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Co-Chairs: Marcus PowlowskiYonah Martin





# Special Joint Committee on Medical Assistance in Dying

Tuesday, March 24, 2026

• (1935)

[English]

**The Joint Chair (Marcus Powlowski (Thunder Bay—Rainy River, Lib.)):** I call this meeting to order. Let's get this show on the road.

Welcome to meeting number two of the Special Joint Committee on Medical Assistance in Dying. This is meeting number two, and this is probably about the third or fourth chapter. Many of you have been through previous incarnations of a similar committee.

Pursuant to the order of reference of the Senate adopted on February 26, 2026, and the order of reference of the House of Commons adopted on February 13, 2026, the committee is meeting to study the eligibility for medical assistance in dying of those whose sole condition is mental illness.

Today's meeting is taking place in hybrid format, pursuant to the Standing Orders. Members are attending in person in the room. We have no one attending remotely, which makes my life easier.

I'd like to make a few comments for the benefit of witnesses and members.

To begin with, please wait until I recognize you by name before speaking. I will remind you that all comments should be addressed through the chair. That's me. If you wish to speak, please raise your hand.

With that, let me welcome our initial panel, our first two witnesses.

Appearing today as individuals are Dr. Sonu Gaind, professor of psychiatry, faculty of medicine, University of Toronto, and Dr. Mona Gupta, full clinical professor, department of psychiatry and addictions, Université de Montréal.

Welcome.

The floor is yours for opening remarks of up to five minutes. When there are about 30 seconds remaining, I will try to indicate that your time is almost up. You can go a little bit over afterwards, but if you go on too long, I'll have to cut you off, unfortunately.

Who would like to go first? You're looking at each other.

Okay, Sonu, you start.

**Dr. K. Sonu Gaind (Professor of Psychiatry, Faculty of Medicine, University of Toronto, As an Individual):** Thank you, Mr. Chair and committee. I will endeavour to stay within the five minutes.

My name is Sonu Gaind. I'm a psychiatrist and professor at the University of Toronto, a past president of the Canadian Psychiatric Association and the former chief of psychiatry of two large Toronto hospitals. I've written chapters on suicide for international medical textbooks, and I was the physician chair of the Humber River hospital's MAID team. I'm not a conscientious objector.

Thank you for the chance to speak here.

• (1940)

As you know, the prior AMAD committee concluded that we were not ready to provide MAID solely for mental illness, because MAID assessors could not predict irremediability. They'd actually be wrong more often than they'd be right, and they could not filter out suicidality. This particularly risked marginalized individuals seeking death as a treatment for social suffering.

In 2024, the committee recommended an indefinite pause, and Parliament enacted a three-year delay. Since then, none of those issues have been resolved. Instead, we have even more evidence showing we are not ready to provide MAID for mental illness. In fact, doing so would be the height of irresponsibility.

MAID reporting data mostly tracks illness suffering and ignores many known suicide risk factors, so we can't know the full scope of how much suicidality fuels MAID requests. Despite this limitation, we have evidence showing strong suicide risk factors fuelling especially track 2 MAID. This would get even worse if MAID was provided for solely mental illness.

Feeling a burden, loneliness and isolation are known suicide risk factors that we already see as significant drivers in about half of all track 2 cases. Those with mental illness have higher rates of psychosocial suffering. It is impossible to filter this out, since these factors related to life suffering are actually the same as suicide risk factors. There is nothing to filter. It's the same thing.

Data also shows signals of marginalization associated with track 2 MAID. In 2024, the Ontario coroner concluded that those getting track 2 MAID were much more likely to live in neighbourhoods with higher residential instability, higher material deprivation and greater dependency. Despite using less sensitive geographic-based proxy data rather than individual-level markers, we still see those signals emerge.

Dr. Gupta previously testified that she was not concerned about twice as many women as men getting psychiatric euthanasia in Europe. We're already seeing more women than men getting track 2 MAID. All these things would get even worse if MAID was provided for mental illness and addictions.

Since 2023, international groups looking at Canada have warned against MAID for mental illness. In 2025, the International Association for Suicide Prevention concluded that due to the inability to predict who will have "a poor or hopeless prognosis, and [who] will substantially improve, with or without treatment" for mental illness, "we should not allow" psychiatric euthanasia. Also in 2025, the American Psychiatric Association released its position opposing physician-assisted death solely for mental illness.

This is not about partisanship. This is about evidence.

In contrast, the same people who wrongly claimed in 2024 and earlier in 2023 that we were ready then are again claiming that we are ready now. The accumulated evidence shows they are even more wrong now than they were in the past.

Last time, I called prior assurances of readiness "reassurance theatre". Unfortunately, this has continued, with expansion ideologues suggesting we just need a consensus or to engage in a Delphi process to sort these things out.

**The Joint Chair (Marcus Powlowski):** Dr. Gaiind, I'm sorry to interrupt. Could you just slow down a little? We have to give enough time to the interpreters.

**K. Sonu Gaiind:** If anything, this highlights the absence of actual data supporting the safe provision of MAID for mental illness. On one hand, we have increasing evidence that we're not ready to safely provide psychiatric euthanasia. On the other hand, you may get a consensus of ideologues ignoring that evidence and proposing ways to provide MAID for mental illness anyway. That is not readiness. That's snake oil.

Some have argued that since we already have challenges with nebulous track 2 assessments, it would be discrimination not to extend those assessments to those with mental illness. Those ideological experts have it precisely backward. It would be the ultimate discrimination to expose those struggling with mental illness and addictions to assessors who cannot filter out suicidality, who cannot predict prognosis and whose unscientific assessments would particularly risk the most marginalized with suicide risk factors from social suffering.

We are not ready. If anything, the past three years show it is not a matter of simply thinking we can be ready in three, four or five years. This expansion should be paused until evidence—not constructed consensus—demonstrates that expansion can be done safely.

Thank you.

• (1945)

**The Joint Chair (Marcus Powlowski):** Thank you.

Next is Dr. Gupta. You have five minutes.

[Translation]

**Dr. Mona Gupta (Full Clinical Professor, Department of Psychiatry and Addiction, Université de Montréal, As an Individual):** Dear members of the Special Joint Committee on Medical Assistance in Dying, thank you very much for inviting me to appear before you today.

I am a psychiatrist and researcher in the Department of Psychiatry and Addiction at the Université de Montréal. I have been involved from the outset in the discussion on medical assistance in dying, or MAID, for people with mental health conditions, as a member of the Council of Canadian Academies' working group, and as chair of the Expert Panel on MAID and Mental Illness and the working group on the Model Practice Standard for Medical Assistance in Dying. In my clinical practice, I act as a consultant to colleagues who assess requests for MAID. I assess requests myself.

Stakeholders in Canada's MAID system have achieved several objectives in their preparations for providing MAID to people with mental health conditions. I outlined these in my submission, but today I will highlight three that have been achieved in the period since the committee's meeting in 2023.

Firstly, psychiatrists have reached a consensus that mental disorders can develop into serious and irreversible health problems. On this subject, the Canadian Psychiatric Association, or CPA, has developed clinical guidelines based on sound methodology and supported by a review of the scientific literature. This work, which is due to be published in early April 2026, complements the clinical recommendations made by the Canadian Association of MAID Assessors and Providers, or CAAMEP, in its document entitled "Assessing Incurability for Requests for Medical Assistance in Dying". This report clarifies that a person who has not received adequate care or support may not be eligible for MAID.

Secondly, the document drafted by the CPA provides clear recommendations on the assessment and management of suicide risk in the context of a request for MAID. These recommendations reflect Canadian best practice in this area.

Thirdly, the CPA and CAAMEP have developed clinical guidelines on assessing capacity to consent to MAID for people with mental health conditions. In other words, clinicians from various disciplines agree on how to assess the relevant aspects of a request for MAID, and they are prepared to do so.

[English]

In this same period of time, several other countries have decriminalized assisted dying. Some have MAID regimes similar to Canada's in that they allow assisted dying for persons whose natural deaths are not reasonably foreseeable. These include Germany, Austria, Spain and Colombia. All of these countries, as well as those where the practice preceded Canada's—the Netherlands, Belgium, Luxembourg and Switzerland—have considered the question of whether their regimes apply to people with mental disorders. They have all reached the same conclusion. There is no justification on clinical, ethical or legal grounds to exclude all people with mental disorders from the possibility of accessing assisted dying. Canada now stands alone among permissive jurisdictions to do so.

As for the things that have not been accomplished over the last two years or, indeed, the last five years since the exclusion first came into force, I submit that it has never been explained why it is acceptable to allow MAID for a person with a physical condition with an uncertain prognosis, yet this is a justification to exclude those with mental conditions.

It has never been explained why it is acceptable to allow MAID if a person with both a mental disorder and a physical disorder has experienced suicidality, yet this is a justification to exclude those with mental disorders as their sole condition.

Most importantly, it has never been explained why this debate continues to conflate serious mental disorders with life problems such as sadness following a relationship breakup or a job loss. These kinds of statements deny the existence of severe, chronic and treatment-refractory mental disorders and tell Canadians who suffer from them, as does the law in this country, that a mental illness is not an illness.

Throughout the committee process, I would urge you to consider two questions that are essential in formulating policy on this issue. One, are the justifications offered for exclusion grounded in the assumption that mental disorders, no matter how serious, are merely life problems? Two, are any of the justifications for exclusion really only applicable to persons with mental disorders?

Thank you for your attention.

● (1950)

**The Joint Chair (Marcus Powlowski):** Thank you. That was under time.

For the first round of questioning, I will start off with Mr. Lawton from the Conservative Party of Canada.

Go ahead, Mr. Lawton.

**Andrew Lawton (Elgin—St. Thomas—London South, CPC):** Thank you, Chair.

Thank you, witnesses, for being here.

I'll start with you, Dr. Gupta. You were clear in your comments that you don't think it's reasonable to deny people with only a mental illness access to MAID if it's permitted for people with a physical condition.

Do you believe all mental health diagnoses could lead to someone being eligible for MAID?

**Dr. Mona Gupta:** Mr. Chair, it's an excellent question. I think the Canadian legislation is quite clear—

**Andrew Lawton:** If I may reclaim my time, it was a yes-or-no question, Doctor.

**The Joint Chair (Marcus Powlowski):** I will allow you to briefly finish your response, Dr. Gupta.

**Dr. Mona Gupta:** Yes.

The legislation is clear that it's trying to capture people in certain kinds of clinical circumstances rather than point to specific diagnoses. I would say that what's important is the circumstances of the person, not the medical category we classify them with.

**Andrew Lawton:** Just for clarity, though, do you believe there are certain diagnoses that could never rise to that level of being “grievous and irremediable” and justify medical assistance in dying as far as diagnostic mental illnesses are concerned?

**Dr. Mona Gupta:** There are certainly diagnoses that, by definition, are intended to be time-limited or reactive to certain kinds of circumstances. I think we can safely assume that those would not meet the legislated criteria as they are currently written.

**Andrew Lawton:** Do you believe an eating disorder could qualify someone for MAID?

**Dr. Mona Gupta:** Again, I think the legislation is clear that it really depends on the circumstances of the person.

**Andrew Lawton:** It could.

**Dr. Mona Gupta:** Potentially.

**Andrew Lawton:** Could a major depressive disorder as well?

**Dr. Mona Gupta:** Again, it depends on the clinical circumstances of the person.

**Andrew Lawton:** Is there a consensus amongst psychiatrists on how many treatments one needs to try, or for how long one needs to seek treatment, for it to be classed as treatment-resistant?

**Dr. Mona Gupta:** The use of the term “treatment resistance” in the clinical research literature is meant to capture different populations, depending on the goal of the study being undertaken. There’s a range of different definitions, but of course, as we know, treatment-resistant is not the term used in the legislation. It is a different term that describes a different set of circumstances than what recent researchers are interested in when they want to identify a population they consider treatment-resistant.

**Andrew Lawton:** Would it be reasonable to expect someone in a situation like this, where they have a diagnosis of a mental illness, to try all available treatments before qualifying for MAID?

**Dr. Mona Gupta:** Again, I think it is difficult to make rules about a diagnosis. I think we have to look at the individual person. Certainly, ordinary clinical practice would be that you would pursue all the usual standard, accepted treatments for a condition and then some—proposed experimental treatments, innovative treatments, etc.—but an individual may have reasons that they can’t take advantage of those treatments. They may not tolerate them. They may not be available. Really, it may be so experimental that it’s available in only one centre in the country. It may not really be considered safe for that person in light of their other health circumstances. There are some variables there.

If what you’re suggesting is the standard suite of recommended treatments, that’s what people ideally would have, absolutely.

**Andrew Lawton:** In terms of choice, though, I know that shock therapy is something that someone may find to be very helpful for them. Someone else may be put off by it. Would you ever suggest that a patient has to try it, if there is a legitimate justification to use that therapy for their condition, or would you say that a patient has a choice to say, no, they don’t want that treatment even though it’s available, and they would rather go through the MAID process?

**Dr. Mona Gupta:** That’s a really good point. People always have a choice, if they are capable, to refuse a recommended treatment. That is the state of consent and capacity law in this country, but that doesn’t make the person automatically eligible for MAID, if that’s what you’re getting at.

**Andrew Lawton:** Would it make them ineligible for MAID, though, if they did not want to try a treatment that a psychiatrist thought could help them?

**Dr. Mona Gupta:** Again, I think we’re in a hypothetical here. If, in the context of a clinical conversation about treatment, it was clear that electroconvulsive therapy, or ECT, was an appropriate treatment for that person’s condition, they hadn’t tried it, there was no reason not to go forward, the person was saying that under no circumstances would they have it, and they insisted on having MAID, I think it would be fair for the assessor to say, “I can’t find you eligible in this circumstance. Perhaps at a later time we can talk about this again.”

On the other hand, if there was a good reason not to go forward with ECT—there were some risks in terms of the person’s health or, to take a hypothetical scenario, the person was a lifelong activist against ECT—would it be reasonable to force that person to do something that they, for moral or other reasons, were just in disagreement with? That might be a situation where you would say, no, it’s not reasonable to try to force that person to undertake that.

I think there’s a lot of individual variation here.

• (1955)

**Andrew Lawton:** We’ve each done a hypothetical now.

Thank you.

**The Joint Chair (Marcus Powlowski):** Thank you.

The next round of questioning goes to Dr. Jacek from the Liberal Party.

**Hon. Helena Jacek (Markham—Stouffville, Lib.):** Thank you so much, Chair.

Thank you to our witnesses today.

In a sense, I’m following up on how Mr. Lawton approached his questions.

Supposing we take a case of a schizophrenic who has tried many different medications and has severe side effects. You talked about looking at clinical circumstances. If someone in a situation like that came to you, could you lead us through how you would actually assess their situation, so we can get a real picture of how a practitioner would approach such a situation?

**Dr. Mona Gupta:** I’d start by pointing out that these processes have been elaborated on in a number of different clinical guidance documents, so what I’m going to describe to you is both my opinion as a practitioner and also something that the clinical community has developed together.

When somebody makes a request for MAID, first a conversation needs to be had: Why now? Where did this come from? What’s going on that led them to this request? In my experience, people don’t wake up one morning and say they want to have MAID. It’s usually something that they have thought about for a long period of time. They’ve talked to their loved ones or those in their social circle about it. They will usually explain those things.

You would begin by discussing what the process involves, which, for somebody whose natural death is not reasonably foreseeable, would likely be a fairly lengthy process that may involve seeing not only the two assessors as required but also a third consultant if neither had expertise in the person’s condition, and indeed any other consultants who were necessary. For example, in my program, sometimes the social worker will come with me to see the patient, and sometimes she’ll see the patient on her own. That, of course, isn’t required by law, but if I need that assistance, then I will ask for that assistance.

As I mentioned to you in my description in my introduction, I am a consultant. Mental disorder as a sole condition is not permitted, but my colleagues will say, “You know what? This person has had a psychiatric history. We’d really like to get a psychiatrist involved.”

We would spend time gathering the necessary consultations. We would certainly gather their past medical records. That would include the medical reason they were asking for MAID, as well as the other medical problems they were experiencing. We would get in touch with their primary care provider and the specialists who had been involved in their care, if there were some.

Then, most importantly, we would get involved with the people who were actively treating them, and not just doctors. In the case of mental disorders, there's often a clinical team involving nurses, occupational therapists, social workers, etc., and we would discuss it with them.

Last but not least would be people in their social circle who really have a deeper lived understanding of what this person is going through, whether they're in a state of decline and how that has evolved over time.

It's an elaborate process that involves multiple visits and a lot of conversation and dialogue. It's not simply an encounter between two people.

**Hon. Helena Jaczek:** Would it also include questions around thinking of suicide and whether they had had that type of thinking or had attempted suicide? Is that part of what you would see as an assessment?

**Dr. Mona Gupta:** That's absolutely part of any standard psychiatric consultation, really, but also for any evaluation for assisted dying.

I'm glad you raised this, because I think it's really important to remember that suicidality and suicide risk does not attach only to mental disorders. People who do not have mental disorders can be at risk and can complete suicide. It is very well documented that people in the first months after diagnosis of certain types of cancer have a higher rate of completed suicide than those in the general population. In fact, suicide risk evaluation is relevant to all of MAID assessment, not only for people with mental disorders as their sole condition.

It's also important to remember the opposite: that simply having a mental disorder does not necessarily make you at risk for suicide. There are people with mental disorders who have never had suicidal thoughts, who have never made a suicide attempt and who have never contemplated it in any way.

Again, to come back to the other gentleman's question, I can tell you about these things in general, but so much depends on the individual and their circumstances, and the assessment process has to be individualized to their needs.

Absolutely, suicidality is part of an assessment. For someone for whom it's a prominent problem, the guidance that we have in this country is that interventions that target suicidality ought to be tried. Certainly, for somebody who's in a crisis, it's not even time to be talking about a MAID assessment. That's not going to happen. Things need to settle down. That person needs to be looked after. Things need to be safe before that can even be contemplated.

• (2000)

**The Joint Chair (Marcus Powlowski):** Thank you, Dr. Gupta.

[*Translation*]

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

**Luc Thériault (Montcalm, BQ):** I've heard this line of argument before: that our opponents and their views with which we don't agree are merely ideological, whereas we base our position on science. From an epistemological point of view, it's not particularly convincing.

That said, Dr. Gupta, we often forget that making a request does not automatically mean one is eligible for medical assistance in dying. We overlook the entire process that determines eligibility or ineligibility. That is the subject of today's discussion.

A report by the expert panel has suggested conditions under which MAID could be extended to mental health conditions where these represent the sole medical issue cited. The fact that a patient makes a request does not automatically make this person eligible.

These conditions apply in particular to patients contemplating suicide or to newly admitted and diagnosed patients whose request is based on structural vulnerabilities. When a suicidal patient requests medical assistance in dying, at the very least, we have the opportunity to raise a red flag and treat that person.

This was made very clear in your expert report. The patients' circumstances and context are taken into account. One recommendation even stated that, if a link could be established with structural vulnerabilities, proceeding with the request would be out of the question. You even go so far as to suggest providing them with financial assistance, helping them find accommodation, and so on.

These conditions apply if patients refuse, without justification, all treatments that could improve their condition, even though accessible and effective treatments are available, and if the assessors are unable to reach a conclusion on all or some of the criteria. Some say that a psychiatrist cannot make reliable diagnoses or prognoses, and they wonder whether, ultimately, it really is a science.

If a patient cannot meet all or some of these criteria, that person is not eligible.

Am I wrong?

**Dr. Mona Gupta:** Thank you for your question.

You have accurately described the process, the criteria, and the fact that all requirements must be met. That is exactly what an eligibility assessment is. This process is an eligibility assessment. It is not intended to provide unconditional access to MAID.

**Luc Thériault:** On page 10 of your report, you state the following:

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

This is a far cry from the claims made by those who argue that people suffering from depression will be able to access medical assistance in dying.

• (2005)

**Dr. Mona Gupta:** I fully agree that what you have just read is the standard, accepted approach that follows best practice in suicide risk management.

**Luc Thériault:** You have undertaken training, and you mentioned that you had worked alongside Dr. Daws. You said the following on this subject:

What struck me about Dr. Daws's comments is that individuals whose mental health conditions are the sole medical condition cited when requesting medical assistance in dying will be in the reassuring hands of experienced clinicians who, in their practice of medical assistance in dying over the past seven years, have already managed the full range of complexities that can arise in requests from individuals whose mental health conditions are the sole medical condition cited. Her comment also confirms the expert panel's findings, namely that the complexities so often attributed to mental health conditions are not, in fact, unique to mental health conditions and are already being addressed within our current medical assistance in dying system.

**Dr. Mona Gupta:** Thank you for the question.

I fully agree that the complexity often attributed to mental health conditions already exists in other conditions for which MAID is sought. I do not believe that any new complexity will arise if MAID is granted for patients whose mental health conditions are their sole medical issue.

**The Joint Chair (Marcus Powlowski):** Thank you very much.

Senator Dalphond, you have the floor for three minutes.

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

I would like to thank the witnesses for joining us.

My question is for you, Dr. Gupta.

Earlier, you mentioned how the situation has developed since the publication of our report in 2024. That report was based on the report from the expert panel you chaired in 2022. Subsequently, Health Canada also set up a special task force to assist and guide assessors. As I understand it, they do not distinguish between incurable mental illness and other types of illness. Perhaps you could tell us more about that.

Could you tell us about how the situation has developed? Earlier, you mentioned the CPA, which is now more divided than it was when we met with its representatives at the time.

**Dr. Mona Gupta:** Thank you very much for your question.

A number of activities have taken place. I have highlighted a few that have been carried out since the committee submitted its report in 2024. Since the publication of the federal expert panel's report, several committees have been established, and a great deal of work has been done to assist and prepare clinicians to deal with requests for MAID from people whose sole medical issue is mental health conditions.

Firstly, a working group commissioned by Health Canada developed the Model Practice Standard for Medical Assistance in Dying. The aim was to help provincial and territorial regulatory bodies update their practice standards for MAID to bring them into line with all new clinical situations. I am thinking in particular of patients whose mental health conditions are their sole medical issue. Obviously, it is up to the regulatory authorities to decide exactly how and when they will incorporate this into their standards. However, I

note that several have taken note of the model and have amended their practice standards accordingly.

Subsequently, CAAMEP drafted a number of documents containing clinical recommendations for clinicians, particularly regarding the assessment of the criterion of incurability in the case of a serious and incurable illness. This has extended to the full range of medical conditions from which a person requesting MAID might suffer, as well as to the way in which incurability is assessed in the context of various cases. We often think of cancer, but there are many other diseases from which an individual requesting MAID might suffer.

We therefore need to take a different approach, because the term "incurable" is not necessarily the right word. It is used in clinical practice to describe different types of illnesses. As such, we need to adapt and choose between this legal term and the clinical practice standards used to determine whether the person has undergone all appropriate treatments. That's why CAAMEP has produced this document.

Recently—

• (2010)

**The Joint Chair (Marcus Powlowski):** Unfortunately, your time is up.

[*English*]

Senator Martin, you have three minutes.

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

It is concerning listening to your answers, Dr. Gupta, that these assessors may not have expertise, so I'm wondering about how the training is taking place and what happens when you don't have the expertise to really understand what is happening?

I have those questions, but I have limited time, so my questions are for Dr. Gaiind.

Dr. Gaiind, when you testified before this committee in November 2023, you described Canada's MAID expansion trajectory as not so much a slippery slope but a runaway train. Do you stand by your characterization of a runaway train? I see the expansion, and where we are today is alarming to me as a legislator. Has anything changed since your last testimony in 2023, and has that changed your mind?

**K. Sonu Gaiind:** I do stand by that characterization. In fact, I'd make it even more specific. It's like the Lac-Mégantic disaster. Not only is it a runaway train, but we have had and are having the warning signs, based in evidence, that if we expand MAID for solely mental illness, we will be providing it to suicidal people who could and would have gotten better. That is a runaway train. In fact, I'm not the only one now making that characterization. That was made a week or two ago in *The Atlantic*, in the article done by Charles Lane.

I will point out on this front, about its being a runaway train, that I must say I disagree with virtually every single reassurance that Dr. Gupta has given. She has given reassurances that are not based on evidence. One question asked was, “Why are we conflating, so to speak, mental illness with these social circumstances?” I believe Dr. Gupta even said that it diminishes or denies the seriousness of mental illness. It does no such thing. Refusing to acknowledge that people with mental illness have far more psychosocial suffering...that in itself is stigmatizing and denies the reality of mental illness. In fact, the very high rates of social suffering are precisely linked to suicide risk factors.

If you look at the suicide prevention strategy in the States—I have to say “the States” because we lack one in Canada, where we don’t have a national suicide prevention strategy and yet we’re talking about expanding MAID for solely mental illness—most of those factors relate to the very things I’m talking about to help prevent suicide: social suffering. Only a small number of them relate to illness. This idea that we’re somehow discriminating against people with mental illness if we recognize that.... It is backwards.

I will also further point out, in terms of the runaway train analogy, that reassurances are not evidence, and reassurances are not safeguards. When the previous panel, chaired by Dr. Gupta, had its opportunity to recommend specific safeguards in law, they refused to. They said, “We cannot actually say how many treatments, the types of treatments, etc., that someone should have before getting MAID for mental illness,” despite the fact that our country has no due care requirement.

**The Joint Chair (Marcus Powlowski):** Thank you, Dr. Gaidin, and thank you, Senator Martin.

We go now to Senator Moodie. You have the floor for three minutes.

**Hon. Rosemary Moodie (Senator, Ontario, ISG):** Thank you, Mr. Chair.

My question is for Dr. Gupta. I’d like you to outline for us what professional training and supports have been developed, specifically how professional associations have worked to move forward in terms of making their members more familiar and up to the task of clinical assessments and providing clinical care in this area. Let’s start there.

**Dr. Mona Gupta:** I want to start by mentioning that all clinicians.... I’m going to say “physicians”, because I’m a physician, so I’m going to speak for my own profession. All physicians have a statutory regulatory obligation to be competent before we undertake any clinical activity.

The thing that prevents me from doing ECT, even though it’s something psychiatrists do, is that I’m not trained to do it personally. It is the same thing that would prevent me from engaging in MAID assessment with a patient who had a condition that I was unfamiliar with, or in a circumstance that I was not comfortable managing in my role as a psychiatrist. We already have a basic obligation not to engage in therapeutic acts for which we are not trained. That applies to every single thing we do. That applies to MAID as well.

We have a responsibility to acquire those competencies once we have finished our training, because then we’re in the wild and we have to make sure that if we’re doing new things, we acquire those competencies.

There are different ways to obtain competencies. One is to follow formal training programs. One is to do it under the supervision and mentorship of colleagues. In the MAID space, in fact, we have both of those things. We have a formal training program that has been developed by CAMAP, the Canadian Association of MAID Assessors and Providers, which covers the full range of MAID activities and is available to physicians and nurse practitioners, but CAMAP is not the only provider of training in MAID. For example, the Université Laval offered a comprehensive MAID training course. Practitioners will get their training from the provider that is available to them, and there are outlets for mentorship, supervision and case consultation should they need it.

I just want to come back to the last point. Senator Martin raised it, and it is the most important of them all. It is that if you do not have expertise in the patient’s condition for track 2, you must obtain a consultation with a person who has that expertise. That’s not merely a question of clinical judgment; that is a statutory requirement.

I think the combination of the law, professional guidance, training, mentorship, supervision and case consultation through structures that provinces and territories have put in place provide a comprehensive way to ensure that practitioners achieve their competencies and continue to develop in their professional abilities with contact and interaction and guidance from their colleagues.

• (2015)

**The Joint Chair (Marcus Powlowski):** Thank you, Dr. Gupta.

We will go to Senator Wallin for three minutes.

**Hon. Pamela Wallin (Senator, Saskatchewan, CSG):** I have three quick questions for Dr. Gupta. You know that our time here is short.

We’ve all read your CV, and you’ve been involved in this intently. Based on your experience, if MAID is approved for patients whose sole underlying condition is mental illness, do you believe we have standards and practices and clinical assessments that will protect patients with mental disorders?

**Dr. Mona Gupta:** Yes, I do.

I think the clinical community has worked very hard to develop standards. I think we have devoted more time and attention to people with mental disorders than to any other patient group. I think that’s a good thing. I think that’s something we should be proud of, and I think we are ready to move on to the next phase.

**Hon. Pamela Wallin:** As my second question, I just want to confirm something that you mentioned, which is that some mental disorders are considered irreversible and that this condition can be assessed.

**Dr. Mona Gupta:** Yes, the guidance document that the Canadian Psychiatric Association has developed gives clinicians a strategy for reasoning clinically about whether a person's condition is a grievous and irremediable medical condition.

**Hon. Pamela Wallin:** I know you can't actually answer my last question based on evidence, because this is not a legal practice in Canada at this point, but is there any evidence in other quarters that the marginalized or those living in poverty or those with life problems are more likely to access MAID or have MAID offered to them than those who have better incomes and live in better conditions?

**Dr. Mona Gupta:** Thanks to the excellent data collection that has been happening through Health Canada, the best data that we have in fact indicates the opposite—that MAID is accessed to a greater extent by people who are better off, who are white and who are in better social situations.

In some ways, it's not surprising, because it's true in general in health care that people who are better off tend to access it, and the same is true for MAID.

● (2020)

**Hon. Pamela Wallin:** In terms of readiness, you think the providers and assessors are in a good place to take this on, should they be asked to do so.

**Dr. Mona Gupta:** Yes, I do. I think it's like any new practice in that not everybody will rush out and start doing it. People who are more experienced—we've had MAID for 10 years now—will take a leadership role. They will supervise and mentor newer and younger and less experienced colleagues.

**The Joint Chair (Marcus Powlowski):** Thank you, Senator Wallin.

Senator Wells, you have the floor for three minutes.

**Hon. Kristopher Wells (Senator, Alberta, PSG):** Great.

Dr. Gupta, the purpose of this committee is to study readiness across the country. Can you talk to us about the elements of clinical readiness and what we should be assessing?

**Dr. Mona Gupta:** Essentially, clinical readiness involves the things I mentioned earlier. It involves training that somebody can undertake in order to obtain a competence they need in order to do a clinical activity. It involves clinical guidance, if that's necessary, in the form of guidelines or documents that explain more technical points, if that's needed. Most importantly, it involves a community of practice of other people who are doing the same activity that can provide sober second thought—no pun intended—on your practice and to whom you can go for advice and assistance and to discuss challenging cases in real time so that you can get feedback on them. It requires supervision, if needed, for newer and inexperienced colleagues who need to have direct guidance in real time.

Those are the elements of introducing any new practice into medicine.

**The Joint Chair (Marcus Powlowski):** Thank you.

We'll go on to the second round.

Ms. Jansen, you have three minutes.

**Tamara Jansen (Cloverdale—Langley City, CPC):** On behalf of my mom and dad and sister, Dr. Gaiind, I'd like to ask you a question. You mentioned that the idea that we can reliably separate suicidality from a MAID request, or even predict that a mental illness is truly irremediable, is, in your words, “snake oil”. That's a pretty serious warning.

Can you walk us through what the evidence actually shows? How often do doctors get these predictions wrong? How much overlap is there between someone who is suicidal and someone who would qualify under psychiatric MAID?

**K. Sonu Gaiind:** What the actual evidence shows—again, reassurances aside—is that even with our best precision modelling, for something as severe as treatment-resistant depression for potential MAID assessments, assessors would get them wrong more than 50% of the time. A study done by Marie Nicolini showed 47% accuracy, which is interesting; it's actually worse than flipping a coin.

Nothing has changed in terms of developing more evidence to say that we can make better predictions. In fact, it's the opposite. Even Dr. Gupta has agreed, in a report she chaired, that you can't make determinations of irremediability. She suggested that this should be an ethical decision each and every time by an assessor. I'll let people think about whether they want their physician providing death to make an assessment of irremediability as an ethical decision.

Regarding suicidality, you actually cannot separate those factors, because, as I mentioned, they're the same factors, and we are seeing those, contrary to what Dr. Gupta said. We are seeing those emerge already in track 2 data, which will only get worse if it's expanded to MAID for mental illness.

**Tamara Jansen:** Okay.

Dr. Gaiind, I'm trying to understand something else. We heard that currently more women are accessing track 2 MAID. The explanation we were given was that, well, it makes sense; women have more chronic conditions. When you unpack that, though, what it means is that many women are living with such long-term, non-terminal things as chronic pain, disability or ongoing health issues.

If we see more women in that situation choosing MAID, especially when you add on layers of isolation and financial stress, should we be treating that as something Canadians should just expect?

**K. Sonu Gaiind:** I would be terrified if we actually fell to that normalization of thinking, that more women than men should get MAID for psychiatric conditions. We know that twice as many women as men attempt suicide when depressed. Most do not die by suicide. Most do not even try again. The obvious concern is about whether we are converting a transient suicidality to a permanent death by MAID. We see that in Netherlands. Again, there's evidence that has not been brought forward here that about twice as many women as men in the Netherlands are getting MAID for psychiatric conditions.

You know, in terms of more women than men having some of these conditions, and that being used as a justification for why we may see some more track 2 women, or even people in socially marginalized situations getting track 2, if a drug company made a pill that mistakenly ended the lives of more women than men and the lives of people who showed markers of suicidality like social suffering, I cannot imagine that we'd say it was then okay that more women were dying since they were more likely to have chronic conditions anyway. None of these women on track 2, or on MAID for mental illness, would have otherwise died. We would be facilitating their death.

• (2025)

**The Joint Chair (Marcus Powlowski):** Thank you, Dr. Gupta.

Ms. Koutrakis, you have the floor for three minutes.

**Annie Koutrakis (Vimy, Lib.):** Thank you, Mr. Chair, and thank you to our witnesses for being here tonight.

My question is for Dr. Gupta.

As you know, Dr. Gupta, some individuals can currently access MAID when their underlying condition is a neurocognitive disorder, such as dementia or Parkinson's disease, in certain circumstances. Would shifting from the term "mental illness" to the term "mental disorder", as proposed in Bill C-218, risk inadvertently excluding those individuals from access to MAID?

**Dr. Mona Gupta:** As you may have read in different reports and so on, "mental illness" is not a standard clinical term. The standard clinical term is "mental disorder", and that includes everything that's in our classification scheme. The one we use in Canada the most is the DSM-5, published by the American Psychiatric Association.

Dementia, which is actually classified as "major neurocognitive disorder", is always the result of some other condition. If "mental disorder" were to be excluded, then "major neurocognitive disorder"—i.e., dementia—would also be excluded, because it is considered a diagnosable mental disorder.

**Annie Koutrakis:** Can you identify a single dataset that tracks outcomes specifically for MAID assessments where mental illness is the sole underlying condition and that we could use to measure whether the system is operating safely if the exclusion were lifted?

**Dr. Mona Gupta:** I just want to make sure, Mr. Chair, that I understand the question.

Do you mean datasets in other countries?

**Annie Koutrakis:** Yes.

**Dr. Mona Gupta:** Certainly the Netherlands and Belgium probably have the most robust data collection, because they have an oversight process, similar to what we have in Quebec, through which they review, through a commission, every declaration of a euthanasia death. They would have data on the numbers of requests, those that were accepted and those that were denied, as well as some information about the patients. That's what we can rely upon.

There are growing datasets in other countries that I've mentioned, but some of them are fairly young regimes, and that data takes time to accumulate.

**Annie Koutrakis:** In your opinion, or in what you have seen in your studies, are there some provinces or territories in Canada that are better prepared than others?

**Dr. Mona Gupta:** It has been five years since the exclusion clause was first introduced, and provinces and territories have had quite a bit of time. If we recall, Bill C-14 was passed and a MAID system grew up overnight. In Quebec, we had 18 months to prepare, but that was 18 months for an entire MAID system. It's been five years now, and I think provinces and territories are competent. In fact, it is their responsibility and their jurisdiction to create a MAID system that is suitable for their local needs.

In my experience in talking with my colleagues across the country, they all have slightly different systems, but those systems are designed with the intent of serving the people of that jurisdiction in the best way that those authorities have deemed suitable.

**The Joint Chair (Marcus Powlowski):** Thank you, Dr. Gupta and Ms. Koutrakis.

[Translation]

Mr. Thériault, you have the floor again for two minutes.

**Luc Thériault:** Dr. Gupta, in a *National Post* article featuring an interview with Dr. Gaiind, it is stated that a doctor in the Netherlands must conclude that the person's suffering is unbearable. Both the doctor and the patient must be convinced that there are no reasonable alternatives. However, Dr. Gaiind points out that Canada currently has no similar requirements regarding reasonable care. People must be informed of the means available to alleviate their suffering.

On page 13 of the report, it states:

[...] the incurability of a mental disorder cannot be established in the absence of multiple attempts at interventions with therapeutic aims.

Here, we're getting into the definition of "reasonable".

Recommendation 8 states that assessors should ensure that the requester is consistent and thinking rationally during a period of stability, not during a period of crisis.

Then, in Recommendation 10, it states:

The requester should be assessed by at least one assessor with expertise in the condition(s). In cases involving MAiD MD-SUMC, the assessor with expertise in the condition should be a psychiatrist independent from the treating team/provider. Assessors with expertise in the person's condition(s) should review the diagnosis, and ensure the requester is aware of all reasonable options for treatment and has given them serious consideration.

It strikes me as a bit out of place. Do you agree with Dr. Gaind that there is no such concept of reasonable care being provided?

• (2030)

**Dr. Mona Gupta:** Thank you very much for the question.

I disagree with his assessment of clinical guidelines and best practice regarding eligibility assessment.

I think what happened in Canada is exactly what we wanted. That is, once there is a legislative framework governed by the Criminal Code—we agree that it is not in the Criminal Code that reasonable treatment options will be set out—it is up to clinicians to produce documents containing clinical guidelines, which tell clinicians what they must do and what steps to follow. That is exactly what is found in the report and in the documents I mentioned.

**The Joint Chair (Marcus Powlowski):** Thank you very much.

Mr. Dalphond, you have the floor for another two minutes.

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

If you would like to resume answering my last question, Ms. Gupta, you had gotten as far as “recently”.

**Dr. Mona Gupta:** Thank you very much.

**Hon. Pierre Dalphond:** You have one minute and forty-five seconds to finish your overview.

**Dr. Mona Gupta:** Yes.

Very recently, the Canadian Psychiatric Association set up a working group to draft a document containing recommendations, specifically to explain to clinicians how to assess a mental disorder and determine whether it constitutes a serious and irreversible medical condition. This document also addresses the management of suicide risk in the context of a request for medical assistance in dying.

This is therefore a document produced by psychiatrists to assist clinicians, including psychiatrists, when the requester has a mental disorder.

**Hon. Pierre Dalphond:** Could you forward this document to the committee?

**Dr. Mona Gupta:** Yes. As soon as it is published, I will be able to send it to you.

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

[English]

**K. Sonu Gaind:** Mr. Chair, I reiterate a point of personal privilege on a comment Monsieur Thériault made. He specifically referenced something of mine in an article that is inaccurate.

**The Joint Chair (Marcus Powlowski):** What is the point you want to make?

**K. Sonu Gaind:** The point is that he was suggesting that my comment that we lack a due care requirement is inaccurate. It's per-

fectly accurate. We don't have any legislative safeguards for that. That was the point I was making.

**The Joint Chair (Marcus Powlowski):** We've formally finished the order of questioning. Let me pose—

**The Joint Chair (Hon. Yonah Martin):** What about me?

**The Joint Chair (Marcus Powlowski):** Senator Martin, the most important person of all....

**The Joint Chair (Hon. Yonah Martin):** I know Dr. Gupta says that her colleagues say the provinces are ready, but I'm aware that nine out of 10 provinces have said they are not ready.

Dr. Gaind, are we ready for this?

You mentioned safeguards, and you're concerned about that. Would you comment on that?

**K. Sonu Gaind:** Thank you, Senator.

I would love to comment on it more. I'll have to be very brief, given the time.

I could go on at significant length about the lack of safeguards in response to the reassurances Dr. Gupta has provided. Among those are the lack of readiness for making the predictions I've discussed for separating suicidality. We can't.

It's even the issue of the guidance from the Canadian Psychiatric Association. That's my former association. I'm a past president of that. Their guidance has been really troubling, because it lacks evidence. It's based, again, on consensus. They said in 2023 that we were ready. They said in 2024 that we were ready, but it's a constructed consensus that most psychiatrists do not share. Most psychiatrists in the country are against expanding MAiD solely for mental illness. The reason for that is not based on ideology. The reason for that is based on evidence and concern about extending these assessments to suicidal individuals who are marginalized.

**The Joint Chair (Marcus Powlowski):** Thank you.

I'll exercise my discretion as chair to ask a very brief question.

Dr. Gupta, you seem like an excellent psychiatrist. I really like some of the things you suggested.

You talked about having to look, as an assessor, at previous medical records. You would consult other treating physicians and treating psychiatrists. You would look at the social circle and talk to them. You would look at the clinical teams. All of this is very admirable. You talked about how people should have tried other forms of treatment. You talked to even third or fourth psychiatrists.

Dr. Gaind, under the current legislation, is any of that a requirement?

• (2035)

**K. Sonu Gaiind:** None of that is in the legislative safeguards. The groups that have looked at it and recommended expanding MAID for mental illness, including Dr. Gupta's panel, from which two members resigned, refused to recommend any additional legislative safeguards.

I will agree that most MAID assessors are diligent, but it's false to equate goodwill and predominant group competence with safeguards. They're not the same thing. Even a small group without safeguards can do a lot of damage, and that is what the concern is.

**The Joint Chair (Marcus Powlowski):** With that, I conclude the first panel. We'll go on to the second panel, so there will be a brief pause.

We'll suspend.

• (2035)

(Pause)

• (2040)

**The Joint Chair (Marcus Powlowski):** For the second hour, I'd like to welcome the two new guests.

We have Jocelyn Downie, professor emeritus, faculties of law and medicine at Dalhousie University, and Dr. Trudo Lemmens, professor and Scholl chair in health law and policy, Jackman faculty of law, University of Toronto.

Each of you will have five minutes to make your opening comments. Can we start with you, Professor Downie?

**Jocelyn Downie (Professor Emeritus, Faculties of Law and Medicine, Dalhousie University, As an Individual):** Thank you, Mr. Chair.

Good evening. Thank you for the invitation to be here.

I am Jocelyn Downie. I'm a professor emeritus in the faculties of law and medicine at Dalhousie University. I've been active in legal and ethical academic research on MAID since the early 1990s. I was a member of the legal team in Carter, and I've served on multiple expert panels and participated in the drafting of clinical guidance and regulatory standards.

With that, let's jump right in.

A barrier to accessing MAID MI-SUMC is a limit on the section 7 and section 15 charter rights of persons with mental illness. The Supreme Court of Canada held in the Carter case that a ban on MAID is unconstitutional if it prohibits access for those with a grievous and irremediable medical condition, including an illness, disease or disability, and mental illness falls within this category.

Some will say this is not true, but their arguments have been advanced in court on two occasions and roundly rejected. I invite you to read Carter, as well as paragraphs 43 to 59 of the Alberta Court of Appeal in E.F. and paragraphs 483 to 501 of the Quebec Superior Court in Truchon, both confirming that mental illness falls within the Carter ambit.

Note also that Truchon wasn't appealed because the government found it "compelling", strongly believed it would lose and didn't want to make people suffer in the meantime.

Some will claim that things have changed sufficiently since Carter to change the conclusion that to ban MAID MI-SUMC is to breach the charter, but they have not. If anything, government data and peer-reviewed analysis—not anecdotes breathlessly reported by media and recklessly spread over social media and even presented to parliamentary committees—show that the evidence supporting the SCC's conclusion has only grown stronger. For example, the official Health Canada data on all MAID provisions since 2016 show that socio-economic vulnerabilities and marginalization are not drivers of requests for MAID.

Ontario v. G is also essential reading for the committee, as on the SCC's logic, a blanket ban on access to MAID MI-SUMC unjustifiably violates section 15 of the charter by failing to allow for individualized assessments. Therefore, the answer from a legal perspective about whether to allow MAID MI-SUMC was and remains robustly "yes".

The next response might then be, "But this is different, because it's just a temporary exclusion and it can be justified under section 1." This is also not true.

On metrics for justification, permissible justifications are clinical and regulatory readiness, but not political readiness. The last two Truchon extension decisions have strong wording on this.

On burden of proof, the government's extension of the exclusion clearly bears it.

On threshold, the burden is very heavy for a government seeking to continue to breach charter rights after a finding of unconstitutionality. The Department of Justice Canada itself recognizes this on its website.

As you have heard and will continue to hear, clinical readiness has been met. Based on my research, I can attest that regulatory readiness has also been met.

Consider finally the following relevant precedents.

Quebec delayed the coming into force of its MAID legislation for 18 months to implement an entire regulatory framework for MAID. The Supreme Court of Canada in Carter gave the government 16 months to put in place an entire regulatory framework for MAID. The Quebec Superior Court, in the Truchon case, gave 18 months to put in place a regime for track 2 MAID. The justification for the four-month Carter extension to the suspension of the declaration of invalidity was a federal election. For Truchon, it was an election, and more extraordinarily, a global pandemic.

Critically, in the Carter and Truchon extensions, eligible individuals could go to court for authorization to access MAID, dramatically reducing the harm of the extensions. The government even covered the applicants' costs through the later Truchon exclusions.

The MI-SUMC exclusion will have reached 72 months by March 2027, just to implement MAID MI-SUMC. There are no comparable justifications and no avenues for individuals to seek court authorization—

• (2045)

**The Joint Chair (Marcus Powlowski):** I'm sorry to interrupt, Professor Downie. I should have given you a warning beforehand that I would give you a little warning of how long you have left. I'm going to give you an extra—

**Jocelyn Downie:** I just need five seconds.

**The Joint Chair (Marcus Powlowski):** That's more than enough.

**Jocelyn Downie:** The balance for any further extension is completely, almost absurdly, inconsistent with the legal threshold and relevant precedents.

In sum, any further extension of the exclusion of MAID MI-SUMC cannot be demonstrably justified and would be in breach of the charter.

Thank you.

**The Joint Chair (Marcus Powlowski):** Thank you, Professor Downie.

Now, Professor Lemmens, you have five minutes.

When there are 30 seconds left, I will hold something up to indicate to you to try to hurry up and finish your remarks.

**Trudo Lemmens (Professor and Scholl Chair in Health Law and Policy, Jackman Faculty of Law, University of Toronto, As an Individual):** Joint chairs, dear members, my name is Trudo Lemmens. I have been a professor of health law and bioethics for over 25 years and have an extensive research record related to MAID, including MAID for mental illness. I am a member of the Ontario MAID death review committee, but I speak in my own name. Thank you for inviting me.

Let me be blunt: There are myriad reasons not to introduce MAID for the sole reason of mental illness, and they are clearer than ever. First, it is not constitutionally required. Second, evidence from Canada, Belgium and the Netherlands shows it would create significant additional risks of premature death for many Canadians with mental illness.

On constitutionality, I will be brief. Submissions to AMAD by constitutional scholars and a letter signed by more than 30 scholars, including leading constitutional and human rights experts, support this. The committee can also consult a co-authored analysis in the *Manitoba Law Journal*, and I'm sure they will hear from other constitutional colleagues.

Second, it is wrong to claim that denying MAID for mental illness alone is discriminatory simply because people with concurrent physical conditions have access, as is sometimes stated. This reverses the burden of justification. Instead we must ask what current MAID problems tell us about the risk in expanding access.

Troubling evidence is accumulating. The Ontario MAID death review committee reports cited by the UN Committee on the Rights of Persons with Disabilities in support of its request not to introduce MAID for mental illness and to withdraw track 2 MAID contain case summaries that reveal at times sloppy, impressionistic and minimalistic assessments. These reports include cases in which unaddressed suicidality, psychosis, substance use issues, pressure from caregiver burnout and cognitive impairments did not stop MAID providers from ending people's lives. Some cases involved only cursory reviews of mental health history.

Judicial interventions, other reports and media reports reveal similar concerns elsewhere. Examples include a woman seeking suicide prevention in B.C. being informed about MAID and a man who was involuntarily hospitalized for suicidality receiving MAID while on a day pass.

Current practice provides a critical insight: Some MAID providers already function as a pole of attraction for suicidal people. In Canada, and in Belgium and the Netherlands, which permit psychiatric euthanasia, a small number of permissive clinicians drive controversial cases. People shop for assessors who are willing to say yes, even when care teams are working toward recovery. Such providers become a predictable pathway, much like a suicide-prone bridge, drawing people toward a guaranteed death.

We know that when a known pathway is removed, many people who otherwise would die by suicide will be saved. MAID for mental illness does the opposite of what we otherwise do—namely, installing special guardrails on such bridges. It institutionalizes a medicalized method of death for mental illnesses in which hopelessness is often a key symptom.

Gender concerns are key too. Women attempt suicide at about twice the rate of men, and in jurisdictions allowing psychiatric euthanasia, many more women than men receive it. Of 30 youth aged 17 to 30 who received psychiatric euthanasia in the Netherlands in 2024, an overwhelming majority were women.

Reassurances that the practice will remain rare and limited to cases of years of treatment failure are speculative and unfounded. MDRC reports already indicate that MAID has been provided despite unaddressed mental health and substance use issues, minimal exploration of palliative, disability or community supports, and track shifting from track 2 to track 1.

We will further see many more cases than in Belgium or the Netherlands, where psychiatric euthanasia, particularly in the Netherlands, is on the rise. Some psychiatrists there already use non-existing clinical concepts, such as “mentally terminal”, to approve patients for euthanasia. Unlike in Canada, Belgian and Dutch law still at least requires a clinician provider to agree that no other treatment options remain. Canada’s MAID law and policy emphasize access over protection.

Several Canadian provinces face worse problems with access to timely and quality mental health care, as 10% of people wait for six months or more for mental health care and 50% wait for a month.

The question before Parliament is very concrete: Knowing that people with intersecting disabilities already face risk of death in our MAID regime, will the law strengthen guardrails and prioritize suicide prevention or do the opposite?

Thank you.

• (2050)

**The Joint Chair (Marcus Powlowski):** Thank you, Professor Lemmens.

For the first round of questioning, we’ll start off with Mr. Cooper from the Conservative Party for five minutes.

**Michael Cooper (St. Albert—Sturgeon River, CPC):** Thank you, Mr. Chair.

Professor Lemmens, Professor Downie asserted that the declaration in Carter was that “a grievous and irremediable medical condition” includes mental disorders. The last time Professor Downie appeared before this committee, in November 2023, she stated that if the Supreme Court intended otherwise, the court would have said so expressly. What Professor Downie conveniently didn’t mention is that the court went on to state:

The scope of this declaration is intended to respond to the factual circumstances in this case. We make no pronouncement on other situations where physician-assisted dying may be sought.

To be clear, the factual circumstances in Carter did not in any way involve persons seeking MAID who had an underlying mental health disorder. Is that correct?

• (2055)

**Trudo Lemmens:** Yes, that is obviously correct. There are other statements as well that have to be taken into consideration in the Carter case.

When Belgian evidence was presented before the Supreme Court—which was exceptionally allowed because the government made an argument that developments in Belgium should be taken into consideration at the Supreme Court level—these were changes that had taken place since the British Columbia Supreme Court decision in Carter.

The court said of that evidence that the Belgian evidence was deemed not relevant because it related to euthanasia for mental illness for minors and for minor conditions. The court also said that the Belgian evidence indicated problems with the system that left too much discretion in its rules, while we have a system that actually allows for more discretion, so clearly I think there are other statements.

I would also emphasize that in the Carter decision itself there are very frequent references throughout the judgment—and I urge people to read the judgment—to end-of-life situations, to treatment withdrawal for people that will result in immediate death. The comparison that the Supreme Court made in Carter was really with end-of-life practices, and it left one year in the constitutional dialogue that we have in Canada, one year for Parliament to enact new legislation.

**Michael Cooper:** That’s right. The reference to the evidence from Belgium with respect to psychiatric disorders was that the court expressly stated that it fell outside the scope of the decision. That was at paragraph 111. Isn’t that the only express mention of psychiatric disorders in the Carter decision? It was to say it had no bearing on the case.

**Trudo Lemmens:** That’s right.

**Michael Cooper:** Okay. Professor Downie then goes on to cite the E.F. decision of the Court of Appeal of Alberta, but isn’t it the case that the E.F. decision was before Bill C-14?

That decision did not involve any interpretation of charter rights, nor the consideration of the constitutionality of any legislative provision. The court grounded its decision in stating that it was a “limited inquiry [that] is individual- and fact-specific”.

**Trudo Lemmens:** Yes. That’s correct.

I would also say that the court there ruled that Carter could not be seen as excluding mental illness in the particular case where in a particular interim period they had to rely on the Carter decision, but the court also dealt with the case of conversion disorder.

I would urge people to really look at what that case involved, at a commentary that has been published on conversion disorder, and, I would say, at the red flag that goes up when you look at how this case was decided.

There is a commentary that was written by an expert, Trevor Hurwitz, in the *Journal of Ethics in Mental Health*, which emphasizes that in this particular case, for example, there was only a chart review to confirm the diagnosis of the lady in question. Trevor Hurwitz, in that article, goes into the details of the complexity of diagnosing such conditions. I would say that the case actually highlights the dangers of allowing fast-track—

**Michael Cooper:** Thank you. Time is very limited.

I want to deal finally with the Truchon decision. Isn't Professor Downie confusing or conflating issues tackled by the court related to decisional capacity and vulnerability as opposed to eligibility for MAID where mental illness is the sole underlying condition, in the reasoning of Madam Justice Baudouin?

**Trudo Lemmens:** Again, the Truchon decision is a lower court decision. It was not appealed. We can disagree about the reasons that it was not appealed, but many people have criticized it for its not being appealed.

It's also important to emphasize that the Truchon decision was not about mental illness, and the court recognized that. There are discussions about mental illness and suicide, but I would also indicate that in the Truchon decision, for example, the court relied significantly on a declaration by the International Association for Suicide Prevention. That declaration, which made an artificial distinction between assisted dying and suicide, has since been withdrawn and has been replaced with an explicit expression of concern by that same organization with regard to the danger of expanding euthanasia and assisted dying legalization outside of the end-of-life context. Therefore, I would question the reliability of the Truchon decision when it comes to issues around mental illness.

• (2100)

**The Joint Chair (Marcus Powlowski):** Thank you both.

Mr. Maloney.

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

Thank you to both witnesses for being here today. I know this isn't the first time for either of you to appear before this committee. It's your first time in this iteration, but we've met before on at least two prior occasions. I take it that neither of your positions have changed much since the last time we were here.

You just nodded. Thank you.

To start with, I want to pick up on something both of you said.

Professor Lemmens, you said that the system emphasizes access versus protection.

Professor Downie, you, on the other hand, said that clinical readiness has been met.

Those are inconsistent statements, in my opinion.

A witness we had in the first hour, Dr. Gupta, said that there's a consensus in the psychiatric community that the issues can be addressed, that they're ready and that it's irremediable. I always have trouble pronouncing irremediable.

That's what I want to talk about with you, Professor Downie. Have you ever done any medical legal work?

**Jocelyn Downie:** What do you mean by that? I'd have to ask.... Do you mean advising people about a case?

**James Maloney:** Yes. Have you ever given an opinion in a legal case?

**Jocelyn Downie:** Yes.

**James Maloney:** Do you believe the system is ready from a legal perspective?

**Jocelyn Downie:** Yes.

**James Maloney:** Do you believe it's important that the system be ready from a medical perspective?

**Jocelyn Downie:** Yes.

**James Maloney:** Okay.

Do you believe it is ready, when there's not a large consensus of doctors who agree that it's ready to go?

**Jocelyn Downie:** Yes.

Can I explain?

**James Maloney:** I would like to hear you explain that, please.

**Jocelyn Downie:** It matters if what they're saying is that there isn't clinical readiness. If the clinicians who do MAID say that there isn't clinical readiness, then that would be a concern. If it's about clinicians disagreeing about whether MAID for mental illness should be allowed, that is irrelevant to the decision. That is your decision. That's a public policy decision, not a clinical decision. Clinical readiness is clinical, and the clinical community for MAID has demonstrated its readiness.

**James Maloney:** I'm glad you brought that up, because I was going to go there.

If you're dealing with a patient who has terminal lung cancer and you get 10 doctors to examine that person, they're all going to agree that it's incurable, right? Is that fair?

**Jocelyn Downie:** It depends. I'm sorry, but—

**James Maloney:** It does.

**Jocelyn Downie:** —clinicians disagree all the.... You're not going to get 10 out of 10, necessarily.

**James Maloney:** I think you could probably get 10 doctors. However, if you have 10 psychiatrists who examine a person with a mental health condition, you're not guaranteed to get 10 consistent views on the issue, are you?

**Jocelyn Downie:** That's just like in almost every other medical situation.

**James Maloney:** No, I'm talking about.... This is why it's important, Professor. There's a very important distinction, in my opinion, between serious physical medical conditions and what we're talking about here, which is mental health. In the former, you're guaranteed to get a consensus on the diagnosis. If I have a broken arm, 10 doctors are going to agree that I have a broken arm 10 out of 10 times. However, if I have a mental health condition, I'm not going to get 10 out of 10 doctors who say I have a mental health condition.

**Jocelyn Downie:** What I would say to that is that there are physical conditions for which you are not going to get 10 out of 10 agreement from people, and there are some mental disorders about which you would get 10 out of 10 agreement from psychiatrists. What we demonstrate—

**James Maloney:** Okay, but what I'm saying is that if I have a broken arm—Professor, you're not a doctor—10 out of 10 people are going to agree that I have a broken arm. You can't argue with that, can you?

**Jocelyn Downie:** No, but what I'm saying is there are some psychiatric.... It doesn't—

**James Maloney:** If I have a mental health condition, you're not always going to get 10 out of 10 people who agree that I have a mental health condition.

**Jocelyn Downie:** You're taking—

**James Maloney:** You can't say that with the same degree of certainty, can you?

**Jocelyn Downie:** It's not the same thing. It's apples and oranges. You're asking about one specific—

• (2105)

**James Maloney:** No, it's a medical diagnosis, and that's what we're talking about.

**Jocelyn Downie:** No, you're not giving the diagnosis. You give the broken arm, but then you say “mental health”. What you have to do to make it apples and apples is give a specific mental disorder and then compare it to a broken arm. You could get mental disorders that you will get 10 out of 10 for, and you will get physical disorders, other than a broken arm—

**James Maloney:** Okay. Thank you for that.

There are cases where you will, but there are cases where you won't. Is that fair?

**Jocelyn Downie:** Yes, and the point is that this is, therefore, discriminatory.

**James Maloney:** That's an important distinction when you're talking about medical assistance in dying, isn't it?

**Jocelyn Downie:** No, because you're discriminating. You're drawing a distinction between mental illness and physical illness. There are characteristics—what you're pointing to is this notion of consensus about whether it's incurable or not—which will fall on both sides of mental and physical. You can't justify treating mental differently from physical, given that the element you've identified falls on both sides.

**James Maloney:** I agree that you shouldn't treat them differently if you can say with absolute certainty that the accuracy of the medi-

cal diagnosis is the same in both circumstances, and I don't think you or anybody else can say that.

**The Joint Chair (Marcus Powlowski):** We're over the time. As much as this has been a very good back-and-forth, we will move on to the next person in line, which is my friend Monsieur Thériault, for five minutes.

[*Translation*]

Mr. Thériault, you have the floor.

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

Professor Downie, I noticed you were taking notes. Unless you have any reservations, I would like you to answer Mr. Cooper's questions.

[*English*]

**Jocelyn Downie:** Gladly. The court, in Carter, absolutely had psychiatric illness in front of it. I was there. Joe Arvay, the lead counsel who argued the case, explained in a previous parliamentary committee hearing that psychiatric illness was present through affidavits and was in front of the court.

The second point is that if you look at E.F., what they did—and what I was relying on—is look at whether Carter, within its parameters of “a grievous and irremediable medical condition”, included mental illness. It did, which means that the striking down of the absolute ban on MAID for people with a “grievous and irremediable medical condition” captures mental illness. That is what E.F. said it was.

Truchon expressly addressed the meaning of Carter, and it expressly addressed the issue of psychiatric patients and mental disorders. There's a whole passage. That's why I've given you the paragraph numbers where the judge in that case went directly into the evidence about mental illness, psychiatric illness and what's gone on in the Netherlands, Belgium and so on. She quoted the E.F. decision and Carter, and explained the paragraph that gets cited—paragraph 127 is cited all the time—and the evidence that was introduced from Belgium.

That is exactly what the courts considered. The argument you've heard tonight against what I presented is exactly what was presented in court, in E.F., to the Court of Appeal of Alberta, and in Truchon. In both cases, it was found to be unpersuasive. They said the quote was taken out of context; they do consider psychiatric illness, and it's not excluded by their saying these are the parameters. It's all explained. It's difficult in the time constraints we have to explain the legal arguments, which is why I gave the passages, but what's been said about psychiatric illness not being before the courts is not true in all of the cases.

What is an issue, in looking at those three cases, to be specific, is mental illness inside “a grievous and irremediable medical condition”, because the Supreme Court of Canada said it was unconstitutional to ban it for “a grievous and irremediable medical condition”. The answer from those cases, and the judgment of the Department of Justice, was that it is included in “a grievous and irremediable medical condition”.

[Translation]

**Luc Thériault:** How much time do I have left, Mr. Chair.

• (2110)

**The Joint Chair (Marcus Powlowski):** You have one minute and thirty seconds left.

**Luc Thériault:** That's excellent.

Professor Downie, let's talk about clinical ethics.

You have been involved from the outset in this debate on medical assistance in dying and access to it.

As we know, it is Parliament that passes laws. Could you explain to us why this Parliament has consistently lagged behind on this issue and was forced by the Supreme Court to move forward and amend the Criminal Code? To what do you attribute this?

The citizens we represent agree on this. When it comes to medical assistance in dying in Quebec, approval ratings stand at 88 or 90%. Mr. Lemmens may not agree with all forms of medical assistance in dying, but in Quebec, we do agree. We even have legislation.

How do you explain that it is the Supreme Court that has to tell parliamentarians to do their job?

[English]

**Jocelyn Downie:** I asked former senator Carstairs that years ago, and she explained it to me this way. She said that people who support MAID—the vast majority of Canadians—have been supporting it for decades and are not single-issue voters.

People who are opposed to MAID—it's a right-to-life movement that was against it at the time she was talking about—will target you for being in support of MAID, so you'll lose an election. If you take the pro position, if you go that way, you'll lose an election on that single issue.

Others, people like me who support MAID.... I'm not making my political decision on the basis of what the MP or the party thinks about MAID.

I think it's a political calculation. What happens is—this is very frank—that they look at what the impact on elections will be and they don't want to inflame and alienate people who are opposed to MAID. They know the court will come along. That's what happened after the last time this extension happened. They said, "We know you'll go to court." They can wrap themselves in the court, and they don't have to take the political heat for it.

**The Joint Chair (Marcus Powlowski):** Thank you. The time is up.

[Translation]

Senator Dalphond, you have the floor for three minutes.

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

[English]

Professor Downie, you said that the regulatory readiness was there and the clinical readiness as well. Can you elaborate on the regulatory readiness you're referring to?

**Jocelyn Downie:** Yes. When I said I had the research, one is looking back at what the regulators said to the last AMAD iteration, and the regulators came and said they were ready. They were already ready, so they're still going to be ready.

I would also say that when you look at the structure of professional self-regulation, it requires.... They have a statutory obligation to be ready for whatever gets thrown at them, whether it's a change in the law or a clinical change—and they are. Their statutory obligation is to protect the public, which means they—

**Hon. Pierre Dalphond:** Are you aware, since you were last here three years ago, of any kind of change in the regulations, across whatever province in Canada, that is addressing that issue of mental illness as a sole condition to access MAID?

**Jocelyn Downie:** My understanding is that the colleges have all looked at it and made determinations in different ways as to whether they need to change anything in order to deal with mental illness. I know that some have felt that there's actually nothing that needs to be changed, in part because.... Of course, people with mental disorders are already able to access MAID. If you have concerns about capacity assessments, incurability and so on, they can already access it as long as they have a physical condition.

They've looked at them, and they've made adjustments where they believed them to be needed. That's where the decision-making actually rests appropriately. The federal government, as you well know, does Criminal Code. The provinces do health and delegate regulation of clinicians to the colleges, and they're ready.

**Hon. Pierre Dalphond:** You also refer to clinical readiness. What brings you to that conclusion?

**Jocelyn Downie:** It's that there are the training programs. You have the CAMAP national curriculum and various educational programs throughout the country. You have the practice guidance that comes from CAMAP as well, and the CPA is forthcoming.

That's the typical way you get clinical readiness for a new intervention. You make sure you have the training and the education available to people. You make sure you have guidance from the professional associations, if that's needed. Those have all been done. There is actually nothing else that needs to be done. Everything has been done. Things will continue in clinical practice to evolve, as they always do, and the clinical groups will respond appropriately, whether it be a regulatory body or CAMAP and other kinds of associations.

• (2115)

**The Joint Chair (Marcus Powlowski):** Thank you, Professor Downie.

Next up is Senator Martin.

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

My question is for Professor Lemmens.

You serve on the Ontario MAID death review committee, as you've already stated, and you've published peer-reviewed analysis drawing on the committee's publicly released reports. Without breaching the confidentiality of any internal deliberations, could you tell the committee about specific published cases in which mental health drivers such as depression, hopelessness, grief or psychosocial suffering played a significant role in the deaths of people whose primary eligibility pathway was track 2?

I'm asking because those cases, in the existing, more restrictive system, are the most direct evidence of what could happen at scale if MAID were expanded for mental illness as a sole underlying condition.

**Trudo Lemmens:** As I already indicated in my statement, I think it's the wrong approach to start saying, as Professor Downie does, that people already have access to MAID for mental illness so these situations have been addressed where needed.

My work, as a member of the Ontario MAID death review committee... We reviewed the full files. We talk in detail about these files. The reports are published, and I would urge the members to read these reports. I'm not saying these are the majority of cases, but these contain cases that show that people with very serious mental illness have really been fast-tracked to death in Canada.

I find it quite stunning, actually, that when we engage in discussions about this at the professional level, there is such a polarization in this debate. Instead of saying, "Oh, maybe these cases are serious and maybe we have to look at them in more detail," there is immediate push-back. People say this cannot be true and the college has looked at it and it's all been solved.

I can read you a case. Mr. A had inflammatory bowel disease. He "could not maintain employment, he found personal relationships difficult to sustain, and he was dependent on family for housing and financial support." He had "a history of mental illness, previous episodes of suicidality, and on-going alcohol and opioid misuse." He received information about MAID during a psychiatric assessment.

If you ask suicide specialists what they think about the fact that a psychiatric expert would ask a person who is struggling if they know about MAID...

The report says that his substance use "was not explored...and he was not offered addiction treatments." There was "no documented input" from his family, who had concerns about his MAID request. "The MAiD provider personally transported Mr. A in their vehicle to an external location for the provision of MAiD."

That's just an example of some of the cases I've seen—

**The Joint Chair (Hon. Yonah Martin):** Professor, I'm out of time. I wonder if you could send the link to this report that has these cases. I think it would be of great importance for us to look at. You said it's publicly available.

**Trudo Lemmens:** Yes. I can also send you a peer-reviewed publication that Dr. Ramona Coelho, David Shannon and I, three members of the review committee—

**The Joint Chair (Hon. Yonah Martin):** Yes, please do. Thank you.

**Trudo Lemmens:** I can share that. They're very short summaries of the reports, which are much longer.

**The Joint Chair (Marcus Powlowski):** Thank you.

We now go on to Senator Moodie.

**Hon. Rosemary Moodie:** Thank you, Mr. Chair.

Professor Downie, I'm going to quickly read to you a letter received by the committee from the Federation of Medical Regulatory Authorities of Canada, in which Dr. Adey states:

Whatever decisions are taken regarding the next steps of legislation related to MAiD... We have a legal duty to be ready.

With respect to MAiD specifically, the question of regulatory readiness was raised in the aftermath of the Carter decision.... At each juncture, when the law changed, the regulators were ready.

Do you agree? Is this your observation of what has happened?

The second question I have has to do with your thoughts on the coroner's MAID death review committee. What is your view on the claims that have been made about the work of the MDRC?

Finally, do the current legal and regulatory frameworks adequately address the issue of vulnerability?

• (2120)

**Jocelyn Downie:** First, with regard to the regulators, they are the best situated to make the assessment of their readiness. It doesn't surprise me that they say that they're ready, because they were ready before, as I said. I would agree with that analysis of their need to be ready.

In terms of the MDRC, I think it is really important to understand its mandate. Its mandate is not compliance. It doesn't do assessments for compliance. It is not empowered to make findings of non-compliance with the law. It also doesn't aim for consensus. It discusses, and the reports include comments.

One thing I would urge is caution when you receive these reports and are reading them and then comparing them to what is seen in the media about them. Notice the fact that the reports will expressly say, "We are not making findings." They have different people expressing their views—a negative view on a particular case, for example—and then you'll see that represented in the media as a finding of the MDRC. That's just not true; that's not how it works. That's an expression of opinion by the person who said it in that committee hearing, and they're saying it again in the media. Be very cautious about what the MDRC is actually doing.

It can perform a very important function, because we should be looking at everything. We should be talking about the complex cases. We should be trying to figure out how clinical practice should evolve in the face of all of the complexities.

**Hon. Rosemary Moodie:** What is your thought on—

**Jocelyn Downie:** It's vulnerability. Absolutely, the eligibility criteria and the procedural safeguards were written in order to address the issue of vulnerability, and they do so. You must be fully informed. It must be a voluntary decision with no coercion or undue influence. When you are track 2, you have to be told about all of the things that are available to you as options.

The final thing I'd say is that the evidence speaks for the quality of the readiness in relation to protecting vulnerability, because the evidence is very strong from Health Canada that socio-economic vulnerability and marginalization are not drivers of MAID. This was the fear before. This was expressed as that we were going to go down a slippery slope and that this will happen. We now have years of data that show that it's a privilege and that it's not vulnerability.

**The Joint Chair (Marcus Powlowski):** Thank you, Professor Downie.

We will go to Senator Wallin.

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

I'm going to frame my question this way, Professor Downie. Considering the decisions of Carter, Truchon and E.F.—and you've laid it out as best as you can in the time limits—and given your academic and legal experience, including in the courtrooms where these cases were litigated, what are the consequences of a government decision to deny access to MAID to those for whom mental illness is the sole underlying cause? What are the consequences for the patients, for the practitioners who are trying to serve their patients, and for the governments that, according to the courts, are in breach of the Constitution, particularly section 15?

**Jocelyn Downie:** With regard to the impact on patients, I would encourage the committee to watch a documentary by Marc de Guerre, who talked to two people who, after the documentary, ended their lives by suicide because of the extension. They had been waiting, and they said, "We cannot wait anymore."

What will happen if there is an extension or an exclusion is that people will die by suicide. They will go to Switzerland because they can access it there, or they will not get MAID in either way and will continue to experience enduring and intolerable suffering caused by a serious and incurable disease. They just have to have that suffering.

The consequences for the government are to end up in court. That's what keeps happening. We had to go to court to get Carter. That gave us something. It was shrunk by Parliament, so we had to go to court on Truchon to get it back out to Carter. Then Bill C-7 came along and took it away, and we had to go back out to....

You need governments to have courage and a recognition of their obligation to respect the charter. That's what the government did the last time with respect to not appealing Truchon. It spoke about it.

**Hon. Pamela Wallin:** Could you give a quick word on the practitioners? They are doing their part. They are being trained and readied for this, and they have an obligation to patients, too.

**Jocelyn Downie:** They do, and it puts them in a very difficult situation. I hope you will speak with some clinicians, because they are put in the position of explaining why it is that the suffering from a physical condition is considered worthy of Parliament say-

ing, "I have a way to end it," but suffering from a mental illness is not.

What do you think people who have a mental illness think when they read the provision in the Criminal Code that says that "a mental illness is not...an illness, disease or disability"? Clinicians have patients asking them those questions, and what are they to say? Yes, using the language of the Supreme Court of Canada...? It's cruel.

• (2125)

**The Joint Chair (Marcus Powlowski):** Thank you.

We'll go on to Mr. Patzer. You have five minutes.

I'm sorry. I've forgotten Senator Wells. My apologies.

Senator Wells, you have three minutes.

**Hon. Kristopher Wells:** Thank you.

I'm going to ask some questions, perhaps as a summary of what we've been hearing so far today, and particularly of you, Professor Downie, as one of the leading legal experts on MAID in Canada.

Do you believe the current legal framework is sufficient?

**Jocelyn Downie:** Yes, absolutely.

**Hon. Kristopher Wells:** Do you have any constitutional concerns?

**Jocelyn Downie:** Only that the exclusion gets extended, because I think that would be a breach of the charter, but keeping it as it is, no.

**Hon. Kristopher Wells:** Does the current framework that exists address the issue of vulnerability that we've been hearing about?

**Jocelyn Downie:** Absolutely. Look at the eligibility criteria and the procedural safeguards and the data that show it is working.

**Hon. Kristopher Wells:** Are there any missing regulatory components?

**Jocelyn Downie:** No.

**Hon. Kristopher Wells:** Do you believe we need new regulations coming out of the discussions we're having here?

**Jocelyn Downie:** No, because there is nothing unique about mental illness.

If you're saying they're insufficient, then you need to go back to the drawing board on MAID, so no, if you introduce mental illness, it doesn't introduce a need for new regulations.

**Hon. Kristopher Wells:** How would you address or respond to claims of harms to persons with disabilities?

**Jocelyn Downie:** The first thing I'd say is that you need to listen to persons with disabilities, because the organizations are not representing the majority of persons with disabilities. We know from the studies that the majority of people with disabilities believe in track 2.

The second thing I'd say is that the harms that people were concerned about are not manifesting. People said that people with disabilities were going to access MAID because they don't have access to disability supports and services. Again, look through the Health Canada data. It's very clear that well over 90% of people who access MAID and have a disability do have access to disability supports and services, so that is a myth.

The harms that were feared are not materializing, and the harm to persons with disabilities right now is the threat to track 2.

**Hon. Kristopher Wells:** Fundamentally, it seems to me this is really about two things.

It's about choice. It's about choice for individuals, if they meet the assessment conditions, to choose MAID, and we shouldn't be taking away someone's choice.

Secondly, it's about trust: trust in the highly qualified medical professionals to make an accurate assessment based on their expertise and the clinical guidelines and standards of practice that the federal government has invested millions of dollars in over the last three years or so to develop with the leading experts in Canada.

Do you have comments on that?

**The Joint Chair (Marcus Powlowski):** We're out of time.

**Hon. Kristopher Wells:** I think I still have 15 seconds.

**The Joint Chair (Marcus Powlowski):** You have two seconds. I would point out that although the senators have shorter times, they've consistently gone over, and as a result they've actually had proportionately far more time than the elected representatives.

**Hon. Kristopher Wells:** That's impossible when you have five minutes versus three minutes—

**The Joint Chair (Marcus Powlowski):** Okay. You have five seconds to finish and get a response.

**Jocelyn Downie:** Read the Wilson decision about the fundamental choice, the importance of choice about the course of your life and your death—that's Justice Bertha Wilson—and read Justice Smith in the trial decision on trust in health care providers.

**The Joint Chair (Marcus Powlowski):** Thank you.

MP Cooper is next.

**Michael Cooper:** Thank you.

Professor Lemmens, Professor Downie stated that it's somehow misleading and out of context to conclude that MAID for mental illness fell outside the scope of the Carter decision, but the only paragraph that references psychiatric disorders, paragraph 111, reads that:

Professor Montero's affidavit reviews a number of recent, controversial, and high-profile cases of assistance in dying in Belgium which would not fall within the parameters suggested in these reasons, such as euthanasia for minors or persons with psychiatric disorders...

It says "would not fall within the parameters suggested in these reasons". Would you care to comment?

• (2130)

**Trudo Lemmens:** I've already explained it. As Professor Downie says, in the time limits of this discussion, it's hard to give details about constitutional arguments.

We have The Manitoba Law Journal, in which we discuss in detail the various cases—I can share them with the committee—and look at the arguments for why we think the Carter decision actually did not include mental illness and why it's fair for Parliament to state that irremediability, based on the evidence psychiatrists will provide, does not match mental illness. In a way, Parliament has simply looked at the concept of an irremediable medical condition.

I want to emphasize again that I find it strange how people forget that the Carter decision emphasized the need for stringent safeguards and balance, and explicitly recognized the role of criminal law in protecting life. I want to emphasize that.

There is certainly a difference of interpretation of the Carter decision in that context.

**Michael Cooper:** Before I turn it over to Mr. Patzer, with respect to E.F. and Truchon, neither is a binding decision. Is that right?

**Trudo Lemmens:** Are you asking for a comment on the E.F. case?

**Michael Cooper:** It's one decision. It's an Alberta Court of Appeal decision. The Truchon decision is a Superior Court of Quebec decision. They're not binding nationally.

**Trudo Lemmens:** Yes, but they were taken at a time when there was no legislation. If you look at constitutional scholars who coined the concept of constitutional dialogue, in a later publication they actually accepted the idea. Professor Hogg, for example, accepted the idea that the first parliamentary law on MAID was an acceptable example of the dialogue between the Supreme Court and the legislative.... I would leave it at that.

**The Joint Chair (Marcus Powlowski):** Mr. Patzer, I'm afraid we've run out the clock.

That brings us to Dr. Jaczek.

**Hon. Helena Jaczek:** Thank you, Chair.

Professor Downie, we heard from Dr. Gupta earlier in the first panel. From what I heard when she gave her testimony, she described a process of assessment that really made a request for MAID a last resort. Every avenue was going to be looked at in terms of alternative treatment, etc. Other assessors would be consulted, etc.

You have also assured us that you feel the regulatory framework is sufficient. However, Dr. Lemmens, in response to Senator Martin, gave us an example where the full assessment was perhaps not done.

Is there anything that should be required in that assessment that could in some way be legislated? Is there some sort of regulatory framework that might be required?

**Jocelyn Downie:** It's extremely difficult to comment in relation to that case, because of what I said about the MDRC and it not being a finding. They don't have all the facts in front of them. They're not making statements in order to make findings of fact about the case, so it's hard. I can't say what would have been better, because I don't know that what's being described is accurate.

However, do people need more? I think we have the guidance. We have the training program. We have the fundamental clinicians' obligation to do only that which they're capable of doing. They have an obligation to follow the law, which requires this careful analysis of capacity and voluntariness.

The final thing I would say, going back to the point about trust, is that clinicians take this extremely seriously. They are very careful, because they don't want to provide MAID to someone for whom something could be done such that they will no longer want MAID. That is actually a very important safeguard in our system, and it was recognized by Justice Smith at the trial level in Carter that we already trust clinicians with so much, so why would we suddenly say they're not trustworthy to ensure that they do careful assessments and so on? They do palliative sedation. They withhold and withdraw life-sustaining treatment. They do all these things without one iota of the oversight and regulation of MAID. It really throws a hand grenade into medical practice to suggest that we don't have enough, based on what we have.

• (2135)

**The Joint Chair (Marcus Powlowski):** Your time is pretty well up.

I'll move on now.

[*Translation*]

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

**Luc Thériault:** There are clearly different interpretations of the case of Truchon v. Procureur général du Canada and the Carter decision.

Throughout the history of Canadian law, it has always been the courts that have settled such matters. It was the Supreme Court that ruled on the matter and called upon lawmakers to ensure that the law complied with the Canadian Charter of Rights and Freedoms.

In the meantime, why would it be appropriate at this point to ask the Supreme Court to clarify this issue and rule specifically on it? Could it clarify its position, and could the government make such a request? Would that not put an end to the interpretations suggesting that the Truchon case did not comply with the Carter decision and that the latter does not say what it says?

Nothing has been done on the legal front for the past three years.

[*English*]

**Jocelyn Downie:** They could. They chose not to the last time around. I don't know whether they would make that same decision now. There is also a case in front of the courts right now, because after the last extension, it was clear we had to go to court.

The exclusion is being challenged in Ontario at the moment. That will eventually end up in the Supreme Court of Canada. Even if the government does.... Doing the reference would be faster, but

the case will get up to the Supreme Court of Canada. This will be answered eventually.

[*Translation*]

**Luc Thériault:** What concerns me is that we are placing the burden on people who are already struggling with an illness, and that they are left to defend themselves before the Supreme Court. From the outset, this is how Canadian law has developed on the issue of medical assistance in dying.

Parliamentarians have never taken an approach like that in Quebec, for example, where they took two years to pass a law and took the time to listen to everyone.

Here, we are told: this is the Supreme Court's deadline. Since parliamentarians have not done their job, the Court is telling them to do so and to ensure that an amendment to the Criminal Code is introduced that complies with the Charter.

The burden of having to appear before the Supreme Court is being placed on the patient, and that, in my view, is unacceptable.

[*English*]

**The Joint Chair (Marcus Powlowski):** With that, we've run out of time, so there's no opportunity to respond.

We go next to Senator Moodie for two minutes.

**Hon. Rosemary Moodie:** Thank you. My very quick question is for Professor Downie.

You have made the case before that the constitutionality of MAID was settled by Carter and affirmed by E.F. and Truchon. Please make that case again for me, because I'm struggling with the idea that a question of interpretation allows us to wander from the facts of the case. Help me understand what you believe to be the truth in this matter.

The second thing I'd ask is this: Do you believe that physicians always agree with each other about diagnosis in physical medicine, treatment or planning for physical conditions, and conversely, do psychiatrists agree in some cases about diagnosis and treatment?

As a neonatal intensivist, I can tell you we have not agreed on many cases that I've been involved in. Please help me here.

**Jocelyn Downie:** I'll take the quick one first. They do not always agree with respect to physical conditions in terms of the diagnosis, prognosis and treatment, and they sometimes agree in the context of mental illness about diagnosis, prognosis and treatment. This does not create a distinction between physical and mental. It doesn't justify treating them differently. We have complex cases everywhere.

Regarding the truth of the matter of Carter, we've gone back and forth. You've heard the same thing more than once from both sides on the interpretation of Carter. The thing I would add to what was presented is that Justice adopted the interpretation that I have advanced. The government has already accepted that Carter stands for the principle that "grievous and irremediable medical condition" includes mental illness. It has accepted the Carter and the Truchon decisions, as the arguments were good. They're not binding, granted, but it said they were good. It agrees with them, so it has adopted that position. I take that as a reasonable starting point for the government not then turning around and excluding any further.

The only extra justification you can have with respect to Carter is in terms of a temporary exclusion, and what I'm pointing out is that that's no longer valid.

• (2140)

**The Joint Chair (Marcus Powlowski):** Thank you, Professor Downie.

Senator Wallin, you have two minutes.

**Hon. Pamela Wallin:** I know that this may not be specifically your area as an academic and a lawyer, but my colleague here raised the question of choice. There are so many issues on which the governments of the day say that this is a question of personal choice—I'm thinking of abortion—and that a person should, in consultation with their doctor and maybe family members as well, come to those conclusions. I see parallels, of course, with this issue. This is a matter of choice. There is no circumstance that I can see where MAID is mandatory for anybody. You must ask for it. You must be counselled six ways to Sunday.

Can you talk about that, and what that means in a legal framework?

**Jocelyn Downie:** It's very clear that nobody ever—ever—would get MAID that they didn't want. That's clearly excluded in the law. No clinician would ever do that, absolutely.

Your point about abortion is important, because we had to get abortion rights through the courts too. It's telling. As well, abortion came in Quebec. They were leaders on that. They were leaders on same-sex marriage. They were leaders on MAID. It's through the consultative processes they do that they get there.

I think I would point you back to, in fact, the abortion decision in Morgentaler, where the idea of the freedom to make choices that are fundamental to our lives is expressed incredibly powerfully by Chief Justice Dickson and Justice Bertha Wilson. That was a long time ago, but that is a through line in Canadian constitutional law. It's a fundamental commitment to respecting people's autonomy. Yes, we protect the vulnerable, but we must respect autonomy.

**The Joint Chair (Marcus Powlowski):** Thank you, Professor Downie and Senator Wallin. We are out of time.

With that, I'd like to thank the witnesses for appearing before us and for the very worthwhile testimony.

We're going to briefly suspend. Then we have to come back briefly to discuss what we decided in subcommittee. I believe the Conservatives also have a motion.

We're suspended....

Senator Wallin.

**Hon. Pamela Wallin:** I have a couple of questions that I'd like answered, but are we going in camera? What is the procedure here?

**The Joint Chair (Marcus Powlowski):** No, we're not going in camera.

**Hon. Pamela Wallin:** Should I go ahead and ask my questions?

**The Joint Chair (Marcus Powlowski):** Go ahead.

**Hon. Pamela Wallin:** First, there was a comment by an earlier witness, who intervened on what I think he said was a point of personal privilege to counter testimony that was provided by somebody else. I want to know what our rules are around that.

Then, Chair, there was your own intervention. We have spelled out the time allocation for each member and each party and all of that. You chose to say that with the prerogative of the chair, you would intervene. I'm trying to figure out what the rules are around that, because it impacts everybody's time.

**The Joint Chair (Marcus Powlowski):** Let me answer the second question first, on the chair asking questions.

This is a hybrid committee, so there are different rules. I actually consulted with the clerk, who is the legal expert on this. Yes, the chair has the prerogative to, at times, ask questions. Certainly, if you're in the House of Commons and you've been in certain committees, certain chairs frequently do so. John McKay almost always asks a brief question at the end. I do not believe it is out of order to do so.

**Hon. Pamela Wallin:** Can we get some clarification? This is a joint committee. We negotiated the time allocations of two minutes and three minutes very specifically, so I would like some clarification.

As well, are there any comments on the first question I raised? It may be perfectly within order, but I'm just asking.

**The Joint Chair (Marcus Powlowski):** I forget what the question was.

• (2145)

**Hon. Pamela Wallin:** It was about one of the witnesses raising a question of personal privilege. I think that was the phrase he used. I'm just wondering what we.... All witnesses will want to countermand what they have heard from others.

**The Joint Chair (Marcus Powlowski):** To my knowledge, there isn't any legal ability within the committee for them to do something like that, but I think it's polite at times, if it's very brief....

As to the chair, again, it is my understanding that it's within the discretion of the chair to ask a brief question like that at times. As chair, I would point out that in these joint committees the chair can pass a motion, and the chair can vote, which is a different thing from our committees.

With that, can I suspend? Then we'll come back and discuss the decision of the subcommittee and also hear the motion from the Conservatives.

We're suspended.

Discussing the subcommittee has to be in camera. I'm sorry. Somebody asked about that.

*[Proceedings continue in camera]*

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