important to ensure that.

Monitoring is a way for us to record and to manage the delivery of MAID. If we're not managing and we're not telling people's stories, we are not going to be able to understand why people are making the difficult choice of MAID over life, and what those reasons are.

The Joint Chair (Hon. Yonah Martin): Yes. What about the concerns that you have raised around the capacity to consent, particularly in the context of patients suffering from a mental disorder being hospitalized and treated against their will?

Ms. Ellen Cohen: Quite often, people who are put into hospital against their will are treated and come out, and I think it's wrong to be.... In my opinion, people are being treated unfairly. If somebody is ill and they go into hospital, they shouldn't have to be told that they have to stay there because of....

I'm not really being clear. I'm sorry. I'm a bit overwhelmed.

The Joint Chair (Hon. Yonah Martin): You have answered a lot of questions for us, so thank you very much.

I don't think I have enough time for a third question, but thank you.

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

I'll now return the chair to Senator Martin.

The Joint Chair (Hon. Yonah Martin): This concludes our first panel. Again, we want to thank our witnesses for their testimony and for answering all of our questions. We wish that we had more time with each of you, but thank you very much.

We'll now suspend while we prepare for the second panel.

Thank you.

• (0945) _____ (Pause) _____

• (0950)

The Joint Chair (Hon. Yonah Martin): We are ready to resume, colleagues.

I have just a few comments for the benefit of our new witnesses.

Before speaking, please wait until I recognize you by name. All comments should be addressed through the joint chairs. When speaking, please speak slowly and clearly. Interpretation in this video conference will work like at an in-person committee meeting. You have the choice, at the bottom of your screen, of floor, English or French. When you are not speaking, please keep your microphone on mute.

We'd now like to welcome both of the witnesses on our second panel, who are also here to discuss MAID when a mental disorder is the sole underlying medical condition. They are, as individuals, Ms. Justine Dembo and Dr. Natalie Le Sage, physician, clinical researcher and MAID provider.

Thank you, both, for joining us this morning.

We will have your testimonies of five minutes each—first Ms. Dembo, followed by Dr. Le Sage—and then we will go into our first round of questions.

Ms. Dembo, the floor is yours for five minutes.

Dr. Justine Dembo (Psychiatrist, Medical Assistance in Dying Assessor, As an Individual): Thank you. I'm honoured to have been invited today to speak with the joint committee.

I'm a psychiatrist at Sunnybrook Health Sciences Centre in Toronto and an assistant professor at the University at Toronto. I've been a MAID assessor since 2015.

I've been engaged in MAID research since before Carter, and I have been teaching psychiatric residents and medical professionals, including MAID assessors and providers, about MAID on a regular basis. I'm currently part of the development of two MAID curriculum modules through the Canadian Association of MAiD Assessors and Providers. I was an expert witness for the Truchon and Lamb cases. I was also a member of the government expert panel.

I'm speaking today as an individual, independent of my involvement with these organizations, so the opinions I'm presenting are completely my own. I'm hoping to focus on a few important points.

First, I would like to emphasize that many committee members may be receiving incorrect information about how the MAID process actually unfolds on the ground. You may have been given, by some individuals who are not involved in MAID assessment or provision, false information regarding the degree of rigour and caution exercised by assessors and providers, as well as about the degree of care these medical professionals put into their work and the efforts they make to improve the quality of life of MAID requesters. I'm happy to walk you through how I approach MAID assessments if you ask that of me today.

I urge you to be cautious in accepting comments about the MAID process by individuals who are not involved in the process directly. I urge you to remember that MAID assessors and providers are conscientious individuals who care about life and quality of life. They do not proceed unless, after a thorough evaluation, they are satisfied that a patient clearly meets all criteria and that proceeding is the right thing to do. All of us are doctors and nurse practitioners who entered medicine in order to help people and who remain deeply committed to that.

I can speak only for myself, but I am part of a network of other MAID assessors and providers. I have been witness to the immense efforts my colleagues make to ensure that they are leaving no stone unturned in their attempts to find other ways to help alleviate a patient's suffering and in their efforts to ensure that patients are making a fully autonomous and capable choice that is free from coercion.

Many of my track two assessments—that is, for patients who do not have a reasonably foreseeable natural death—proceed over the course of months to years, with multiple visits and with the implementation of additional supports, interventions and sometimes very creative attempts at improving quality of life.

Second, I am also concerned that the committee members have heard that MAID is being used as an alternative to the implementation of either better medical care or psychosocial supports such as housing. I did address this concern in detail in the brief I submitted to you on May 9, 2022. I urge you to review that brief.

For the moment, I will simply say that to phrase it in this way creates a false dichotomy. MAID is never a substitute for medical care or housing. Someone who requests MAID must be assessed in the totality of their circumstances, which requires taking into account issues such as whether a lack of adequate medical care or housing is contributing to the request. The safeguard requiring irremediability of the condition relates to this matter. I urge you to review the government panel report's section on grievous and irremediable medical conditions, as I fully stand behind the recommendations we made.

The panel report states that MAID assessors should establish incurability and irreversibility with reference to treatment attempts made, the impacts of those treatments and the severity of the illness, disease or disability. The panel also states that, as with many chronic conditions, the incurability of a mental disorder cannot be established in the absence of extensive attempts at interventions with therapeutic aims. This means that someone who has not had access to adequate care would not be eligible for MAID. Therefore, MAID could never be used as a substitute for good psychiatric care.

The panel recommendations were intended to build upon the strength of the already-existing safeguards and guidelines, and I believe they do just that.

I'm going to add that I strongly disagree with an earlier witness that there was no space for meaningful discussions about vulnerability. In fact, the panel discussed vulnerability at great length. The panel recommendations add additional guidance and protocols and provide detailed interpretations of the currently existing criteria. This will help guide assessors and providers to understand better how to follow the law, with respect to both MAID in general and MAID in sole mental illness. Following these guidelines would ensure an extremely comprehensive, thorough and cautious approach.

Thank you so much for your attention. I'll stop there and I welcome your questions today.

● (0955)

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

Next we will have Dr. Le Sage.

[*Translation*]

Dr. Natalie Le Sage (Physician, Clinical Researcher and Medical Assistance in Dying Provider, As an Individual): Thank you so much.

I would like to start out by thanking the committee for inviting me to give testimony for your important study.

I have practised and taught emergency medicine for over 30 years in a teaching hospital that had a psychiatric ER unit. I am also a clinician-scientist, and I was a member of the research ethics committee of the same hospital for seven years. I am therefore well aware of the notions of capacity to consent to care, of suicidal risk, of informed consent and the right to self-determination. I am now at the end of my career and my practice almost exclusively consists of providing medical assistance in dying.

At the ER unit, I was called upon to evaluate hundreds of patients suffering from mental disorders who were at crisis point. I remember one patient who was receiving excellent support from multidisciplinary teams within our system, but for whom effective treatment options were limited. At one point, she started to suffer from major health problems and decided to refuse treatment. This was not enough, unfortunately, and she took her own life after suffering for many years. Perhaps she could have had a more serene death.

My time as a member of the ethics committee was also an enriching experience. I think that the current debate is similar in many ways to research ethics. It seems that by claiming to protect vulnerable populations, we ignore them or exclude them from the accepted rules that apply to the general population. Paradoxically, we find ourselves discriminating against them, which by definition is contrary to our ethics.

The current law already establishes conditions for eligibility to medical assistance in dying, and these conditions could very well be applied to mental disorders. Of course, in cases where a mental disorder is the sole underlying medical condition, we do see some difficulties in applying the rules, especially when it comes to establishing capacity, incurability and irreversible decline. Moreover, it is not always easy to distinguish between suicidal ideation and a reasonable request for MAID.

In those cases, what conditions or safeguards would we need?

As a practitioner providing MAID, I believe it would be important and necessary that the professional opinion of a psychiatrist be part of the file to confirm the incurability and the irreversibility of the patient's mental disorder, as well as the absence of criteria contraindicating MAID. That said, I do not think that the two assessors have to be psychiatrists, especially as a lack of resources could constitute a huge barrier, especially in remote areas.

If the attending psychiatrist wishes to be an assessor, that person would be, in my opinion, the most appropriate candidate. That person would be able to establish the grievous and incurable nature of the disorder affecting his or her patient, their suffering as well as their capacity to consent. I believe that by requiring a second psychiatric evaluation in these circumstances, we would be creating another barrier that would unduly reduce these patients' access to MAID.

In conclusion, I believe it is important to eliminate the discrimination surrounding access to MAID for patients for whom a mental disorder is the sole underlying medical condition. It is possible, with the appropriate framework, to ensure that these patients are deemed eligible. However, the framework must not constitute an insurmountable barrier to patients who are suffering hugely.

I thank you for your attention and I would be pleased to answer any questions.

• (1000)

[English]

The Joint Chair (Hon. Yonah Martin): Thank you very much to both of you for appearing before our committee today.

We'll go into our first round. We will begin with Mr. Cooper for two and a half minutes, followed by Madame Vien for the remainder of the time.

Mr. Cooper, go ahead.

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

I will direct my question to Dr. Dembo.

In 2013, you wrote an article entitled “The Ethics of Providing Hope in Psychotherapy”, in which you describe “Patient 1” as a “38-year-old woman with schizophrenia and obsessive-compulsive disorder, with both illnesses proving resistant to multiple medications and psychotherapies”, who had suffered “10 years of chronic, severe distress”.

You saw her in an intensive care unit, and after thoroughly assessing her and conducting a detailed review of the literature, you concluded that “there was almost no likelihood that she could recover”. Yet instead of helping her die, you conveyed hope to her. After another treatment attempt, her symptoms “vanished, and she has now remained well for 2 years. She is once again engaged in academic and advocacy work, as well as with friends and family, and grateful to be alive”. You concluded that “in hindsight, it seems that we did the right thing, but, at the time, we could not have possibly known.”

Does that not underscore the determination of the expert panel that you served on, which stated, on page 9, that “it is difficult, if

not impossible, for clinicians to make accurate predictions about the future for an individual patient” in cases of mental illness? Doesn't that demonstrate the significant risk, in opening the door to sole mental illness, that persons will have their lives prematurely ended, persons like “Patient 1”? At the time, MAID was not available.

• (1005)

Dr. Justine Dembo: Thank you for your question, Mr. Cooper. You brought up some very important points.

That publication is interesting because it's been brought up in some of the cases that I have testified for. That was a situation where MAID laws did not exist in Canada. That patient was not assessed for MAID eligibility whatsoever, so we have no idea whether she would have been eligible for MAID or not. Also, that was two years of improvement followed by another deterioration, unfortunately.

You're right, and I agree with what we said in the panel, that it is challenging to predict irremediability in the case of sole mental illness on a case-by-case basis. That said, there's a degree of uncertainty that is equal to that in MAID on track two already. Even in track one, we have uncertainty about whether a patient might change their mind or adjust to their life-threatening condition at the last minute.

The key is, I think, to assess patients on a case-by-case basis, remembering that patients with autonomy and capacity are allowed to make decisions in the face of uncertainty in medicine all the time. We as the assessors must share in that decision-making process with them and do the best we can, but this kind of imperfection exists throughout medicine.

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

You have the floor, Madame Vien.

[Translation]

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

Welcome, all.

Dr. Dembo, Quebec has decided not to proceed on this issue. Some people are talking about discrimination when we raise the possibility of giving the same weight to mental disorders as that given to physical illness when it comes to administering MAID.

What do you think about discrimination in this instance?

[English]

Dr. Justine Dembo: Can I just clarify if what you're asking about is the idea that it would be discriminatory to exclude patients with sole mental illness?

[Translation]

Mrs. Dominique Vien: Yes, absolutely.

[English]

Dr. Justine Dembo: Thank you for asking that question.

Yes, I do believe it would be discriminatory on several levels.

Number one, people with mental illness, especially chronic and severe mental illness, can suffer unbearably for decades. Their life course can be derailed. Their personhood can be detracted from. They can be in physical pain as well as emotional pain, and their distress, their suffering, is equally valid, as valid as the suffering of someone with what we term a physical condition.

There's also the challenge that we can't fully distinguish physical from mental in many types of conditions, such as chronic pain, which would be eligible under track two.

To say that someone with a mental illness just shouldn't be eligible, that being a blanket statement where people don't even get the chance to be assessed as individuals in their unique circumstances, to me is very stigmatizing in the way that mental illness has a history of being stigmatized.

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

Next is Madame Brière.

[Translation]

Mrs. Élisabeth Brière (Sherbrooke, Lib.): Hello.

Thank you, Madam Chair.

I would like to thank our two witnesses for their very informative presentations. Their experience and their work will really help us in our study.

Dr. Dembo, you have already stated that physical suffering, just like psychological suffering, could compromise decision-making as well as free and informed consent. You believe that the individual should be evaluated in both instances.

Does that mean that you believe that we should consider requests on a case-by-case basis?

Finally, what should we be assessing?

[English]

Dr. Justine Dembo: Thank you so much. That's a really important question on a few levels.

Yes, I think we're looking at the person. There's actually a writer on suffering who was in medicine, Eric Cassell, who talks a lot about suffering being a situation where the integrity of the person is threatened. I think that applies to both physical and mental illness. Assessing on a case-by-case basis is the only way to get an understanding of that unique person, their needs and their circumstances. Having an assessment also creates a relationship between the assessor and the person being assessed. It is within that unique relation-

ship that the assessor and the person being assessed can come to a shared understanding of the situation and can collaborate. I think it is vital that people be assessed case by case rather than through a blanket statement.

With respect to your comment about physical pain, I think you're referring to what I mentioned around the severity of suffering both physically and mentally. That's also something that I think can only be assessed qualitatively between the assessor and the person being assessed.

I hope I've answered your question.

• (1010)

Mrs. Élisabeth Brière: Yes. Thank you very much.

[Translation]

When it comes to discrimination, we have heard that it is possible to correctly assess persons whose sole underlying medical condition is a mental disorder and that the framework should not constitute a barrier to those who are suffering.

Doctor Le Sage, could you further elaborate on what you said in your presentation?

Dr. Natalie Le Sage: As my colleague said, the framework for physical illness provided for in the act sets out strict eligibility criteria. When a patient is considered eligible, that means that the criteria have been applied carefully.

You have to understand that we are not taking here about a neighbour who is depressed after his divorce. I believe your committee has heard this on numerous occasions. We are talking about rare cases, situations where the psychiatrist is able to assess the irreversibility of the disorder. We are talking about serious chronic illness.

As a provider, I will have all the available information, just as we do currently. Since we have been providing MAID to persons whose death is not reasonably foreseeable, that is to say since March 2021, we have already been confronted with this type of situation when it comes to physical illness. I am speaking of the uncertainty surrounding prognosis. We carefully apply the criteria in order to avoid discriminating against the patient.

The same conditions apply to mental disorders.

Mrs. Élisabeth Brière: Would it be possible to strike a balance between a good assessment and avoiding creating barriers for these persons?

Dr. Natalie Le Sage: You have to avoid creating too many barriers that would make accessing MAID more difficult and that would add nothing to the quality and the thoroughness of the assessment.

Mrs. Élisabeth Brière: A number of years ago, I met a representative of an organization called Pro-Def Estrie in Sherbrooke, whose mission was to protect the rights of persons suffering from mental disorders. That person confirmed that it is discriminatory to not offer those persons access to MAID.

I share your opinion, and I was pleased to hear your arguments. Thank you very much.

[English]

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

[Translation]

Mr. Luc Thériault: Hello.

My questions are for Dr. Le Sage.

If I understood you correctly, people are not able to access MAID when mental disorders are the sole underlying medical condition, unless it is possible to establish the chronic nature of the disorder, which would be over a long period of time. On top of the chronic nature of the disorder, the person would have to have tried a certain number of treatments. Is that correct?

• (1015)

Dr. Natalie Le Sage: Yes, indeed. The psychiatrist providing MAID must establish that the person has been suffering from a serious disorder over a long period of time which is chronic, and which does not respond to treatment. Often in reports, the period of time indicated is expressed in decades. It is clear that we are absolutely not talking about giving access to MAID to a person who is taken to ER after trying to commit suicide for the first time. This is absolutely not the case. As we have stressed, MAID must not be a way of responding to a lack of resources or to a problem in accessing care.

In all cases, there is a strong analogy to be made with physical illness. When we evaluate a request for MAID, we must be sure that the person has been able to access palliative care and treatment for their suffering. The same criteria apply to mental disorders. We must be sure that the person has received care aimed at reducing his or her suffering.

Medicine, however, has its limits. Medicine has its limits in cardiology, respirology and oncology, why wouldn't psychiatry? You could think that if the system were perfect, we could get a 100% success rate with psychiatric treatment, but that would be false. It's like believing in unicorns.

Mr. Luc Thériault: I don't have a lot of time left.

I would like to talk about the other barriers that could impede access to care. Recommendation 10 in the experts' report clearly states that the assessor should be: "a psychiatrist independent from the treating team/provider." I think, given your experience in the field, that would be a problem. You believe that there could be a lack of psychiatrists for the provision of MAID

I would ask you to be brief, because I may have another question.

Dr. Natalie Le Sage: Is the question for Dr. Dembo or myself?

Mr. Luc Thériault: It is for you.

Dr. Natalie Le Sage: As has been stated innumerable times, these patients have already been assessed by at least one if not more psychiatrists. We can therefore presume that the patients eligible for MAID are suffering from a grievous illness. I would remind you that these are grievous and incurable illnesses. To require more as-

sessments in a remote region, or even in a city, could create a barrier. Such an assessment would not provide any more information and would not make the process any more thorough.

Mr. Luc Thériault: Is the March 2023 deadline realistic? Given your experience in the field, will we be able to provide this service and to do the work properly by March 2023?

My question is for Dr. Dembo.

[English]

Dr. Justine Dembo: Thank you for that question.

Whether or not March 2023 is a realistic deadline depends on how committed and efficient various provincial and local bodies can be in implementing guidelines based on the panel's reports. I'm hoping they can do that.

I would also say, though, putting that aside, that MAID assessors and providers have been assessing patients on track two for quite some time now, and the issues that come up in track two and mental illness are very similar. I actually think that already assessors and providers are getting practice and are prepared to be able to implement the recommendations by March 2023.

• (1020)

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

Before I turn to Mr. MacGregor, I'm going to also turn it over to our co-chair, Monsieur Garneau.

Mr. MacGregor, you have five minutes.

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

Thank you to Dr. Dembo and Dr. Le Sage for guiding our committee through this subject matter.

Dr. Dembo, I'd like to start with you. In the history you have in treating patients and with how intimately familiar you are with some of their conditions and so on, as a percentage of the patients you have seen, how many would you say would actually qualify for medical assistance in dying where a mental disorder is the sole underlying condition? We're just trying to get a sense of what the population would be in this regard.

Dr. Justine Dembo: That's an important question and a difficult one to answer, because the law has not yet changed. That said, I think of the patients I see overall. I work with a population of highly treatment-resistant patients with OCD who get sent to our tertiary care centre. Most of them have other comorbid illnesses like depression that is also severe. Some of them have talked with me about MAID for sole mental illness, and I follow a few who ultimately would like to proceed.

I'd say the percentage who would likely be eligible is relatively small, of those I follow at this time who would like to proceed with MAID. But I would also say that the percentage of patients with severe psychiatric illness who ultimately would want to even be assessed for MAID is very small, and the percentage of people who have irremediable conditions is small.

I can't give you a number, but I would say that the majority of people who would apply would probably not be eligible, based on what I'm seeing the applications might look like.

Mr. Alistair MacGregor: Thank you for that. That was an answer.

We've heard concerns about the fact that, like every other field of medicine, the development of treatments is always expanding. New research is going on, etc. I guess some of our witnesses have related their concern that someone could qualify for medical assistance in dying, and then maybe in a few years' time a treatment comes out that is successful in treating that condition—we don't yet know.

Can you clarify whether physicians, especially assessors, would consider it a duty of care to have done their research into the most advanced state of research that's available for treatment right now? Can you just expand on that a bit more?

Dr. Justine Dembo: I'd say that in any aspect of medicine there's always the chance that another treatment is around the corner that could cure or significantly help that patient, and any patient making a decision about withdrawal of life support or MAID or other highly consequential decisions does run the risk of missing out on something that may have helped a few years in the future. Part of assessing the capacity to make these decisions includes an assessment of the person's ability to understand that.

I think I lost track of the second part of your question. Could I ask you to repeat it?

Mr. Alistair MacGregor: It was just whether it's considered a duty of care to be apprised of all the latest research in treatment.

Dr. Justine Dembo: Yes, I believe it is. In the reading of the expert panel report, I hope it comes across that in one of our recommendations not only do we suggest an independent psychiatrist who's an expert in the condition, but we may sometimes require two psychiatrists or a subspecialist consultation to make sure that no stone has been left unturned, and to make sure that someone with expertise in that person's specific psychiatric condition would also be able to assess and provide information on the most recent or even experimental treatments that might be worth trying before proceeding with MAID.

That is certainly how I handle it, clinically, and how my colleagues handle it.

Mr. Alistair MacGregor: Thank you.

Finally, you provided an answer on the March date that is rapidly approaching, but we've already produced an interim report on this subject. There has been a flurry of other reports, as well.

What do you think this parliamentary committee should be producing, specifically, in terms of recommendations to the federal government when we get to the point where we're ready to table our final report?

• (1025)

Dr. Justine Dembo: I hope I understand your question correctly.

My inclination is to say that I very much stand behind all of the recommendations we made on the expert panel, and I would hope those recommendations are translated into guidance items and pro-

ocols for provincial and local authorities to follow, once they start receiving these MAID requests. I think that needs to be implemented, and I would like to see that moving faster than it is.

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

[*Translation*]

I will now turn over to the senators. Because there are only two of them, I will give each senator a maximum of seven and a half minutes. We will start with Senator Mégie.

Senator Mégie, you have the floor.

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

My first question is for Dr. Dembo.

Doctor Dembo, seeing as you work in the field and that you are also involved in research, I would like you to describe the process that allows you to assess the eligibility of someone for MAID and ask you to describe the time required for each step. When we were talking about the general population, we spoke of the length of time for each step, and of the fact that the period could be extended, et cetera. Please tell us about the length of each step for persons suffering from mental disorders.

[*English*]

Dr. Justine Dembo: Am I correct in thinking that question was for me?

Hon. Marie-Françoise Mégie: Yes.

Dr. Justine Dembo: Thank you.

May I ask if it would be all right for me to partly read from something I previously prepared, where I walk through the process of a MAID assessment, or would you prefer I were brief?

[*Translation*]

Hon. Marie-Françoise Mégie: Could you tell us a bit more about the length of time for these steps?

You may be brief.

[*English*]

Dr. Justine Dembo: I'm so sorry. The interpretation just disappeared.

The Joint Chair (Hon. Marc Garneau): Please summarize, Dr. Dembo.

Dr. Justine Dembo: It really depends on the patient. Remember that, right now, we are not assessing people for sole mental illness, but rather using patients on track two as examples. I can expand on how that might apply.

The first step is always gathering the information provided by the person referring the patient to me. That takes a lot of work: reading through all the person's previous charts provided to me, and the reasons for the referral. Then there is a meeting with the patient. The initial meeting is usually two hours, and that's usually not the only time we meet. I suspect, for sole mental illness, it will be much more than just a few meetings—probably several two-hour meetings over the span of months or possibly years. It could be a very lengthy time span, as it has been with track two.

In between steps, one wants to look at whether a patient has been offered appropriate treatments and has seriously considered them. This can involve having them go through certain interventions—not just medical treatments, but interventions involving finance, housing and social supports. All of that takes time to put into place. These serial assessments would occur over a long period of time, in my view.

I hope that helps.

[Translation]

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

I better understand why the barriers would be doubled if a second psychiatric assessment were required. Have I understood correctly?

[English]

Dr. Justine Dembo: There are real obstacles to obtaining psychiatric assessments for MAID right now, even for track two patients. I expect there will be delays for patients who are waiting for an expert psychiatric opinion on their MAID request for mental illness, especially if a second specialist is required. That's another delay. I think that, right now, the way things are, it's unavoidable.

[Translation]

Hon. Marie-Françoise Mégie: Thank you.

My second question is for Dr. Le Sage.

Doctor Le Sage, as you know, people suffering from mental disorders are often stigmatized in our society. You have indicated that the exclusion of these persons is actually discriminatory. In your opinion, how could excluding them increase their stigmatization?

Do you have a concrete example to give us in light of your experience in the field?

• (1030)

Dr. Natalie Le Sage: Thank you for the question.

My experience in the field has allowed me to assess patients suffering from physical illnesses and their eligibility for MAID under the current law. I have also assessed patients who, despite the fact that they mainly suffered from a physical illness and met all the eligibility criteria, also had a secondary a mental disorder that required a psychiatric assessment. We have to look at the various aspects that, when we are dealing with a mental disorder, as was stated previously, are a bit trickier.

I observed that in many cases, the attitude of healthcare professionals was different when dealing with patients suffering from a mental disorder. They didn't even see anymore the physical health

problem that made those persons eligible for MAID. Even if the patients were not suicidal, even if they were lucid and met all the criteria, those patients were sometimes discriminated against because of their mental health issues. Oftentimes, this even had a discernable impact by pushing back the moment when their request for MAID was heard. That was the form of discrimination that I observed.

As we have been saying from the beginning, I think that the cases where a mental disorder is the sole underlying condition are exceptional ones. All psychiatrists are saying that to close the door on these patients is tantamount to not listening or not being empathetic to their suffering. To me, as a doctor, that is unacceptable.

Hon. Marie-Françoise Mégie: Thank you.

If I have any speaking time left, I would like to give it to Senator Dalphond.

The Joint Chair (Hon. Marc Garneau): That's fine.

Senator Dalphond, you have in total about eight and a half minutes.

Hon. Pierre Dalphond: Thank you, Chair.

We have spoken about many subjects, so I am not sure I will need all the time given to me. The witnesses do not have to feel rushed.

[English]

My first questions will be for Dr. Dembo.

You are a member of the task force, and that group has come up with a substantive report. Are you confident that the task force guidelines are sufficient? Certainly I have followed some criticism that was expressed further to the release of the report. Has this brought you to change your mind or to say, "Maybe we should have also said something about the following issues"?

Is there something you would like to say? Would you say, "Our task force report is fine; its guidelines are sufficient" or "After further thought, I will recommend that we have the following"?

Dr. Justine Dembo: Thank you for that question.

Yes, I believe that the expert panel recommendations are very comprehensive and thorough. I have thought about that at length, and I can't think of anything that I would want to add or feel the need to add. Partly, I say that because I think the pre-existing safeguards that are already in place for track two are quite thorough if they are followed appropriately by assessors and providers.

Along with the recommendation in the panel report that assessors and providers be trained in a standardized way.... I hope you know that there are training programs being developed, and I'm part of the development of those training modules. If assessors receive that additional training, they can provide assessments in a more standardized way and they can follow the existing guidelines and the safeguards that are already there, plus the additional elements that are added in through the panel report, which refine what is already there and allow assessors to interpret the current legislation even more clearly.

I am quite satisfied with the way the report elaborates on that. My only concern is making sure that it is followed and that the recommendations are implemented locally.

Hon. Pierre Dalphond: I understand—Dr. Le Sage referred to it before—that when there is comorbidity and we have somebody who is on track two, the process involves an assessment of the ability to consent and the need to make sure that the request is not based on improper mental reasons, but is based on comorbidity. You have to do a mental assessment.

In other words, is the practice already familiar, to a certain extent, of assessing mental conditions as a cause for access to MAID?

• (1035)

Dr. Justine Dembo: Is that question for me as well?

Hon. Pierre Dalphond: Yes.

Dr. Justine Dembo: Thank you.

Yes, I think that's actually a very important point. We have already been assessing capacity for MAID in people who have serious mental health conditions and who have a comorbid physical disorder that makes them eligible. That's not just on track two, but also on track one.

Psychiatrists are trained in capacity assessment, to begin with, in other highly consequential medical decisions such as withdrawal of life support or the ability to refuse life-sustaining treatment, so I think much of this is already familiar. There are always going to be nuances, but I don't think those nuances are specific to the diagnosis, such as a diagnosis of mental illness. The nuance is going to be specific to each patient in each of their own unique circumstances.

Hon. Pierre Dalphond: In a sense, when we transition in March to having access to track two, including for those whose sole condition is a mental condition, the system won't be taken by surprise in a completely new setting that they were not familiar with. That's what I understand from your answer.

Dr. Justine Dembo: My sense is that those of us who have been providing assessments for track two will not feel surprised.

I do think the system will struggle, because my understanding is that there are very few assessors right now who feel willing to accept those cases, so there will be a bottleneck in terms of the number of applications versus the psychiatrists willing to do those assessments.

I don't see that as a terribly negative thing. It does absolutely put up an obstacle, but on the other hand it allows for assessments to be more longitudinal, just naturally, as it unfolds.

Hon. Pierre Dalphond: Thank you.

[*Translation*]

Doctor Le Sage, my next question is for you.

Some witnesses were concerned by the fact that certain mental disorders are associated with suicidal tendencies. You touched upon this earlier. In those cases, what do you do to keep that person from being eligible for MAID?

One of the arguments against that we regularly hear is that this would allow people who are suicidal to request MAID.

Dr. Natalie Le Sage: At the risk of repeating myself, we do not assess people when they are in crisis. At the ER, I have seen numerous patients who have reached a crisis point. Those patients who are going through an acute phase would not become eligible.

I will now put on my hat as a MAID provider and assessor.

When a patient goes through an acute suicidal crisis, he or she is not eligible for MAID. We assess a patient who may have had a cluster of repeated crises as well as long and frequent periods of hospitalization. Because that person is able and not suicidal, he or she will talk about their suffering. The patient would be assessed by an entire team and by his or her psychiatrist. We are not talking about a situation where the patient is acutely suicidal. These patients do not have access to MAID. There's not a single provider who would consider that such a patient would be eligible.

Hon. Pierre Dalphond: I have another question for you, Doctor Le Sage.

Yesterday, I watched the Quebec election debate. All the candidates talked about a particular topic, which is the lack of resources for mental health.

Is there a risk that current resources, which are perhaps already insufficient, would be used to assess requests for MAID, which would aggravate the problem? Is the system able to handle the additional load of requests for MAID in cases of mental disorders?

• (1040)

Dr. Natalie Le Sage: I will once again make the analogy with a physical illness.

Contrary to what other have stated, since MAID has been authorized in our country, palliative care, which consists of treatment and support, has probably been offered more frequently, rather than the opposite. When we assess MAID requests, we are required to make sure that the patient has had access to various care options. We must ensure that their suffering is not linked to the fact that there are gaps in the provision of healthcare. We see that the patients are already receiving palliative care but that they no longer wish to, or that such care has been offered to them but they would prefer to have MAID.

In the case of a patient whose sole underlying condition is a mental disorder, we are obligated to assess if there's something missing within the care on offer. We have to make sure that all resources have been used to help the patient.

All psychiatrists have been saying that these cases are rather rare, and the people would have received support from the healthcare system and would have had access to resources over many years.

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

[*English*]

This brings us to the end of our second panel. I would like to thank our—

[*Translation*]

Hon. Marie-Françoise Mégie: Mr. Chair, pardon me, but I have a quick question for Dr. Dembo.

The Joint Chair (Hon. Marc Garneau): Go ahead, Senator Mégie.

Hon. Marie-Françoise Mégie: Doctor Dembo, I believe you have a document that sums up the various steps included in the process. This document would be most useful to our committee. Would you be able to forward it to one of the committee clerks?

[*English*]

Dr. Justine Dembo: Absolutely. I'd be happy to send them later today.

[*Translation*]

Hon. Marie-Françoise Mégie: Thank you.

[*English*]

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

I'd like to thank Dr. Dembo and Dr. Le Sage.

[*Translation*]

Thank you for sharing your time and your expertise with us today. Thank you also for answering our questions pertaining to our extremely important study.

[*English*]

We very much appreciate that you took the time to be with us to answer all of our questions.

With that, this committee is adjourned.

Thank you.

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