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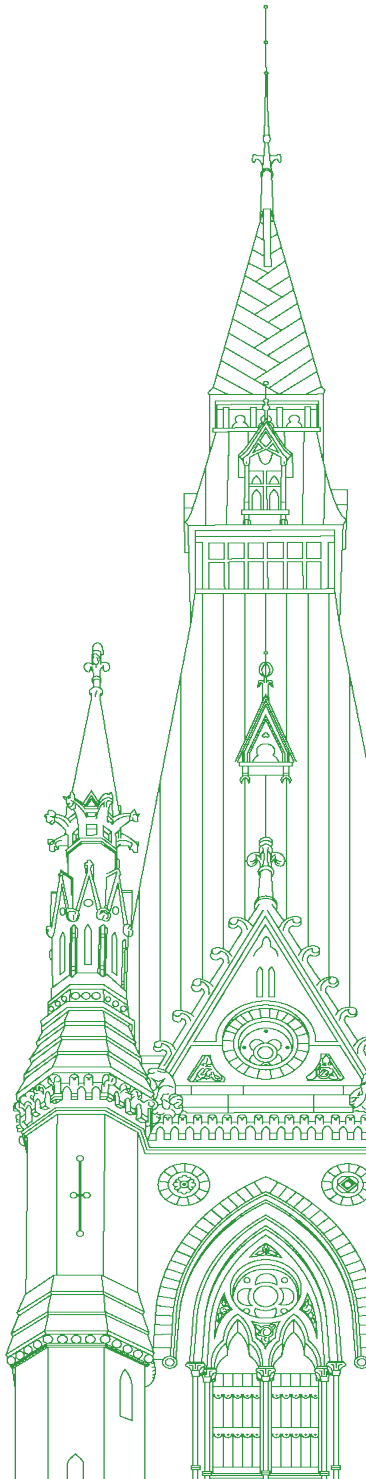

Co-Chairs: Mr. René ArseneaultThe Honourable Yonah Martin

Special Joint Committee on Medical Assistance in Dying

Tuesday, November 28, 2023

● (1830)

[*English*]

The Joint Chair (Hon. Yonah Martin): Welcome to all of our witnesses this evening, and to those joining us online.

My name is Yonah Martin, and I am the Senate's joint chair of this committee. I am joined by Shelby Kramp-Neuman, the House of Commons vice-chair of the committee.

Today, we continue our examination of the degree of preparedness attained for a safe and adequate application of medical assistance in dying where mental disorder is the sole underlying medical condition, in accordance with recommendation 13 of the committee's second report.

Before I introduce our witnesses, I want to advise our House colleagues that, potentially, there could be votes in the Senate in the second hour, so we'll be called away, at which point we will suspend the committee meeting. We don't know just yet what will happen, but it would be in the second hour.

For our first panel this evening, we have H. Archibald Kaiser, professor at the Schulich School of Law and department of psychiatry at Dalhousie University's faculty of medicine, as an individual, by video conference; Dr. Tarek Rajji, chair of the medical advisory committee at the Centre for Addiction and Mental Health; Dr. Mauril Gaudreault, president of Collège des médecins du Québec; and Dr. André Luyet, psychiatrist, both by video conference.

Welcome to our witnesses for this first panel. You will each have five minutes for your opening remarks. We trust that you will be within the five minutes.

We will begin with Professor Kaiser, followed by Dr. Rajji and Dr. Gaudreault. I'm not sure if Dr. Luyet is sharing the five minutes, or whether it will just be Dr. Gaudreault.

We'll begin with Professor Kaiser. You have five minutes.

Mr. H. Archibald Kaiser (Professor, Schulich School of Law and Department of Psychiatry, Faculty of Medicine (Cross-Appointment), Dalhousie University, As an Individual): Good evening, and thank you for this opportunity of contributing to your reflections.

I'm opposed to this change in Canadian criminal law. I don't think Canada will ever be ready, from a public policy perspective, for MAID for persons with mental illness. Adoption would alienate and harm people with disabilities in Canada, contrary to our charter and to our international human rights law obligations, and it will diminish our well-earned UN reputation.

First, medical assistance in dying is a misnomer for persons with mental illness who die from other vulnerabilities: stigma, discrimination, social exclusion, impoverishment, violence by others and poor physical health.

Next, the intersectional realities of mental illness, intellectual disability and substance use disorders amplify my concerns. There are higher rates of dying by suicide not only for persons with mental illness but also for others experiencing health inequities, including indigenous peoples, trans people, trauma survivors and the increasing number of persons facing psychosocial and economic stressors.

As noted by CAMH, different suicide prevention strategies will be needed for different populations, but everyone deserves those efforts, not the legal normalization of dying by suicide.

The Supreme Court concluded in 1991 that people with mental illness have historically been the subjects of abuse, neglect and discrimination. In 2020, they said that stigmatizing attitudes persist, and they provide support for legislative solutions and justifications for social inequities and injustices.

This would be a vast extension of existing MAID justifications, which would enable departure from the regular criminal law, which must protect our most vulnerable. Those who participate in MAID in good faith are not individually culpable, but society will clearly be demonstrating, as the Law Reform Commission of Canada feared 40 years ago, its ignoble motives if it extends MAID.

This stretching of MAID is not a benefit advancing equality. It's quite the contrary. It aggravates discrimination, marginalization and inequality. As the Supreme Court cautioned in 2020, laws like this give discrimination “the force of law” because it “reinforces, perpetuates or exacerbates [a group's] disadvantage” and “violates the equality guarantee”.

The principles of the Convention on the Rights of Persons with Disabilities are obligatory. Article 4 requires the abolition of “laws...that constitute discrimination”. Article 10 demands the “effective enjoyment” of the “inherent right to life”. Article 25 is “the right to the enjoyment of the highest attainable standard of health”, including the right to an adequate standard of living.

The extension of MAID to persons with mental illness would amount to a terrible setback under the CRPD. It is morally disconcerting and violative of democratic values that the protests of persons with disabilities have been dismissed, but it's also contrary to the CRPD, article 4, which requires us to “closely consult with and actively involve persons with disabilities” to, in article 29, “ensure that persons with disabilities can effectively and fully participate in political and public life”.

There is strident opposition, for example, by the Council of Canadians with Disabilities, which speaks for 170 NGOs. They say, “MPs...have stubbornly ignored the concerns expressed by the disability community.... This is a fight for our lives.”

Organizations like People First Canada, for which I am currently a provincial adviser, have repudiated this initiative as well. They say, “it makes it easier than ever to cancel us out.” It's “dangerous and discriminatory”. It “could be deadly to Canadians with disabilities”. As the president said forcefully, please vote to “kill the bill”, not us.

Canada has sullied its reputation with the United Nations. The Special Rapporteur on the Rights of Persons with Disabilities said, in 2019, Canada must “ensure that persons with disabilities do not request assisted dying” simply because there are no “community-based alternatives”.

In 2021, three UN special envoys were unusually worried that “a social assumption might follow (or be subtly reinforced) that it is better to be dead than to live with a disability”, that the extension would “result in a two-tiered system in which some would get suicide prevention and others suicide assistance, based on their disability status and specific vulnerabilities.”

Canada is at a crossroads. Either protect the rights of persons with disabilities, specifically with mental illness, or extend state-authorized death to make those with disabilities feel more silenced, devalued, betrayed and abandoned.

Thanks so much for this opportunity.

● (1835)

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

Next, we will have Dr. Rajji for five minutes.

You have the floor.

Dr. Tarek Rajji (Chair, Medical Advisory Committee, Centre for Addiction and Mental Health): Thank you for this opportunity to present on behalf of the Centre for Addiction and Mental Health, or CAMH.

CAMH is Canada's largest mental health teaching hospital and one of the world's leading research centres in its field. CAMH conducts groundbreaking research, provides expert training to health care professionals and scientists, develops innovative health promotion and prevention strategies, and advocates on public policy issues.

Most importantly, we provide evidence-informed and recovery-focused treatment and care to hundreds of patients every day with acute and chronic mental illnesses and substance use disorders.

Over the past several years, CAMH has made several submissions to government committees related to medical assistance in dying and mental illness. Our position has been, and remains, that we are concerned about the expansion of MAID to people whose sole underlying medical condition is mental illness at this time.

We want to be clear that this position is not based on the belief that suffering caused by mental illness is not comparable to suffering caused by physical illness. There is no doubt that mental illness can be grievous and cause people physical and psychological suffering. We are not here to debate that.

CAMH's concern is that the health care system is not ready for March 2024. The clinical guidelines, resources and processes are not in place to assess, determine eligibility for and support or deliver MAID when eligibility is confirmed to people whose sole underlying medical condition is mental illness. This includes differentiating between suicidal plans and the request for MAID. More time is needed.

The federal model practice standards are a good first step in highlighting the benchmarks that health professional regulators can expect from their members who choose to offer MAID, but it is not enough. Health professional regulators also rely on their members having access to the best available evidence through clinical practice guidelines.

Guidelines for MAID cases where mental illness is the sole underlying condition do not currently exist. That is why CAMH is hearing loud and clear from physicians, nurse practitioners and other clinicians that they need more clarity and directions on how to determine whether a person has an irremediable mental illness and is eligible for MAID, including how to separate a request for MAID from a suicidal attempt or plan.

To address this gap, CAMH experts have been working hard with partners for the past year to develop practice guidelines, based on the limited evidence available at this time, that will allow for standardized assessments and more reliable decisions regarding that determination of MAID cases where mental illness is the sole underlying condition.

Importantly, given the lack of evidence in the field at this time, CAMH and others have been clear that these guidelines must be consensus-based. This has not been an easy task. We have been working toward it, but have not been able to reach consensus on what information needs to be collected and how a determination of irremediableness should be made.

We're making progress, but more time and funding for interprofessional and interorganizational collaboration are needed. Getting to consensus within health care and community organizations, and nationally, will take longer. Given the life-or-death consequences of these decisions, we want to get it right, and we know the government does too.

It is also important for the government to understand that the health care system is not equipped to handle the increase in MAID requests that are expected to come in March 2024. In Ontario, there is already a lack of resources to handle MAID track two cases, and the existing infrastructure will not be able to support additional demand.

CAMH and our partner hospitals, through the Toronto Academic Health Science Network, have submitted a proposal to the provincial government to enhance the existing MAID coordination service and create a track two consultation table to address the increase in inquiries and applications for MAID where mental illness is the only underlying medical condition. We're awaiting a response.

Central to our proposal is the recognition that there are already a limited number of MAID assessors and providers who take care of track two cases. Those who have expertise in mental illness and conducting mental health assessments are even more limited. It is crucial that we have more time to build this community of practice.

Without time to ensure that the guidelines, resources and experts are in place, access to MAID for people whose sole underlying medical condition is mental illness would be limited and inconsistent, and may exacerbate existing inequities within the health care system. It may also lead to confusion, distress and frustration for patients, their families and health care providers.

Therefore, CAMH is urging further delay in extending MAID eligibility to people whose sole underlying condition is mental illness at this time, until the health care system is ready and health care providers have the resources they need to provide high-quality, standardized and equitable services.

● (1840)

Finally, it is important to re-emphasize what was mentioned at the beginning. Mental illness can be severe and cause suffering that can be comparable to physical illness, but the health care available for mental illness is not comparable to the health care available for physical illness. Mental health care has been significantly underfunded compared to physical health care.

There are also inconsistencies in treatment covered by different provincial health plans. This means that many people across Canada do not have ready access to the full range of evidence-informed treatments that can assist in their recovery.

For that reason, a delay in MAID expansion would also allow governments and health care experts to work together to determine the best way to integrate MAID into a broader mental health care system.

Thank you for your consideration.

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

Lastly, we'll have Dr. Mauril Gaudreault, for five minutes.

[*Translation*]

Dr. Mauril Gaudreault (President, Collège des médecins du Québec): Madam Chair, members of the committee, we appeared before you nearly a year ago today. Thank you for giving us another opportunity to express our views, this time in relation to mental disorders.

By way of reminder, the mission of the Collège des médecins du Québec, or CMQ, is to protect the public by providing quality medicine. Quality medicine to us means bringing relief to people who are suffering, regardless of their disorder or illness.

The CMQ is of the view that the medical parameters to circumscribe medical assistance in dying, or MAID, are clear. What is not clear are the legal parameters. The Criminal Code and Quebec's Act Respecting End-of-Life Care need to be aligned to ensure that the delivery of this care is consistent right across the country.

In the meantime, the situation is causing confusion among patients and doctors alike.

Further to an inclusive, non-discriminatory, view, one that is based on an individual's diagnosis and takes into account the person as a whole, mental illness is now a designated mental disorder in the International Classification of Diseases, the same as any other disease.

It is now well established in epidemiology that mental disorders are prevalent. In fact, it is estimated that one in five people will experience a mental disorder during their lifetime.

The CMQ is not claiming that MAID is an appropriate response for all individuals with mental disorders. For most, specific treatment options are available, scientifically sound options that offer a more promising outlook through biopsychosocial, recovery and rehabilitation therapies.

The CMQ does, however, believe that access to MAID should not be withheld from patients with mental disorders. That medical view is based on a number of factors. First, it is important to recognize that certain mental health problems can cause suffering just as intense as physical health problems. Second, it is not acceptable to discriminate against patients when it comes to MAID on the basis of their mental health. Everyone is entitled to universal access to care and that right must be upheld. Third it is important to not only protect vulnerable individuals, but also to support their potential and autonomy. Lastly, it is important to consider the mistaken association between a mental disorder and the capacity to consent.

However, stringent clear conditions are essential to avoid any lapses. We have set five such conditions.

First, the decision to grant MAID to someone with a mental disorder should not be viewed solely as an episode of care. Rather, the decision should be made following a fair and comprehensive assessment of the patient's situation.

Second, the patient must not exhibit suicidal ideation, as with major depressive disorders.

Third, the patient must experience intense and prolonged psychological suffering, as confirmed by severe symptoms and overall functional impairment, over a long period of time, leaving them with no hope that the weight of their situation will ease. This prevents them from being fulfilled and causes them to see their existence as devoid of meaning.

Fourth, the patient must have been receiving care and appropriate follow-up over an extensive period of time, have tried multiple available therapies that are recognized to be effective, and have received ongoing and proven psychosocial support.

Fifth, requests must undergo a multidisciplinary assessment, including by the physician or specialized nurse practitioner in the field of mental health who has treated the individual as well as by a consulting psychiatrist in the specific case of the MAID request.

Under these conditions, it would be possible, in the CMQ's view, to provide individuals suffering from a grievous and irreversible mental disorder with access to MAID.

It is important to prevent situations where individuals opt for MAID out of desperation, because they do not have access to proper care or do not consider the care available to be acceptable, such as an extended stay in a facility without the prospect of gaining more autonomy.

The CMQ believes that, regardless of the patient's illness, they still have the right to access all available medical care, in accordance with their condition, without discrimination.

We are confident that the conditions we have identified will ensure that MAID is adequately circumscribed, while guiding clinicians and educating patients and their loved ones.

● (1845)

We understand what an extremely sensitive issue this is. From a medical standpoint, however, the primary consideration is the person's suffering. We have a duty to alleviate that suffering, in accordance with the patient's wishes, when all other means have failed to do so.

Thank you.

● (1850)

[*English*]

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

We will begin our first round of questions, starting with Mr. Fast.

Mr. Fast, you have five minutes.

Hon. Ed Fast (Abbotsford, CPC): Thank you.

My first question is for you, Dr. Rajji. In your presentation to committee on November 5, 2020, you supported a delay in implementing MAID for mental illness due to the issue of irremediability not having been resolved. You stated that irremediability is “an objective determination that must be based on the best medical evidence available”. Then you shared your concern that there were “no established criteria that define if and when a mental illness should be considered irremediable”. You also suggested that without any agreed-upon objective criteria, “any determination that a person has an irremediable mental illness would be inherently subjective and therefore arbitrary”.

Has any of that changed in the intervening three and a half years?

Dr. Tarek Rajji: Thank you for the question.

That's still the case in the way that there's no scientific evidence on it. We still cannot, at this time, determine at the individual level whether the person has an irremediable illness or not because of the trajectory of the illness. This is why I mentioned in the statement today that any criteria about the irremediable nature of the illness need to be based on consensus guidelines. That work needs to happen. Those discussions need to happen among the expert panel to determine, for condition A, what criteria would determine, based on consensus, that this illness is irremediable, so that doctor X and doctor Y reach the same conclusion.

Those criteria may be different for another condition. The criteria for irremediable—again, I would emphasize that this needs to be consensus-based—would be different for depression, maybe, than for schizophrenia or another illness.

Hon. Ed Fast: Professor Kaiser, you have in the past stated that the voices of indigenous Canadians have been ignored as the discussion of Bill C-7 has moved forward. Can you comment a little further on the degree to which indigenous communities have or have not been consulted on the expansion of MAID to the mentally ill?

Mr. H. Archibald Kaiser: Obviously, this question is best put to representatives of indigenous persons, so I have looked to them for the content of my answer.

In February 2021, for example, many distinguished indigenous signatories wrote to Parliament that the consultation here has not been adequate and “has not taken into account the existing health disparities and social inequalities we face compared to non-Indigenous people”. They said, “our population is vulnerable to discrimination and coercion...and should be protected against unsolicited counsel”.

Another witness before the Senate in February 2021 was Dr. Rod McCormick, himself an indigenous person, who said, “our people die of complex and higher rates of disease than the general population”. When they are “already overrepresented at every stage of our health system, it seems ironic to provide...another path to death”.

Finally, Dr. Richardson, who was before the Senate on February 3, 2021, said, “In an environment where both systemic and interpersonal racism exists, I don’t trust that Indigenous people will be safe.” She said, “a bill that does not actually take into account how social [inequalities] disproportionately affect Indigenous [persons] is highly problematic”.

The sum and substance of all of that is this: How much consultation could there be that would remove those deep, abiding, permanent concerns of indigenous Canadians with respect to the mental health care system in Canada in relation to the psychosocial stressors they face? I don't believe there could be adequate consultation, but I believe those are representative voices from indigenous persons.

The Joint Chair (Hon. Yonah Martin): You have one minute remaining.

Hon. Ed Fast: On the issue of irremediability, do you believe there is a consensus within the mental health community on that issue, or is that still outstanding?

Mr. H. Archibald Kaiser: There is emphatically not a consensus. First of all, I think you should listen to Canadians with disabilities, who say.... For example, the CMHA states that “cases of severe and persistent mental illness that are initially resistant to treatment can, in fact, show significant recovery over time."

But today in Impact Ethics, a group of mental health professionals says that “MAID is for irremediable medical conditions, ones that can be predicted to not improve.” Their overall conclusion was that combined with there being a half-level of success only, and the inadequacy of measuring devices, they say—

● (1855)

Hon. Ed Fast: Let me just interrupt you for a second. I just have five seconds left.

Are there any criteria established that would allow the mental health profession to determine irremediability?

Mr. H. Archibald Kaiser: I'm just responding from the point of view of these providers. They said that over half of the time—

The Joint Chair (Hon. Yonah Martin): I'm sorry, Professor. Answer yes or no.

Mr. H. Archibald Kaiser: The answer is that, no, they are not adequate to provide confident predictions, according to medical professionals.

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

We will now go to Mr. Fisher.

You have the floor for five minutes.

Mr. Darren Fisher (Dartmouth—Cole Harbour, Lib.): Thank you very much, Madam Chair.

Thank you to all of our witnesses today.

I'm going to ask the same question that I've asked other witnesses on this committee due to the narrow scope of what we're here to decide.

Dr. Rajji, do you think that the health system is ready for an expansion of MAID eligibility on March 17, 2024, for individuals whose sole underlying medical condition is a mental disorder?

Dr. Tarek Rajji: No, we don't think the system is ready for March 2024.

Mr. Darren Fisher: Dr. Rajji, here are a couple of little scribbles that I threw down when you were giving your testimony: “get it right”, “getting to consensus”, “concerned at this time” and “more time is needed”. If you were to believe that the health care system is ready—if and when—do you support MAID for individuals whose sole underlying medical condition is a mental disorder? I guess I can ask you for the position of CAMH, not your personal opinion.

Dr. Tarek Rajji: CAMH is not saying that mental illness cannot be or should be excluded from being a criterion for MAID for mental illness. What we're saying clearly is that there's work that needs to be done to determine what those criteria are that define one condition as irremediable versus remediable. These criteria need to be established based on consensus because there is no clear, objective evidence at the individual level to determine whether individual X has an irremediable illness. That work has not been done yet.

Mr. Darren Fisher: Just to be a little bit nitpicky for a second just to get clarification.... The position of CAMH is that it doesn't necessarily support MAID expansion.

Dr. Tarek Rajji: At this time, we urge the government not to expand it, yes.

Mr. Darren Fisher: What have you heard from medical practitioners who work at CAMH on whether they feel equipped to undertake assessments, provisions or consultations for MAID where mental illness is the sole underlying condition?

Dr. Tarek Rajji: They are not experts, and that's what we've been hearing. We have several physicians and nurse practitioners who are open to being involved in the process of MAID assessments for eligibility, but we hear them very loudly that they need more guidance. They have no consensus standards to determine, if they see a patient in their office, whether this person has an irremediable illness or not. That's work that we've been involved in. We've been working on this within the CAMH environment internally. It's taking a long time to determine what type of assessment there needs to be, what types of questions there need to be, what types of information we need to collect and then, based on that information, how to determine that individual X has an illness that is irremediable versus remediable. Those decisions need to follow some standards based on consensus. The answer is that they clearly say that they are not ready.

Mr. Darren Fisher: What do you see? Maybe you can expand on the gaps and challenges that might hinder or limit the willingness of psychiatrists working at CAMH to undertake MAID assessments.

Dr. Tarek Rajji: There is a lack of guidelines. How MAID has been approached is not the typical way that we, as clinicians, practice medicine. I'll give you an example. When psychiatrists prescribe an anti-psychotic, that's a medication, and there are different guidelines for how they prescribe it and when they prescribe it for someone with severe depression versus someone with schizophrenia or someone with dementia. There are guidelines that the profession follows to reduce variation and to ensure quality of care. Those discussions haven't happened with respect to MAID.

● (1900)

The Joint Chair (Hon. Yonah Martin): Excuse me, Mr. Fisher, but there's about 40 seconds.

Mr. Darren Fisher: In less than 30 seconds then, Doctor, could you sum up what else needs to be accomplished to ensure readiness?

Dr. Tarek Rajji: In addition to the development of those guidelines, there need to be efforts, as I mentioned in the statement, to build capacity, to also ensure that you're addressing how the social determinants of mental health are contributing to the suffering and the grievances versus the illness itself, and also how to separate a suicide intent and plan from a MAID request. This is also—

The Joint Chair (Hon. Yonah Martin): Thank you very much, Dr. Rajji. The time has expired.

I see that Dr. Luyet's hand is up.

Dr. Luyet, I'm hoping that there will be questions for you as well. It's just that we had the questions from Mr. Fisher to the witness.

We'll move on to the next questioner.

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

[*Translation*]

Mr. Luc Thériault (Montcalm, BQ): Madam Chair, I would be grateful if you would keep in mind the interpretation delay as far as my time is concerned.

Dr. Rajji, you said there weren't any standards or guidelines, but I have here the Model Practice Standard for Medical Assistance in Dying. It's a 46-page document meant for regulatory bodies, physicians and so on. It was prepared by the MAID Practice Standards Task Group and covers patients under track 2.

Are you familiar with the document?

[*English*]

Dr. Tarek Rajji: I believe you're referring to the actual expert panel document for the model of care. Am I right?

[*Translation*]

Mr. Luc Thériault: Are you familiar with the document?

[*English*]

Dr. Tarek Rajji: Yes, and I referred to it—

[*Translation*]

Mr. Luc Thériault: You don't think it lays out guidelines or practice standards?

[*English*]

Dr. Tarek Rajji: No. The document itself states that these are not the guidelines.

[*Translation*]

Mr. Luc Thériault: All right. Thank you. I just wanted to know whether you had read the document, and whether you felt it provided practice standards. I don't have a lot of time.

Dr. Luyet, you are a psychiatrist. What do you make of the views of your colleagues here today? What do you think of Dr. Rajji's position?

Dr. André Luyet (Psychiatrist, Collège des médecins du Québec): I should start by recognizing how sensitive and complex the issue is. Taking the time to do things right is key. However, we should not shut out people whose MAID request is based solely on their mental disorder, because we don't have widely accepted standards and guidelines. We have to keep examining the issue and working together to set parameters and identify best practices and standards, so that a large segment of the population that has been overlooked—those experiencing tremendous suffering because of health disorders—can have access to a type of care that has been available in Canada for a few years already.

We have to keep working on it, but we can't just shut the door on them.

Mr. Luc Thériault: Does the CMQ feel that the level of readiness on the ground in Quebec is sufficient to move forward? Are the parameters you listed earlier enough to ensure the safe and secure delivery of MAID to individuals with mental disorders?

Dr. Mauril Gaudreault: I will answer that.

The committee that came up with those parameters met over a number of months in 2021 and 2022. The medical community was also surveyed regarding the parameters, and we collected expert opinions. I think the five conditions I listed can be used to demonstrate that the person's illness or mental disorder is irreversible. Usually, that applies to situations that have existed for decades.

Yes, I do think the medical community is ready to move forward, in careful compliance with the conditions I listed, of course.

● (1905)

Mr. Luc Thériault: We've heard from psychiatrists who have reservations about expanding MAID access to people with mental disorders precisely because it is difficult to establish the irremediable nature of such disorders.

When asked, however, they did tell us that they saw patients in their practice who never got better, after years, even decades, of treatment. Doesn't that prove that these disorders can be irremediable or incurable?

Dr. Mauril Gaudreault: Yes, absolutely. As far as we're concerned, that shows the irreversible nature of the illness. It's really important to look carefully at the conditions we put forward. For instance, the patient must have had an extensive care trajectory, accessing all possible treatments and psychosocial supports. When all the conditions are met, the patient's illness can be deemed irreversible and MAID should be available to that person, in the CMQ's view.

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

[*English*]

Lastly, we will have Mr. MacGregor for five minutes.

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

I would also like to thank our witnesses for joining our committee and helping us.

Professor Kaiser, I would like to start with you, given that you hold a position that straddles both law and medicine.

I've been on this committee from the start. What I have been struggling with personally is, on one hand respecting the rights of individuals who have agency, capacity and the right to make decisions for their own body, and also with the larger concept of our duty to protect the most vulnerable.

You very clearly said that we are not ready. Can you offer any thoughts on the struggles that we as a committee have had on those two concepts?

Ultimately, do you think that one day we will ever approach a point where we have to respect people's agency or do you think the duty to protect the most vulnerable will always win out when it comes to mental disorders as a sole underlying medical condition?

Mr. H. Archibald Kaiser: The quick answer is that we have to disaggregate the concept of choice and autonomy for a person with a serious, long-term mental illness because of all of the psychosocial factors that infuse diagnosis and experience. If you think about persons with disabilities in general, their choices are driven by poverty, isolation, stigma, loneliness, feeling that they are a burden and so on, as well as potentially being coerced. There's also the suggestion, implicit or otherwise, which the UN is worried about, that they're better off dead than disabled.

When you ask about autonomy, you shouldn't be thinking about it in the same way you would if a person is unencumbered by all of those barriers to participation in society. I don't have a mental illness today, but if you stripped away all of the underpinnings that I enjoy that are protective, then I don't think I'd have the same level of autonomy. I don't think I could truly make the same kind of choice with respect to dying that others who have not been deprived of those fundamental rights could.

The commissioner on human rights in Canada said, “Medical assistance in dying cannot be a default to Canada's failure to fulfill its human rights obligations” because “systemic inequality results in inadequate access to services” and "In many instances people, with disabilities see ending their life as the only option”.

The commissioner on Canadian human rights said that.

● (1910)

Mr. Alistair MacGregor: Thank you.

I'm sorry to interrupt you. My time is a little bit limited and I would like to go to Dr. Rajji.

You, sir, have very clearly told the committee that you don't believe Canada is going to be ready by March 2024. It's quite striking because Parliament had to quickly pass Bill C-39 to give us an additional year. Ultimately, this committee is going to be tasked with presenting a report to both Houses of Parliament with recommendations.

In terms of a recommendation, do you have a time frame in mind? Do you have knowledge of approximately how much time the medical community is going to need to arrive at those conditions you have given both in your opening statement and to other colleagues around this table?

The Joint Chair (Hon. Yonah Martin): You have about one minute, Dr. Rajji.

Dr. Tarek Rajji: I don't have a time. I'm representing CAMH here. We're having discussions within CAMH. It's taking us a long time to think about those guidelines and be more specific than what exists now. The discussions have to happen nationwide, in order to have a sense of how long it's going to take.

I cannot give you an answer in terms of how long this could take.

Mr. Alistair MacGregor: In the 30 seconds I have left, can you expand on the previous answer you were about to give about the difficulties professionals could have in separating suicidal ideation from someone making a claim for medical assistance in dying?

Do you want to expand a bit on that, as well?

Dr. Tarek Rajji: Yes, it is difficult at this point. There is no clear way to separate suicidal ideation or a suicide plan from requests for MAID. Therefore, there needs to be some discussion to see a consensus and agreement, as professionals, on what part of an individual's history with a particular illness would constitute that separation.

It's not simple.

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

[*Translation*]

The Vice-Chair (Mrs. Shelby Kramp-Neuman): Senator Mégie, you may go ahead for three minutes.

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

My question is for Dr. Gaudreault, from the Collège des médecins du Québec.

Could you tell the committee whether the CMQ already has some sort of rule framework in place to oversee the delivery of MAID by members of the college to people whose sole underlying medical condition is a mental disorder?

Dr. Mauril Gaudreault: Sorry, but I didn't understand the whole question.

Hon. Marie-Françoise Mégie: Has the college set up or implemented any rules to oversee members who provide MAID to individuals whose sole underlying condition is a mental disorder, or is the college planning any such framework?

Dr. Mauril Gaudreault: No, Senator, we haven't done that at all. We are still at the discussion stage.

What we conveyed are really the five conditions that would help guide physicians providing MAID to patients whose sole underlying condition was a mental disorder if that became a possibility.

Hon. Marie-Françoise Mégie: Does Quebec have a specific group or groups that provide support for MAID in that circumstance, in other words, for individuals with mental disorders?

Dr. Mauril Gaudreault: As I said earlier, we conducted a survey of physicians, and 55% of them wanted the CMQ to develop specific criteria that would help patients struggling with mental disorders access MAID. It is fair to say, then, that the majority of the medical community, just over 50%, would be in favour of moving forward in that case.

Obviously, it's a complex issue. We agree with everything that's been said, but the CMQ believes we need to keep doing this work so these patients can one day have access to MAID.

Hon. Marie-Françoise Mégie: Thank you.

Thank you, Madam Chair.

[*English*]

The Vice-Chair (Mrs. Shelby Kramp-Neuman): Senator Kutcher, you have three minutes.

● (1915)

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

Dr. Rajji, you keep telling us that you speak on behalf of CAMH. I have here their latest guidelines and considerations for operationalizing MAID. Just to be clear so that the committee knows, there is nothing in this document that says that more clarity is needed, which were your words. There is nothing in this document that urges further delay. There is nothing in this document that says that consensus guidelines must be consensus based. In fact, there is no phrase like the one you used that says “consensus-based criteria”. This does not appear in the CAMH document. I will share the document with everybody.

In fact, contrary to your personal statement on irremediability, the document reads that CAMH has to address this issue on a case-by-case basis. It reads:

> CAMH believes that the determination of whether or not an individual patient is experiencing a grievous and irremediable mental illness that could qualify them for MAID must be based on best clinical judgment and a shared decision-making process with the person making the request and anyone else the person identifies... This determination should be guided by nationally developed practice standards...

Those have been completed. You may not agree with some of them personally, but they have been completed, and they've gone through due process.

The other issue here is that CAMH talks about the importance of every effort to distinguish “a request for MAID, based on an individual’s reasoned determination that life with a grievous and irremediable mental illness is not one they desire” from “suicidality as a symptom of a remediable mental illness”.

You said that could not be done, but that's not what the CAMH document says. I just want to be clear: Are you speaking on your behalf, or are you speaking on CAMH's behalf? I ask because your testimony is contradictory to everything that I read here in the CAMH document.

Dr. Tarek Rajji: I'm speaking on behalf of CAMH. The statement I just read was sent by CAMH public affairs to this committee. I'm not seeing clearly that there is contradiction. I'm not speaking on my own behalf; I'm speaking on CAMH's behalf. I can assure you about that.

Hon. Stanley Kutcher: Excuse me, I'm sorry; we have such a short period of time. I will table this so that the committee members themselves can look to see if the testimony from the witness and the information from CAMH are congruent or not.

By the way, Dr. Rajji, Dr. Mark Lachmann in Ontario, who is the medical lead of Sinai Health's Bridgepoint Hospital, who has been tasked with addressing MAID SUMC in Ontario, says that "We are; however, ready to move ahead with MAiD SUMC in Ontario as of March 17, 2024." He is in direct contradiction to what you just said. I will table with the committee the full report from Dr. Lachmann.

The Vice-Chair (Mrs. Shelby Kramp-Neuman): Thank you, Senator Kutcher.

Next we have Senator Osler for three minutes.

[*Translation*]

Hon. Flordeliz (Gigi) Osler (Senator, Manitoba, CSG)): Thank you, Madam Chair.

[*English*]

My question is for Dr. Rajji.

Dr. Rajji, I was struck by your comment that discussions on quality of care have not been held. This committee did hear from the Federation of Medical Regulatory Authorities of Canada, whose mission is to advance medical regulation on behalf of the public through collaboration, common standards and best practices. When the federation, FMRAC, was here, they, in fact, reported to this committee that they are ready. My question for you is regarding your concerns about the discussions on quality of care not being held. Have you met with FMRAC to discuss your concerns or written to them about the lack of discussions? If so, what was their response?

Dr. Tarek Rajji: No, I have not met with them.

Again, these are not my concerns only. These are the concerns of several physicians who are engaged in developing those guidelines. Guidelines are different from standards. I just want to clarify that point as well. The standards document itself, the one developed by the expert panel, states that these are not clinical guidelines, and this is what is missing to ensure quality. That's CAMH's position that we're describing as to why we're not ready.

Hon. Flordeliz (Gigi) Osler: If CAMH, indeed, does have these concerns, why have you not had that discussion with the Federation of Medical Authorities of Canada?

● (1920)

Dr. Tarek Rajji: We are having internal discussions. We did express this concern to the expert panel when they were developing the model that explained the standards of the regulatory bodies. That was our input. That was our feedback to the expert panel before [*Technical difficulty—Editor*]

The Vice-Chair (Mrs. Shelby Kramp-Neuman): We will pause for a moment.

Would you care to direct your question to another witness?

Hon. Flordeliz (Gigi) Osler: I'd like to hear the remainder of his answer.

The Vice-Chair (Mrs. Shelby Kramp-Neuman): I've paused the time.

Dr. Rajji, your connection is frozen, and we are trying to get you back online.

Dr. Rajji, it looks like you are back.

Dr. Tarek Rajji: Yes, I am back. I am sorry about the disconnection of the Internet at the hospital. I'm not sure if you heard my—

The Vice-Chair (Mrs. Shelby Kramp-Neuman): Yes, Senator Osler has about 45 seconds remaining.

Would you like to finish off? You were in the middle of—

Hon. Flordeliz (Gigi) Osler: Dr. Rajii, have you finished your answer? Your connection froze in the middle of it.

Dr. Tarek Rajji: I'm not sure when I disconnected. I'll make sure.

We did share our feedback with the expert panel that there is a lack of clinical guidelines. We recommended that there would be pursuit of developing those guidelines beyond just the standard, so we did share that feedback, as CAMH, as an organization, to the expert panel when we were asked for our feedback.

Hon. Flordeliz (Gigi) Osler: That's fine, Chair, thank you.

The Vice-Chair (Mrs. Shelby Kramp-Neuman): Senator Osler, we're willing to give you a little bit of grace here.

Hon. Flordeliz (Gigi) Osler: Dr. Rajii, you've mentioned consensus-based decision-making, and I'm wondering if you could provide the committee with some examples from medicine, perhaps from psychiatry, where consensus-based decision-making is used to guide treatment decisions.

Dr. Tarek Rajji: An example of this would be when there is not enough high scientific evidence based on experimental evidence to guide treatment A versus treatment B or intervention A versus intervention B. Then the decision for the guideline will be based on the consensus of experts around that condition.

The Vice-Chair (Mrs. Shelby Kramp-Neuman): Thank you, Dr. Rajii.

Senator Martin, you have three minutes.

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

My question will be for Professor Kaiser. You talked about the Convention on the Rights of Persons with Disabilities, highlighting various articles. You've obviously placed great importance on the input and influence of representative organizations for people with disabilities.

Do you have any theory as to why those organizations feel so ignored?

Mr. H. Archibald Kaiser: That is a tough question in many ways, but their answers are fairly simple. They say that this is a fundamentally ableist society and that those norms that devalue people with disabilities, especially persons with mental illness but also all people with disabilities, are ingrained in our medical systems and our legal system. That is really what we're seeing here, that persons with lived experience, who are the genuine experts about issues surrounding irremediability, psychosocial stressors and predictive issues, are not being heard. They have said universally, since the Rodriguez case, that they do not want this, and that's entirely contrary to the CRPD spirit, which is nothing about us without us.

The paradigm has been completely reversed by lawmaking judicially and in Parliament in terms of people with disabilities. It's just part of a systematic pervasive devaluation of their input into public policy, which is forbidden by the CRPD.

● (1925)

The Joint Chair (Hon. Yonah Martin): There's obviously considerable disagreement about the extent to which MAID for persons with mental illnesses either infringes or promotes charter rights.

What should we do in the face of this division of opinion?

Mr. H. Archibald Kaiser: First of all, I deeply regret the fact that the Truchon case was never appealed in the court of appeal or in the Supreme Court of Canada. Failing that, the government should have had the courage to refer it to the Supreme Court of Canada, and I believe something more progressive would have emerged. I believe they would have denied this new extension.

If you look at it very simply under section 15 of the charter, this law does make a difference that's based upon disability, and it does cause suffering for persons with disabilities, whereas others who experience problems are not offered MAID. Second, it is a discriminatory distinction because it reinforces a grotesque stereotype that the lives of disabled people are not worth living, yet everyone else who experiences some form of obstacle to participation in society, which is not attributable to mental illness, is offered suicide prevention rather than suicide facilitation.

I think the answer would be obvious under our charter. This is a violation of section 15, the equality guarantee. I also think it's a violation of section 7, the principles of fundamental justice and the integrative principle of equality.

The Vice-Chair (Mrs. Shelby Kramp-Neuman): Thank you very much, Dr. Kaiser.

At this point, witnesses, thank you very much for joining us this evening. Your testimony has been appreciated.

Colleagues, we are now going to suspend briefly while we prepare for the second panel. Thank you.

● (1925)

(Pause)

● (1930)

The Vice-Chair (Mrs. Shelby Kramp-Neuman): Colleagues, the meeting has resumed.

I'd like to welcome our witnesses for the second panel, beginning with Dr. Sonu Gaind, chief of the department of psychiatry at Sunnybrook Health Sciences Centre, .

By video conference, we have Dr. Eleanor Gittens, from the Canadian Psychological Association; and Dr. Sam Mikail, psychologist.

Thank you all for joining us.

We're going to begin. You will each have five minutes, and we'll begin with Dr. Gaind.

The floor is yours, Dr. Gaind.

Dr. K. Sonu Gaind (Chief, Department of Psychiatry, Sunnybrook Health Sciences Centre, As an Individual): Thank you very much.

My name is Sonu Gaind. I'm a full professor, psychiatrist and governor at the University of Toronto, the chief of psychiatry at Sunnybrook, and a past president of the Canadian and Ontario Psychiatric Associations.

My expertise is in psycho-oncology. I work with cancer patients and their families. I am not a conscientious objector. I was the physician chair of my prior hospital's MAID team. My roles inform my expertise, but I'm presenting as an individual, not for any group.

Thank you for the chance to speak. My testimony is not easy to say, nor easy to hear, but it's necessary to be said. Those seeking expansion claim that not providing MAID for sole mental illness is discrimination, echoing claims by Senator Kutcher.

The opposite is true for three reasons. MAID is for irremediable medical conditions. These are ones we can predict won't improve. Worldwide evidence shows we cannot predict irremediability in cases of mental illness, meaning that the primary safeguard underpinning MAID is already being bypassed, with evidence showing such predictions are wrong over half the time.

Scientific evidence shows we cannot distinguish suicidality caused by mental illness from motivations leading to psychiatric MAID requests, with overlapping characteristics suggesting there may be no distinction to make.

Finally, those with mental illness have higher rates of psychosocial suffering. This all means that MAID assessors will be wrong over half the time when predicting irremediability, will wrongly believe they are filtering out suicidality and will instead provide death to marginalized, suicidal Canadians who could have improved. That is the ultimate discrimination.

Those setting policy have reassured us that we're ready to provide MAID for mental illness. I've reviewed our legislation, the Health Canada practice standard and the CAMAP training for MAID for mental illness. As someone who supports MAID in general, I assure you that we are not ready.

Regarding irremediability, Dr. Gupta acknowledged in her 2020 AMPQ report that “It is possible that a person who has recourse to MAID...could have regained the desire to live”, saying this should be an ethical decision each time. Her 2022 expert panel refused to recommend any additional legislative safeguards, despite Canada lacking legislative requirements for due care and no reasonable alternatives before MAID, unlike other countries.

Professor Downie claimed that irremediability is a legal term rather than a clinical concept. Try those mental gymnastics on your constituents. Convince them it was okay that their loved ones with mental illness got MAID, not because of a clinical assessment based in medicine or science, but because of the ethics of the particular assessor.

Regarding suicidality, Senator Kutcher and Dr. Green claim suicidal people won't get psychiatric euthanasia, and Dr. Gupta claims assessors can identify and separate suicidality in MAID requests because they have been doing it—

[*Translation*]

Mr. Luc Thériault: Madam Chair, could you ask the witness to slow down? He'll have a chance to say everything he wants to say, but he's going too quickly for the interpreter. They have to be able to understand what he's saying.

● (1935)

[*English*]

Dr. K. Sonu Gaind: I hope I'm not losing time.

The Joint Chair (Hon. Yonah Martin): We've paused the time.

You can continue. Slow down your speech.

Thank you.

Dr. K. Sonu Gaind: I can't slow down. I won't be able to finish my comments.

The Joint Chair (Hon. Yonah Martin): It's because of the translation.

Dr. K. Sonu Gaind: I'm sorry, but I have prepared material I'd like to finish.

The Joint Chair (Hon. Yonah Martin): Okay. We're at two minutes and 54 seconds. I stopped as soon as there was an intervention.

Thank you.

Dr. K. Sonu Gaind: Thank you.

Saying something false repeatedly doesn't make it true, and evidence shows they can't make the distinctions they claim. The CAMAP curriculum dangerously doesn't teach assessors how to distinguish suicidality from psychiatric MAID requests, but convinces them that they can, leading to remarkable statements like Dr. Gubitz asking "whether the patient is suicidal or actually has a reason to wish to die, which is not the same thing."

This highlights a key problem with psychiatric MAID assessments; namely, it's the hubris of the assessor thinking they can determine irremediability and distinguish suicidality from psychiatric MAID requests, when evidence shows they can do neither.

Remarkably, the CAMAP suicide module neglects mentioning known risks to marginalized populations. European data shows a gender gap of twice as many women as men getting psychiatric euthanasia, and of unresolved social suffering. Dr. Gupta stunningly dismissed this, saying this gender gap doesn't concern her since nobody really knows what it means. Signals of a gender gap are already emerging in Canada on track two.

An echo chamber has driven expansion with reassurances but no safeguards—it's reassurance theatre.

In recent weeks, I've worked with over 200 colleagues on debunking a slew of disinformation shaping our policies. You can see today's piece at impactethics.ca. Check the new Society of Canadian Psychiatry site, socpsych.org, for other links.

CPA chair Dr. Freeland reluctantly acknowledged she couldn't say all the readiness is there. The lead for CAMAP's curriculum, Dr. Li, wrote she has grave concerns about our preparedness. Dr. Gupta testified that one to two patients in her practice would qualify. I can't speak to the severity of illness she sees, but Scott Kim, a researcher at NIH, estimated we'd have well over 2,000 patients yearly getting psychiatric euthanasia.

This expansion is not so much a slippery slope as a runaway train, like the Lac-Mégantic disaster. The government has plenty of signs we should not be proceeding. You can choose to go ahead, but you can't pretend you weren't warned.

We are not ready. You'll have to decide whether you stick with an arbitrary deadline or you responsibly stop this train.

Thank you.

The Vice-Chair (Mrs. Shelby Kramp-Neuman): Thank you, Dr. Gaind.

Dr. Gittens, you have five minutes.

Dr. Eleanor Gittens (Member, Canadian Psychological Association): Thank you, Madam Chair and members of the special committee, for your invitation to the Canadian Psychological Association to appear before you this evening.

My name is Dr. Eleanor Gittens, and I am the sitting president of the CPA. I'm a professor and program coordinator in the addictions treatment and prevention program at Georgian College. I'm joined by Dr. Sam Mikail, who is a CPA past president and an adjunct clinical faculty member at the University of Waterloo.

The CPA is the national association for the practice, science and education of psychology. There are approximately 19,000 registered psychologists in Canada.

The CPA recognizes the significant work of the special joint committee on such a sensitive and delicate matter as medical assistance in dying. In considering the pending application of MAID where mental disorder is the sole underlying medical condition, the CPA made a series of recommendations in response to the report of the expert panel on MAID and mental disorders, released in May 2022. This was in advance of the special joint committee's June 2022 interim report. These recommendations have been shared with the ministers of Mental Health and Addictions, Health and Justice, as well as the committee.

The CPA also created the Task Force on End-of-Life and produced two reports. The first was in 2018. It discussed various issues related to MAID, such as decisional capacity, advance directives and the role of psychologists. The other was in 2020. It outlined practice guidelines for psychologists involved in end-of-life decisions.

In the interest of time, we will not cover all the recommendations in our reports, but we would like to highlight the following.

First, the expert panel's report currently recommends that an independent assessor should be involved with MAID where a mental disorder is the sole underlying medical condition. It names psychiatrists as the experts. We fully agree these cases will require an assessment independent of the treating team or provider. However, we strongly recommend that psychologists be named as additional expert assessors in these cases. Psychologists are the country's largest group of regulated mental health care providers able to assess, diagnose and treat mental disorders. We can offer expertise relevant to MAID decisions while expanding the qualified assessor pool. Psychologists' expertise in the administration and interpretation of objective measurements has established validity, reliability and embedded indices aimed at identifying inconsistent responding, feigned responding, symptom exaggeration and suicidal ideation or intent. This is vital to the assessment of individuals requesting MAID where a mental disorder is the sole underlying medical condition.

Second, in the development of the newly established curriculum for MAID assessors, the CPA has not been given an opportunity to review or provide input. Given psychologists' expertise in the development, administration and interpretation of psychometric measures for the purpose of complex assessments, we see this as a significant oversight. When it comes to a decision regarding end of life, and when that decision may be impacted by even the slightest possibility of compromised decision-making due to impaired cognitive functioning, the highest standard of care must be taken in conducting objective assessments, in order to guide the final determination of eligibility. Psychologists, as specialists in the assessment and diagnosis of cognitive functioning, are uniquely positioned to ensure this standard of care.

Given this training, and because they also have extensive training in research methods, psychologists should be equally involved in MAID research questions on end-of-life care when a mental disorder is the sole underlying medical condition. Here we refer to recommendation 19, which states, “The federal government should fund both targeted and investigator-initiated periodic research on questions relating to the practice of MAiD”.

Third, we would also like to address the expert panel's recommendation 2: “MAiD assessors should establish incurability with reference to treatment attempts made up to that point, outcomes of those treatments, and severity and duration of illness, disease or disability.”

● (1940)

This recommendation—

The Vice-Chair (Mrs. Shelby Kramp-Neuman): Thank you, Dr. Gittens.

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

We'll go into the first round of questions.

We will begin with Mr. Cooper for five minutes.

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

I am going to direct my questions to Dr. Gaind.

You mentioned that you thought CAMAP training on MAID and mental illness was not adequate to ensure readiness.

Can you elaborate on that?

Dr. K. Sonu Gaind: I'd be happy to, and I will reiterate that I think it's wholly inadequate. I'll be stronger in saying that.

I think we could have gotten a better use out of our $3.3 million that went for that. However, pejorative comments aside, it's something where, when I look at that, I am looking to see if this helps the assessors in any either evidenced or reasonable way to tease apart things like irremediability. As I said, it's not a question of whether a situation is irremediable; it's whether we can predict it to be. That's the whole point. We're making predictions in advance of giving someone death when they're not dying. There is nothing in there that helps us predict irremediability.

The other one is suicidality. This one, actually, I have to say literally shocked me. I am looking at it right now, but the module on suicidality consists of 10 pages of which five slides have content and a four and a half minute audio clip.

There is nothing in there about, for example, the 2:1 female-to-male ratio of psychiatric euthanasia in the places that get it. There is nothing in there about suicidal risk of marginalized populations. They simply make comments like this: "Managing suicidality is something most clinicians learned at some point in their training.... The general principles of managing suicidality apply in the MAiD context as well, whether the person is making a request under track one or two." I don't even know what that means. It doesn't provide guidance. But it does dangerously tell people that they think they can separate suicidality from a psychiatric MAID request, and no evidence supports that.

● (1945)

Mr. Michael Cooper: On the issue of irremediability and suicidality, Dr. Gupta, in the case of irremediability, says that psychiatrists are equipped to make judgments on a so-called case-by-case basis, exercising their clinical judgment.

With respect to suicidality, Dr. Gupta has asserted that there is no issue in terms of determining that of a rational request from one motivated by suicidal ideation, because supposedly, psychiatrists do this all the time.

I'd be interested in your comments in response.

Dr. K. Sonu Gaind: I've heard that echoed by many people, actually, and it is simply not true.

Our suicide assessments that we're trained to provide through residency are not about distinguishing suicidality from whether somebody wants to die through MAID. It's a completely different thing.

The CAMAP guidance focuses very heavily on whether it's impulsive or not, completely bypassing and missing the fact that many suicides are actually planned out, well thought out over a period of time. There is nothing in there that helps us tease those apart.

Furthermore, the evidence from the European countries shows overlapping characteristics between those who actually attempt suicide—most of whom do not try again and do not take their lives by suicide, and they benefit from suicide prevention—and the people who seek and get psychiatric euthanasia.

The obvious concern is: Are we converting transient suicidality, which may be fixed for a relatively long period of time, but still abates with suicide prevention, into a 100% lethality through MAID? That's why the 2:1 ratio of women to men who get psychiatric euthanasia should terrify any psychiatrist, because that 2:1 ratio is exactly the same as the 2:1 ratio of women to men who attempt suicide when mentally ill, as I said, most of whom do not die by suicide and do not try again.

We think that reflects gender-based marginalization. How can we be ignoring that, as a country, and just say that we're ready to march ahead in March 2024?

Mr. Michael Cooper: In her testimony, Dr. Gupta claimed that "some of the voices that are saying we are not ready have contributed nothing to becoming ready" and that "those voices have not been involved even when opportunities have clearly been presented to them."

Do you agree that is a fair characterization?

Dr. K. Sonu Gaind: I don't agree it's a fair characterization. I am actually shocked that she said that. She should know better than most that many people have wanted to be involved and have not had the opportunity to be. That includes for many things that I can give further details on, but I know that the time for your question is limited, but I do not agree with that.

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

Next we have Ms. Koutrakis, for five minutes.

Ms. Annie Koutrakis (Vimy, Lib.): Thank you, Madam Joint Chair.

Thank you to our witnesses for being here with us tonight.

My questions will be directed to Dr. Gittens and Dr. Mikail. We have heard this question time and time again, and other witnesses have answered it, so I will ask the same one to see how your view differs, if in fact it does.

Do you think that the health system is ready for an expansion of MAID eligibility on March 17, 2024, for individuals whose sole underlying medical condition is a mental disorder?

Dr. Sam Mikail (Psychologist, Canadian Psychological Association): I think the issue of readiness involves looking at several components.

The first is legislation. Is it in place? Yes, it is.

Second, are regulations in place? I would argue that regulations are incomplete because they have not been looked at by the broader mental health community. They have been looked at, as was indicated earlier, by the Federation of Medical Regulatory Authorities. That's a narrow group, I think, that's involved in mental health care, so there's more work to be done there.

A third element in terms of determining readiness is having some indication of what the demand will be, and we have no idea of that. Obviously, we need to measure demand against available resources in terms of individuals who are prepared to do these assessments, and we don't know that ratio.

I think we have a lot of gaps in terms of making that determination.

● (1950)

Ms. Annie Koutrakis: What in your view then needs to be accomplished to ensure readiness of the health system for MAID and mental illness? Could you give this committee one recommendation to take back? What are the points that you think, as an organization or as an individual, would ensure readiness?

Dr. Sam Mikail: I think one of the points Dr. Gittens made in her opening remarks is that it's really critical to look at a thorough and expansive way of assessing someone's request for MAID, whether it's someone with a mental disorder or another track two request.

To do that simply based on an interview, I think, is short-sighted and inadequate. Interviews and conversations with patients are prone to bias, and we need more objective indices of assessing someone's mental state and putting the request within the context of that mental state.

There's a very extensive body of research that goes back to the 1950s and has continued since that makes it very clear that actuarial prediction is far superior to clinical prediction. At the very least, I think that's one of the things that's necessary for us to move to a state of readiness. Look at how these assessments are done and whether that actually meets the standard.

Ms. Annie Koutrakis: Do you feel, Dr. Mikail, that the resources that are in place right now are adequate enough to help people to assess...? Do our health care providers have the resources, the adequate training, the adequate tools they would need to assess whether someone should qualify for MAID or not when faced with a mental disorder?

Dr. Sam Mikail: My view would be no. I don't think we're quite there yet. Again, if we are to take the issue of assessment seriously, expand it beyond simply having a conversation or a clinical interview with the individual, record reviews and so on and so forth, and then include more objective measures, I don't think that training is there, at least not as it currently stands.

The Joint Chair (Hon. Yonah Martin): You have about 40 seconds.

Ms. Annie Koutrakis: Thank you.

Do you think we will get there as a country given what we're seeing so far? Do you think we're ever going to get to the place where we will reach consensus?

Dr. Sam Mikail: No. I don't think there will ever be consensus. I think there will always be people in a segment of the health care community as well as society who don't feel this is something that should occur, and a segment, obviously, that supports it.

I think one of the issues around mental disorders is that we're saying, “mental disorders as the sole underlying medical condition”. Not all mental disorders are medical conditions, and I think we have cornered ourselves by using that terminology.

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

Next, we'll move to Mr. Thériault, for five minutes.

[*Translation*]

Mr. Luc Thériault: Thank you, Madam Chair.

Dr. Gaind, how many years have you been a psychiatrist?

[*English*]

Dr. K. Sonu Gaind: If I have to answer that, publicly, it's maybe 25 years, something like that. It's 20 to 25 years.

[*Translation*]

Mr. Luc Thériault: In all your years of practice, have you ever seen a patient whose condition was irremediable?

[*English*]

Dr. K. Sonu Gaind: I've met patients in the course of my practice who have not gotten better, but I've met more who I never thought would get better and did.

[*Translation*]

Mr. Luc Thériault: I should hope so. Psychiatric treatment has to do more than just provide palliative care to suffering patients indefinitely, does it not?

[*English*]

Dr. K. Sonu Gaind: Absolutely. It's about trying to help somebody re-engage meaning and purpose of life. We are able to do that.

The point I was making in my preceding comments is that I could not have predicted which of those people would or would not get better. The vast majority did get better, and if I had thought they would have—

● (1955)

[*Translation*]

Mr. Luc Thériault: Yes, I understood that. It is quite a distinct situation. That is why mental disorders fall under a distinct category. It's much easier when a person has stage 4 cancer or a terminal illness. That's understandable.

It seems to me that, in its report, the expert panel laid out a certain number of conditions precisely because of that difficulty. For example, the mental disorder has to have chronicity. In the course of that chronic condition, the person may experience suicidal ideation. To my knowledge, suicidal ideation is reversible. Be that as it may, ultimately, there are a small number of patients who, after years of trying every possible treatment meant to improve their condition, continue to believe that their life has no meaning in their final moments. I'm not sure whether you heard his remarks earlier, but the president of the Collège des médecins du Québec spoke about cases where patients consistently saw no meaning in their lives.

Do you not think that the expert panel's report lays out parameters that, at the very least, offer hope of the possibility of providing MAID to individuals with mental disorders in a safe and sustainable way, versus discriminating against them simply because they fall under a category of patients who are difficult to care for from a medical standpoint?

[*English*]

Dr. K. Sonu Gaind: It's not about being medically difficult to care for. It's about being impossible to properly predict that they won't get better. That means that you would be providing death under false pretenses. That's my problem with this.

In terms of your question, I'll answer with two things about the people who don't get better.

The people who have those lengthy trials, and who have suffered that long, I will remind you that we have no legislative safeguards that actually require that. Dr. Gupta's expert panel explicitly said that they are not recommending any additional legislative safeguards.

That is remarkable, because anything else just becomes suggestions and reassurances. Even Dr. Li, the scientific lead for CAMAP has said this.

[*Translation*]

Mr. Luc Thériault: Sorry to cut you off.

Recommendation 10 of the report addresses something that other MAID practice guidelines don't cover. Recommendation 10 calls for the opinion of a second independent psychiatrist or another assessor with expertise in the patient's mental disorder before MAID can be administered.

Furthermore, recommendation 16 calls for a prospective oversight mechanism. What do you think of that recommendation? It's not something that any other practice guidelines in the country or even Quebec cover.

[*English*]

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

Dr. K. Sonu Gaind: Regarding the things that you're quoting, first, I'll point out that it's not in the health practice standard. They actually removed the suggestion that there be a specialist involved, so that is no longer there. Dr. Gupta was one of the six people who also wrote that.

In the same expert panel report, they say, literally, that they are unable to provide guidance on the lengths, number, or types of treatments required before providing MAID for psychiatric illness.

That's not a guidance.

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

[*Translation*]

Mr. Luc Thériault: Just because it's not in the report doesn't mean that we can't put it in place or recommend it. You would be supportive of reinstating recommendation 10, then.

[*English*]

The Joint Chair (Hon. Yonah Martin): Monsieur Thériault, the time has expired. We're over the time by several seconds.

Did you want a quick yes or no?

[*Translation*]

Mr. Luc Thériault: It would be helpful for the committee to hear the witness's answer. Given the interpretation delay, I would like an answer. The fact that it isn't part of the standards doesn't prevent the committee from proposing recommendation 10.

[*English*]

The Joint Chair (Hon. Yonah Martin): Okay, Monsieur Thériault.

Give a brief yes or no to the question.

Dr. K. Sonu Gaind: No, it would not provide the safeguard you're thinking it would.

[*Translation*]

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

[*English*]

We have Mr. MacGregor next for five minutes.

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

Dr. Gaind, I'd like to direct my questions to you.

Much has been made of the fact that someone who has an incurable mental disorder will have to show an extensive treatment history in order to access MAID for MD-SUMC. We have the federal government's expert panel, we have Health Canada's MAID practice standards group and CAMAP. The expert panel did say that no further legislative safeguards are required, and if you read the Criminal Code, there is a requirement that a person has to be "informed of the means that are available".

What are your thoughts on that? You've previously voiced some discomfort with that. Why are these standards not enough compared to an actual legislative safeguard within the Criminal Code?

● (2000)

Dr. K. Sonu Gaind: There are a few things. One is, keep in mind that I know of no other thing we do in medicine that requires a carve-out from the Criminal Code to avoid prosecution for homicide. What we're talking about is helping people die when they're not dying—that's the bottom line of what we're talking about.

In terms of the potentially required safeguards, to answer your question, when they're not in legislation, the consequences are, let's put it this way, that there's a lot of leeway given to assessors. This is not just coming from me; this is coming from people working in the field. Dr. Li, who was the lead for the CAMAP guidelines, has specifically said that the current law permits too much latitude based on practitioners' personal values. Currently, it is a legal fiction that determinations of the eligibility of MAID are based on objective clinical judgment. In fact, I regularly witness practitioners' values influencing the interpretation of the current MAID eligibility criteria and safeguards.

If you recall when Dr. Gupta testified here—I found this quite remarkable—she seemed to use as a measure of things going all right, and thus that we shouldn't worry, the fact that no assessor has been prosecuted. That's not the sort of threshold I go by. If people aren't aware of this, CAMAP guidelines—this is not in the mental illness piece, but in a prior thing from 2022, which they called "The Interpretation and Role of 'Reasonably Foreseeable'"—quite literally go through a process of providing guidance for assessors to convert track two MAID requests to track one and for proceeding with track-two MAID, thereby bypassing all track-two safeguards, including the 90-day period, even if assessors don't agree the patient should be on track one.

Mr. Alistair MacGregor: Thank you for that, Dr. Gaind.

In my opinion, there have been conflicting reports on the figures regarding the number of psychiatrists in Canada who are comfortable with this going forward versus those who are not. I think you have previously referenced the Ontario Medical Association and psychiatrists in Manitoba. Do you have anything to report to the committee on the numbers you are aware of?

Furthermore, how could this committee get its hands on actual surveys of psychiatrists from organizations like the Ontario Medical Association, from Manitoba, so we can have definitive numbers?

Should we be sending for those documents to have them tabled as a part of this report?

Dr. K. Sonu Gaind: I can't speak for Manitoba, but for Ontario, I'm happy to forward those to the committee afterwards so that you can see exactly the questions that were asked and how they were answered. The results of those are consistent with the vast majority of surveys that have been done of psychiatrists. They show that—

Mr. Alistair MacGregor: Do you recall the numbers?

Dr. K. Sonu Gaind: Yes, it's about....

Firstly, most psychiatrists are not conscientious objectors. Like me, they support MAID—I'm not a conscientious objector—with 80% to 85% supporting it, but by a 2:1 ratio, they do not support MAID for sole mental illness. These are not the people who are the most stigmatizing and discriminatory; they've devoted their lives to working with people with mental illness.

I'd be happy to forward you those numbers afterwards.

Mr. Alistair MacGregor: Finally, I'd just like a quick comment from you.

Much has been said...that we don't need to have consensus on this, but what does it say to you when such a high number seem to be opposed, with those kind of ratios?

The Joint Chair (Hon. Yonah Martin): Please be very brief.

Dr. K. Sonu Gaind: What it says to me is that not only has this not been driven by consensus, but that a small minority with ideological viewpoints who are true believers have driven the expansion.

The Vice-Chair (Mrs. Shelby Kramp-Neuman): Thank you.

At this point, we'll transition to questions from the senators.

Senator Osler, you have three minutes.

Hon. Flordeliz (Gigi) Osler: Thank you, Madam Chair.

For something different, I have a question for Dr. Gittens and Dr. Mikail.

In August 2022, the Canadian Psychological Association responded to the "Final Report of the Expert Panel on MAiD and Mental Illness" with a series of recommendations. The recommendations included a statement that psychologists must be included.

Outside of government-operated mental health services, are psychologists covered under any provincial or territorial health insurance plan?

● (2005)

Dr. Eleanor Gittens: Psychologists are not currently covered under a health insurance plan.

In fact, I think it's important to note that in this discussion, when we're talking about MAID where mental disorder is the soul underlying medical condition, we're really asking to examine mental illness in the same way we look at physical illness. As a country, we have not yet established parity. Care and treatment of mental illness are not covered by medicare, nor is it readily accessible.

Hon. Flordeliz (Gigi) Osler: Thank you.

In this context, where many patients currently do pay for psychology services out of pocket, how would the involvement of psychologists assist in this country's state of preparedness and readiness?

Dr. Sam Mikail: I think that's a critical concern. Obviously, doing a thorough assessment is not a short process. It's a fairly detailed process. That can be expensive for someone who is looking to have a psychological assessment for determination of eligibility.

Unless it occurs within a hospital setting or through Veterans Affairs, I think a large majority of people wouldn't be able to proceed.

Hon. Flordeliz (Gigi) Osler: Thank you, Madam Chair.

I will cede the rest of my time back to the committee.

The Vice-Chair (Mrs. Shelby Kramp-Neuman): Thank you.

Senator Kutcher, you have three minutes.

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

Dr. Gaind, I'll ask you a couple of questions. Most of them only require yes-or-no answers, so if you pontificate, I'll regretfully cut you off because we have only three minutes.

The first question is, are the medical regulators of each province responsible for the oversight of medical practice in their jurisdiction?

Dr. K. Sonu Gaind: I guess so.

Hon. Stanley Kutcher: That would be a yes.

We've heard from Dr. Grant, who is the chair of FMRAC, that they are ready. I also have received some correspondence from people who have some responsibility for MAID-readiness in their own provinces.

Dr. Hayden Rubensohn of Alberta said, "Alberta and other Canadian jurisdictions are ready for the sunset clause banning MAiD where a Mental Disorder is the Sole Underlying Medical Condition....to lapse."

Dr. Selene Etches of Nova Scotia said, "Despite the challenges that" the legalization...etc., "we feel well prepared in Nova Scotia."

Dr. Lilian Thorpe of Saskatchewan said, "I believe that we can make the expansion to include MAID MD-SUMC safe and appropriate. I believe we are ready."

It's interesting because those people who are actually responsible for doing this work say that they have readiness.

Can you help this committee understand? Are there bodies in Canada that accredit medical training programs?

Dr. K. Sonu Gaind: As you know, Senator Kutcher, there are.

Hon. Stanley Kutcher: The committee may not know. What are those two bodies that accredit medical training programs?

Dr. K. Sonu Gaind: I'm happy to answer your questions, but it sounds to me like you actually know the answers you want.

Hon. Stanley Kutcher: I'm asking you.

Dr. K. Sonu Gaind: I understand that.

Hon. Stanley Kutcher: What are they?

Dr. K. Sonu Gaind: It's the Royal College and the CFPC.

Hon. Stanley Kutcher: That's the College of Family Physicians of Canada.

Are you aware that they have accredited the CAMAP curriculum?

Dr. K. Sonu Gaind: I'm aware that 100 people seem to have registered for the CAMAP curriculum—

Hon. Stanley Kutcher: No, I'm asking if you are aware that they have accredited the CAMAP program.

Dr. K. Sonu Gaind: I'm not aware of that, and it doesn't mean anything to me.

Hon. Stanley Kutcher: Okay, it doesn't mean anything.

Dr. K. Sonu Gaind: No.

Hon. Stanley Kutcher: I think that helps us understand your testimony better.

Let the record show that those bodies that are responsible for accrediting medical training programs, the Royal College and the College of Family Physicians of Canada, have accredited the program. They are responsible for making sure these training programs meet expected standards.

Are you telling us that your opinion of the program overrides the accreditation process of both the Royal College and the College of Family Physicians?

Dr. K. Sonu Gaind: I'm telling you that those are not based on evidence. It's not my opinion: They're not based on any evidence.

Hon. Stanley Kutcher: It's your opinion, then, that these colleges that accredit our medical training in this country should listen to you.

Dr. K. Sonu Gaind: No, I'm not personalizing it. As I said, it's evidence.

Hon. Stanley Kutcher: Did you actually take the training program, or did you only read the module?

● (2010)

Dr. K. Sonu Gaind: I did not want the number of my download to be co-opted as a sign of readiness. That's happened in a previous committee.

Hon. Stanley Kutcher: No, I didn't ask that. I asked, did you actually take the training program?

Dr. K. Sonu Gaind: I read the module.

The Vice-Chair (Mrs. Shelby Kramp-Neuman): Thank you, Senator Kutcher.

Hon. Stanley Kutcher: We need to finish this, because the module is not the training program.

The Vice-Chair (Mrs. Shelby Kramp-Neuman): No. We've been more than generous with the time. It's been more than three minutes. We need to move on.

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

The Vice-Chair (Mrs. Shelby Kramp-Neuman): Senator Martin, you have three minutes.

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

My question is for Dr. Gaind.

You mentioned in your testimony European data and the gender gap that was emerging. Do you think it's important for Health Canada to collect data on the socio-economic conditions that the people who are administered MAID live through?

Dr. K. Sonu Gaind: Yes, I do.

I was quite disappointed that the data that would be valuable was not actually provided in the last report that came out, for the 2022 data. Despite that, there are signals in there that suggest signs of trouble for the expansion that's happening.

I'm happy to elaborate on those, if you like.

The Joint Chair (Hon. Yonah Martin): Yes. Would you elaborate?

Dr. K. Sonu Gaind: Absolutely.

The data collection right now to pick out marginalization.... This is what we're talking about. The idea that many people still get it for cancer and other things, that's true; but we're expanding it to allow other people to get it for all sorts of other reasons. If we ignore that the marginalized can seek it for reasons different from those of the privileged, that's a problem.

We're not collecting the data properly—or at least it's not being reported—except we have seen some increases in striking things. The largest area of increase, I believe, was the “other” category. That went up to 15%—and that's 15% of 13,000 deaths, I'll remind you. It is now the third most reported category. In that, there is a gender gap' its 17% women to 12.8% men.

The “other” category also includes frailty. You see a similar gender gap, with more women getting MAID for multiple comorbidities, such as arthritis and hearing loss, with 12% versus about 8.3% for males. In all of this, about one-third of people get it citing that they feel they are a burden on their family. There is even more of a gender gap if you then break it down to the non-reasonably foreseeable death, track two, numbers. There, the gender gaps go to up to 60% higher for females than for males.

The Vice-Chair (Mrs. Shelby Kramp-Neuman): You have about one minute.

The Joint Chair (Hon. Yonah Martin): Well, 13,000 is a very astounding number to me.

I was talking to an official from a country comparable to Canada. Their numbers are in the hundreds. I'm actually shocked by the numbers, themselves.

You're saying that Health Canada should be reporting in greater detail the quality, the nature and the adequacy of services people receive before they access MAID.

The Vice-Chair (Mrs. Shelby Kramp-Neuman): Be brief, please.

Dr. K. Sonu Gaind: They should be, and they were supposed to after Bill C-7. I actually thought that was why the report for 2022 was delayed by several months. It came out a few days after the vote on Bill C-314, and it did not have any different reporting data, compared with the prior reports.

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

We're going into the second round of questions.

We have Mr. Cooper, for three minutes.

Mr. Michael Cooper: My questions will be for Dr. Gaind.

Dr. Gaind, Health Canada came out with recent data on MAID for 2022. Do you have any comments or observations on that data and, more specifically, on anything that may be relevant to the question of expanding MAID for mental illness?

Dr. K. Sonu Gaind: I do, and actually I started to allude to that in the prior answer as well. There are some gender differentials—the gender gap—that are emerging in some areas of MAID, including track two and the other areas that I spoke about.

Obviously, on the headline numbers being 4.1% of all Canadian deaths, I have to say that the way Health Canada has reported on that surprises me. It seems rather blasé. They say that it's a steady rate of increase of 30% every year. That wasn't the math when I went to school, so whether that's something that maybe should raise eyebrows.... No other country in the world has had that sort of increase in their first six or seven years of implementing MAID policies. I don't know what it means, but it is significant.

The other thing, which is concerning to me, is we honestly don't know how many people truly were track one. I read the CAMAP guidelines. They essentially say:

> A person may meet the "reasonably foreseeable" criterion if they have demonstrated a clear and serious intent to take steps to make their natural death happen soon or to cause their death to be predictable. Examples might include stated declarations to refuse antibiotic treatment of current or future serious infection...or to voluntarily cease eating and drinking.

I had heard anecdotally of some people being converted, so to speak, from track two to track one. In their guidelines, they actually say you can do that, so I don't even know how many truly were track two versus track one. If you also look at the refusals, the rejection numbers of MAID, you see it's remarkably low. There are troubling signs in the numbers.

● (2015)

Mr. Michael Cooper: It has been asserted by Dr. Gupta, as well as other activists, like Jocelyn Downie, that excluding persons suffering solely from an underlying mental health disorder constitutes a paternalistic assumption that such individuals are unable to make autonomous decisions.

I'd be interested in your comments on that.

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

Dr. K. Sonu Gaind: I disagree with that.

We have a piece in impactethics.ca today that addresses that. Even when somebody is able to make a fully autonomous choice, if the assessor thinks they can do something that they can't, that's the problem. It's not about the autonomous choice of the patient; it's about the assessor pretending that they are doing an assessment that they can't.

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

We have Mr. Maloney. You have three minutes.

Mr. James Maloney (Etobicoke—Lakeshore, Lib.): Actually, Mr. Scarpaleggia is going to take the time.

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

Mr. Francis Scarpaleggia (Lac-Saint-Louis, Lib.): Thank you, Mr. Maloney. That's very gracious of you.

When you're in this part of the batting order, if I may say, all of one's questions have already been asked; nonetheless, I'll revisit some things.

You said, Dr. Gaind, that the training programs are not based on evidence.

Dr. K. Sonu Gaind: That's correct.

Mr. Francis Scarpaleggia: Could you elaborate on that?

Dr. K. Sonu Gaind: I can, especially the two key issues that are problematic for MAID for sole mental illness. The first issue is how you predict irremediability, meaning that the person's condition will not get better. The second is how you supposedly separate suicidality—which benefits from suicide prevention—from motivations of people seeking MAID for psychiatric conditions. There is nothing in there, especially on the latter, that truly talks about how to do that, other than saying you need to make the distinction.

They talk about suicidality as referring to the thoughts, plans or actions to end one's life. They talk about a few other characteristics, and almost all of those also apply to somebody who is asking to end their life through MAID for a psychiatric condition.

Mr. Francis Scarpaleggia: I don't know about the other committee members, but all along I've been operating under the assumption anyway, or this idea, that one would only be eligible after looking over—let's take a number—a 15-20 year span of treatment that did not bear fruit. But you're saying this is not in the law, of course. Did you say it wasn't in the module as well?

Dr. K. Sonu Gaind: In the guidance they give, it is true that—

Mr. Francis Scarpaleggia: Is this the Health Canada guidance?

Dr. K. Sonu Gaind: Actually, it would also be even from the expert panel report. They do talk about how you should weigh the lengths of treatment, but they don't actually say how many treatments or the lengths or types you should have, which is very different than any other guidance we have, even on issues that don't lead to death.

When we're going through what the next step is for somebody who has treatment-resistant depression, for example, we actually have guidance on the sorts of paths we should take. Here it is left completely up to the assessor, and that's the problem because there are no legislative safeguards there. Some assessors may well be very dedicated and comprehensive; others will not be.

I can tell you—just very briefly—that I was speaking with a colleague yesterday—

The Joint Chair (Hon. Yonah Martin): I'm sorry, Dr. Gaind. You have seconds.

Dr. K. Sonu Gaind: —about a patient who got MAID while on a pass from psychiatric hospitalization, and the psychiatric team had not even known.

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

Mr. Thériault, you have two minutes.

[*Translation*]

Mr. Luc Thériault: Okay. Thank you.

You said earlier that in your 25 years as a psychiatrist, a small number of patients had eluded your help. You weren't able to help them get better. Doesn't that prove that this wouldn't capture a huge number of potential requesters, that only a small number of people would have access to MAID, contrary to what you're saying?

If MAID were made available to them, what conditions would you want to see imposed?

● (2020)

[*English*]

Dr. K. Sonu Gaind: I'm going to answer your question from someone who has done a data analysis on this. He's an internationally renowned researcher on MAID and suicide numbers. He estimates that, as a lowball estimate, it will be 1,250 to 2,500 cases per year, but it actually would be higher. The basis of that is that about 5% to 10% of requests for MAID are granted in the Netherlands. When you translate all of that, it suggests that, in Canada, we would end up having between 2,500 to 5,000 requests, and the rules in Canada are more lax—

[*Translation*]

Mr. Luc Thériault: We already know that.

I asked you a specific question.

[*English*]

Dr. K. Sonu Gaind: I'm sorry. I misunderstood. I thought you asked me if it would be a small number of cases, and I said that it wouldn't be. Did I misunderstand the question?

[*Translation*]

Mr. Luc Thériault: What I said was that you told us that, in your 25 years of practice, a small number of patients had eluded your help. Contrary to what you are arguing, then, no doubt only a small number of patients would be able to request MAID or be eligible for it.

Would the patients you weren't able to help have been eligible for MAID, according to your criteria? Conversely, do you reject the possibility outright because you don't think there are ever appropriate conditions in which people who request MAID should receive it?

That's my question.

[*English*]

The Joint Chair (Hon. Yonah Martin): I apologize, Dr.—

Dr. K. Sonu Gaind: I see what you're asking, Mr. Thériault. I don't have a time machine, so I cannot go back in time and predict in advance. If I had, many more would have actually thought that they'd never get better.

The Joint Chair (Hon. Yonah Martin): Now we have the last questioner, Mr. MacGregor, for two minutes.

Mr. Alistair MacGregor: Dr. Gaind, I'll ask you a question that I asked one of the witnesses in the first hour's panel.

I've been on this committee from the beginning. What I've struggled with is recognizing the fact that individuals have rights, have agency, have capacity. Those are constitutionally protected rights. However, also, as a society, we have a duty to protect the most vulnerable. I'm indirectly alluding to the constitutional arguments about this: the fact that, yes, we do have rights and freedoms but that those rights and freedoms can be subject to a section 1 analysis, which can place reasonable limits on them.

My question to you as a physician, a psychiatrist with your years of experience on this specific subject, is this: How have you personally approached trying to reconcile the rights of individuals with their agency, their capacity, their ability, to make decisions for their own body versus our collective rights to defend the most vulnerable?

Dr. K. Sonu Gaind: That's an excellent question; it gets to the heart of a lot of this.

I can tell you that, at the beginning, I used to end my talks with a precariously balanced kind of picture that suggested that we're going to find one bright balance point, a solid line where things are right on this side and incorrect on that side. I no longer do that because I don't think that we can find a balance point. It's the issue of overinclusion or underinclusion. To me, the question becomes this: Which mistakes do we want to make? I think that offering and providing death under false pretenses is a pretty big mistake.

The other point I'll make is that when we expand to sole mental illness, are offering death under the false pretense of saying, “Your medical condition won't improve”—and more than half of the time we would be wrong in that—and think we can separate suicidality.... These are also people who are more marginalized through psychosocial suffering, which we also know fuels MAID requests as you get further and further away from reasonably foreseeable death. People shift to try to escape a life of suffering, and that's challenging.

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

With that, I would like to thank all of our witnesses for your testimony this evening and for answering all our questions. We have reached the end of this panel.

The Vice-Chair (Mrs. Shelby Kramp-Neuman): I did see, Chair, that MP Cooper has raised his hand.

The Joint Chair (Hon. Yonah Martin): Okay.

Mr. Michael Cooper: Thank you very much, Chair.

Just very briefly, I have two questions for the clerk. For the public record, as part of the body of evidence for this study, would he be so kind as to confirm the number of briefs this committee has received? How many will the committee be able to use as part of the body of evidence in its report?

● (2025)

Mr. James Maloney: Madam Chair, we're going into committee business momentarily. I believe this is an issue that, amongst others, will be addressed then. That's not to say it can't surface again. I'm not sure this is the appropriate time to discuss it.

Mr. Michael Cooper: I just would like to get that clarified, and leave it at that.

The Joint Clerk of the Committee (Mr. Jean-François Lafleur): Okay—

Mr. James Maloney: I'll only add that this is the first time this part of discussion is taking place in public.

The Joint Clerk (Mr. Jean-François Lafleur): Up to when...? Today...?

Mr. Michael Cooper: No, by the deadline.

The Vice-Chair (Mrs. Shelby Kramp-Neuman): MP Arseneault...?

[*Translation*]

The Joint Chair (Mr. René Arseneault): Thank you.

I agree with Mr. Maloney that we should discuss this later, when we get to committee business.

If we must discuss it now, though, I'd like an explanation as to how a brief differs from a letter, an email or an opinion. If we are setting the record straight, I'd like to know what counts as a brief versus a simple email.

[*English*]

Mr. Michael Cooper: Well, if I may be recognized—

The Vice-Chair (Mrs. Shelby Kramp-Neuman): Mr. Cooper.

Mr. Michael Cooper: —I don't want to get into a big debate about it here. I just want it for the record, because there was some uncertainty about how many—

Mr. James Maloney: I'm sorry. I'm going to interrupt. I apologize, Mr. Cooper.

First of all, we should probably excuse the witness, unless he's interested in hearing this discussion.

The Vice-Chair (Mrs. Shelby Kramp-Neuman): At this point, I believe we shall.

Dr. Gaind, if you'd like to excuse yourself, thank you very much for your testimony, and to all the witnesses who are online, thank you very much for your thoughtful testimony as well.

We'll move on to the goings-on of the committee business. Thank you.

Dr. K. Sonu Gaind: Thank you for having us.

Mr. James Maloney: My only point is that we're having a discussion half behind the curtain and half out, but it's the same discussion. I think that creates a very awkward circumstance for everybody on this committee.

For the sake of being precautious and erring on the side of not saying something that we shouldn't say in public, we should have a discussion in camera and then, if necessary, carry it on after. That's my only point, really.

Mr. Michael Cooper: I'm assuming I have recognition.

The Vice-Chair (Mrs. Shelby Kramp-Neuman): You do.

Mr. Michael Cooper: In short, my understanding, for the public record, is that there have been more than 900 submissions. None of those will be used as part of the body of evidence, because they will not be translated on time. I think it underscores a simple point: We're not ready.

The second question I have, based upon something that was part of the public record, is in respect of a motion the committee adopted when we last met compelling CAMAP to provide module 7 relating to mental illness immediately—immediately means immediately.

The Vice-Chair (Mrs. Shelby Kramp-Neuman): Senator Kutcher...?

Hon. Stanley Kutcher: Thank you very much.

Since we're having this discussion, honourable colleagues, Mr. Cooper is erroneous in saying that the number of submissions we received proves that we're not ready. That's his own statement. I don't think he's ever even seen them, so how he could make that comment is beyond me. Also, as Mr. Arseneault has said, there could be spurious...all sorts of emails sitting in there that are not briefs.

The second thing is on this issue of the training program. Let's be very clear that the written module is not the training program. It's not even the module. The modules are meant to be applied with an expert trainer. They include case-by-case discussion back and forth. I think—

● (2030)

Mr. James Maloney: I'm sorry but I'm going to interrupt, Senator Kutcher, on the same point that I interrupted Mr. Cooper about, and it's a point of order. I think it's a legitimate one. You can disagree with me if you so choose. We are treading into a territory where we're discussing things and we're carrying on conversations about things that took place in a setting that was in camera. We can't carry on the same conversation in public that we had in camera, and that's what we're trying to do. I think if we go in camera we can resolve all of these issues very quickly and agree on them frankly. We have to err on the side of caution, Senator Kutcher. We're being forced into this discussion, and we don't want to be, and I think it's unnecessary.

The Joint Chair (Hon. Yonah Martin): Mr. Maloney, that's agreed, so we will suspend for a moment to allow our colleagues online to get onto a new link.

[*Proceedings continue in camera*]