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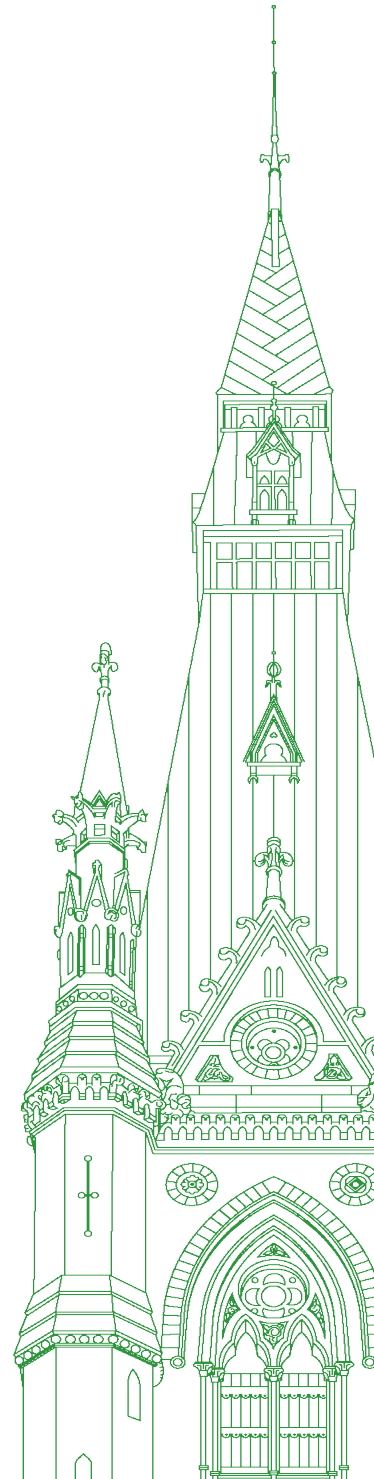
Special Joint Committee on Medical Assistance in Dying

EVIDENCE

NUMBER 003

Tuesday, April 14, 2026

Co-Chairs: Marcus PowlowskiYonah Martin



Special Joint Committee on Medical Assistance in Dying

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• (1835)

[English]

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

Welcome to meeting number three of the Special Joint Committee on Medical Assistance in Dying. Pursuant to the order of reference of the Senate chamber adopted on February 26, 2026, and the order of reference of the House of Commons adopted on February 13, 2026, the special joint committee is meeting to study the eligibility for medical assistance in dying of those whose sole condition is a mental illness.

Today's meeting is taking place in a hybrid format, pursuant to the Standing Orders. Members are attending in person in the room and remotely using the Zoom application.

I know there are some instructions regarding the use of microphones. They will be controlled by our technicians, so you don't have to touch them.

Witnesses, thank you so much for being here today. It's a very important study, and I think your testimony will be very welcome.

Please wait until I recognize you by name before speaking. For those participating by video conference, click on the microphone icon to activate your mic, and please mute yourself when you are not speaking. For those on Zoom, at the bottom of your screen, you can select the appropriate channel for interpretation: floor, English or French. Those in the room can use the earpiece and select the desired channel. Obviously, English is channel 1, and French is channel 2.

I will remind you that all comments should be addressed through the co-chairs. Members in the room, if you wish to speak, please raise your hand.

The way we're doing this is that we have a schedule of questions. After your testimony, we will go into questions in the order we have predetermined. The senators are going to be in alphabetical order. In round two, we will continue with two senators for each of the second rounds.

I think everybody received the first report of the subcommittee and also a motion we discussed at the last committee meeting. You have all received the work plan and some of the key themes we discussed in our meeting on March 24. I want to make sure that you all have a copy.

At this time, I call for your consent for the adoption of this report.

Some hon. members: Agreed.

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

In terms of the motion that was put on the floor by Ms. Jansen, I want to know if any additional discussion needs to take place. You've all had a chance to look at it. We've had a few weeks. I know that Health Canada, the government.... I've had a conversation with Mr. Powlowski, and that, too, is something we'd like to adopt today.

I'd like to ask for your agreement that the motion be adopted.

(Motion agreed to [See Minutes of Proceedings])

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

With that, welcome to our witnesses today.

Appearing on our first panel, we have, from the Department of Health, Ms. Sarah Lawley, assistant deputy minister, health policy branch. From the Department of Justice, we have Kimberly Gibner, deputy assistant deputy minister, policy sector; and Julia Nicol, counsel, criminal law policy section—a familiar face.

Each of you will be given five minutes for your remarks, and then we will have questions from the members and senators.

First, I will call upon Ms. Sarah Lawley for her testimony.

[Translation]

Sarah Lawley (Assistant Deputy Minister, Health Policy Branch, Department of Health): Thank you for giving me the opportunity to testify before you today on this complex and evolving topic.

I will briefly address the context, the provinces' and territories' state of readiness, and the federal support measures that are currently in place.

Medical assistance in dying is about deeply personal experiences of suffering, dignity and choice. People have different views, often staunchly defended. The Government of Canada's objective is to have a federal framework that meets the needs of Canadians, protects those who may be vulnerable, and upholds personal autonomy.

[English]

First, we commend the committee's work on whether a person should be eligible for MAID when the sole underlying grievous and irremediable condition is mental illness.

The question has been examined for several years—

The Joint Chair (Hon. Yonah Martin): I'm sorry. The English interpretation of the French has turned into French.

Could we correct that, please? Thank you.

Please continue.

Sarah Lawley: The question has been examined for several years, including by the Council of Canadian Academies in 2018, the expert panel on MAID and mental illness in 2022 and previous iterations of this committee in 2022, 2023 and 2024.

In 2024, the committee emphasized provincial and territorial health system readiness and concluded at that time that systems were not ready to expand eligibility. Experts have also identified a few recurring clinical issues in readiness to lift the exclusion for mental illness as a sole underlying condition: determining whether the condition is irremediable, distinguishing suicidality from a well-considered MAID request and assessing decision-making capability. Parliament continues to study this issue through ongoing legislative processes, including a private member's bill, Bill C-218.

Second, I will speak to provincial and territorial health system readiness.

MAID, as you know, is delivered by provincial and territorial health systems within the federal legal framework of the Criminal Code. Provinces and territories organize and deliver health care and must ensure practitioners have the tools, supports and governance needed to provide MAID safely.

Provinces and territories already assess some track 2 MAID requests where mental illness is a comorbidity. These cases require rigorous safeguards, and practitioners report that those assessments are complex and time-intensive. There is a time delay built into track 2 processes of a minimum of 90 days; however, assessments where mental illness is also present take much longer.

Track 2 cases remain a very small share of MAID overall. In 2024, our statistics showed that 4.4% of MAID provisions were for people whose natural death was not reasonably foreseeable, or 732 people. Of those 732 people, 13 were reported as having a mental illness as a comorbidity in addition to their underlying medical condition. However, as practitioners are not required to provide detailed information on all of an individual's conditions and comorbidities, this finding should be interpreted cautiously.

International experience suggests that there may be interest for MAID from some people where mental illness is a sole underlying condition, but experts expect that should the exclusion be lifted, approvals would be few.

Since the temporary exclusion was extended in 2024, provinces and territories have continued preparing, though readiness varies across jurisdictions. In many places, mental health services and

end-of-life care sit in different parts of the health system, which means that new coordination and governance are needed.

The federal government is using its convening role to bring together federal, provincial and territorial officials responsible for both medical assistance in dying and mental health services. Struck in 2024, the FPT—federal, provincial, territorial—ADM-level committee on MAID supports senior-level discussions and best-practice sharing across jurisdictions, including on preparations for consideration of mental illness as a sole underlying condition.

Provinces and territories, however, are taking different approaches. For example, Quebec has enacted legislation that prohibits MAID where mental illness is the sole underlying condition, and Alberta has recently introduced a bill that would restrict eligibility for MAID to only individuals whose death is reasonably foreseeable, specifically within one year. Other jurisdictions are building governance to bring together their MAID and mental health systems and increasing training and clinical supports for assessors in preparation for the temporary exclusion to be lifted.

It is, however, fair to say that across jurisdictions mental health system capacity remains a central concern. This includes access to psychiatrists for consultation and broader access to mental health services and treatments.

● (1840)

I have a large section of remarks that talks about what we've done to support the provinces and territories in getting ready to deliver this care, including the MAID curriculum and the Canadian Psychiatric Association's clinical guidance, which was recently released.

[Translation]

In conclusion, I must emphasize how important the committee's work is.

The government recognizes that this is a sensitive and evolving area, welcomes the committee's study, and looks forward to its recommendations.

[English]

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

Next we will hear from Ms. Gibner. You have five minutes.

Kimberly Gibner (Deputy Assistant Deputy Minister, Policy Sector, Department of Justice): Thank you.

[Translation]

Honourable co-chairs and distinguished members of the Special Joint Committee on Medical Assistance in Dying, I am grateful to you for this opportunity to testify before you today as you continue your important study on the Canadian framework for medical assistance in dying. You are focusing on its availability in cases where the only underlying health problem is mental illness.

I would like to start by reviewing the development of the Canadian framework for medical assistance in dying in the Criminal Code. My colleague Julia Nicol and I can help you with that today.

As you know, before legalization, a doctor or nurse practitioner providing medical assistance in dying was liable to be charged with murder or with aiding suicide.

● (1845)

[English]

MAID, as you know, was first legalized in 2016, following the Supreme Court of Canada's decision in Carter, which found that the absolute prohibition on physician-assisted dying was unconstitutional.

The legalization of MAID was done by creating a MAID federal framework within the Criminal Code, which sets out the eligibility criteria and procedural safeguards. In establishing this framework, Parliament had to balance a number of competing interests and societal values, which include the autonomy of individuals, the protection of vulnerable persons from being induced to end their lives and the need to address suicide as a public health issue. MAID is a matter of shared jurisdiction, because the framework is in the Criminal Code, but it's the provinces and territories that are responsible for delivering health care, including operationalizing MAID.

The MAID framework in the Criminal Code is structured around two key elements. Eligibility to determine who can obtain MAID is the first one. The second is the procedural safeguards to ensure that MAID is safely provided. The Criminal Code provides exemptions from criminal liability for practitioners who act in accordance with these requirements.

Although eligibility for MAID was originally restricted in Carter to adults whose death was reasonably foreseeable—we call that track 1—eligibility for MAID was expanded in 2021 to those whose natural death was not reasonably foreseeable, which we call track 2. Mental illness was explicitly excluded in 2021.

Track 2 safeguards were added to the Criminal Code to respond to the complexity of those cases. For example, track 2 safeguards require a minimum 90-day assessment period. An expert in the condition causing the patient's suffering must be consulted or be one of the MAID assessors. Practitioners must offer consultations with relevant professionals and ensure that the person has seriously considered available means to relieve their suffering.

As I noted, the expansion of the MAID framework in 2021 excluded individuals whose sole underlying condition was a mental illness, and that exclusion has been extended twice for system readiness and further study.

As you have heard from my colleague at Health Canada, much has been done for the provinces and territories, the regulators and the medical community to prepare for the safe and consistent assessment of MAID requests where mental illness is the sole underlying condition. In the absence of further legislation, the provision of MAID based on mental illness alone will become lawful on March 17, 2027, under the existing eligibility criteria and track 2 safeguards.

The Supreme Court of Canada noted in Carter that Parliament has leeway under the charter in deciding how to balance the competing interests engaged by MAID. The difficult question of whether or when to permit the provision of MAID on the basis of mental health alone is one that can be answered in different ways in conformity with the charter.

[Translation]

I must thank the committee for its detailed and thoughtful study of these topics. Your work is essential in helping the government find its way through the complexities with compassion and care. We look forward to receiving your report and your recommendations.

[English]

Thank you very much. We would be pleased to answer any questions you might have.

The Joint Chair (Hon. Yonah Martin): Thank you very much to both of you for your testimony.

We'll go to our first round, and we'll begin with Mr. Lawton.

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

Thank you, officials, for your testimony today.

I'd like to start with you, Ms. Lawley.

We have heard in the media and in a number of reports of people who have been denied access to MAID in one province but approved in another. Is there any legal reason that this should be the case under the current system?

Sarah Lawley: I can speak to the health system component. I would defer legal questions to my colleagues from Justice.

Each jurisdiction is able to design a health system to deliver MAID that aligns with what its jurisdiction is asking for. It can be more strict in its requirements for MAID, but it can't be more permissive, so every jurisdiction has a slightly different approach to the way it is delivering MAID and the way its assessment process works.

On the question you asked specifically about whether a person can be denied in one jurisdiction and then move to another jurisdiction, it would depend entirely on the situation and whether a person is a citizen of a jurisdiction long enough to be able to access its health care system and MAID assessment. The assessments are not shared across jurisdictions. The practitioners are not required to reach across jurisdictions.

● (1850)

Andrew Lawton: If a patient is ineligible in Ontario, they should also be ineligible in British Columbia.

Sarah Lawley: In terms of the delivery of the assessment, there is not a yes or no response for most assessors. They look at the entirety of the information in front of them. Admittedly, there will be some variability in what assessors find given the manner in which they have done their assessment, so I can't honestly speak to whether there's a homogeneous approach and a yes or no across the country.

Andrew Lawton: We have a standard in place, and we have a threshold by which people are going to be eligible or ineligible for MAID. I realize there is some judgment that any physician or assessor has to make.

This is the question I have. Let's assume that all of the assessors are viewing patients' health records and their interactions with patients in the same way. In terms of how the system is supposed to work from a design perspective, should there be any difference in eligibility between one province and another?

Sarah Lawley: No. Eligibility is definitely in alignment with the practice standards and guidelines that are being developed to support MAID assessors and what is written in the Criminal Code.

Andrew Lawton: Thank you.

We had one case recently that was reported on widely in the media. Kiano Vafaeian, a 26-year-old, was denied in Ontario and approved in British Columbia. He had long suffered from mental illness. There are purported claims that he fit in the track 2 model with a physical comorbidity.

What can we do to prevent doctor shopping and jurisdiction shopping in the system, if we are going to proceed with this expansion as a country and include mental illness as a sole underlying criterion?

Sarah Lawley: I can assure the committee that the jurisdictions are taking quite seriously any potential jurisdiction shopping or the opportunity for bouncing around the country until you find someone to give you the answer you're looking for.

Because we live in a country where people can change jurisdictions and can request MAID through different jurisdictions, dependent on the time they have been in a jurisdiction and their ability to access the health care system, what we can do is ensure that there is consistency in the standards of practice. That is work we are doing with jurisdictions.

Andrew Lawton: Thank you. I have only a minute left, so I'm hoping to—

The Joint Chair (Hon. Yonah Martin): Yes, there's one minute.

Andrew Lawton: Thank you.

Do assessors have to take into consideration the number of times someone has been refused MAID by previous assessors?

Sarah Lawley: I don't know if I'm fully qualified to answer that question, because I don't do MAID assessments myself. What I can say—

Andrew Lawton: You're representing Health Canada, though. If someone has been denied 20 times, I feel like that would be relevant information that should inform the 21st assessor's view.

Sarah Lawley: Yes.

Andrew Lawton: You are not aware of any requirement where that would have to factor in, or where they would even have to be aware of that.

Sarah Lawley: Honestly, I don't know whether that is in the checklist for the MAID assessors or not.

Andrew Lawton: Would it be relevant for an assessor to understand if someone has been denied in another jurisdiction?

Sarah Lawley: Yes. I think there is a rational logic to that consideration, but I also think it's important to take into consideration that much time could pass between these assessments, and people's health may change.

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

Next we have Ms. Jaczek.

Hon. Helena Jaczek (Markham—Stouffville, Lib.): Thank you to both witnesses for your presentations.

I'd like to continue with this theme of what seems to be emerging as a patchwork of services across the country in relation to MAID. We have the Canada Health Act, which has certain principles. One is comprehensiveness, which requires that all medically necessary services be provided in all jurisdictions. There's also the issue of portability, which has been referred to as moving from province to province. After a certain length of time in another province, you are deemed able to request services in that province.

How do you react, as the Department of Health, to what is evolving as a patchwork of services? I still don't quite understand. To give a specific example, Alberta's Bill 18 seems to be proposing to get rid of track 2, which was approved through Bill C-7, in 2021, as you've said.

Ms. Lawley, try to explain to me how the Canada Health Act is being protected across this country.

● (1855)

Sarah Lawley: It's a very good question. There are two elements to this that I'd like to address.

First, with respect to the Criminal Code, the provinces and territories, as I said, may add requirements for the provision of MAID to make it more strict. What they cannot do is permit what the Criminal Code prohibits. They have the legal right to restrict applications within their jurisdiction.

Second, with respect to the Canada Health Act—also a very good question—the principles set by the CHA are intentionally broad in recognizing that the provinces and territories have jurisdiction over health care. What this means is that the CHA does not require the provinces and territories to insure all services with the same terms and conditions. Yes, MAID is an insured service that must be delivered across this country, but jurisdictions have the right to determine the terms and conditions around the delivery of that.

While you have referred to it as a patchwork, there is variation across our country in the delivery of MAID, and that is permitted by both the Criminal Code and the Canada Health Act.

Hon. Helena Jaczek: Ms. Gibner, could you explain to me a bit more about Alberta's Bill 18? What I understand is that it wishes to eliminate track 2 in the province of Alberta. Is that consistent with previous decisions?

Kimberly Gibner: I can't provide legal advice, of course, but what I would point out is that the Criminal Code has set out some exemptions relating to specific offences in the code so that if practitioners follow the framework as set out, there's an exemption to criminal responsibility. The Criminal Code doesn't provide a right for MAID. It simply decriminalizes certain offences if certain rules are followed. That's the distinction I would add, and I'd reinforce what my colleague said about our federation and the ability of the provinces to legislate in this space as it relates to health care.

As my friend indicated, the provinces certainly couldn't do something more than the Criminal Code does. They can't allow something that the Criminal Code prohibits, but they can certainly provide for health care.

Hon. Helena Jaczek: Ms. Lawley, you wanted to tell us a bit more about preparation. I represent a riding in Ontario. Could you please tell me where Ontario is in terms of preparation?

Sarah Lawley: I would like to speak more broadly in terms of the general preparation of our provinces and territories, as opposed to determining what one province has or does not have, because I feel like I have a very high level of knowledge and not an in-depth delivery knowledge on how Ontario is preparing.

Ontario is actively participating in our committees. It is sharing information and learning from other jurisdictions about how they, too, are preparing. There are some jurisdictions, such as Quebec and Alberta, that have said they are not going to allow for mental illness as a sole underlying condition. There are others that are preparing and are quite actively ready. I would say the vast majority of them are in the process of preparing to be ready for March. Ontario would fall in that big basket, alongside 80% of its colleagues.

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

Next we have Monsieur Thériault for five minutes.

[Translation]

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

Good evening, ladies.

I would like to remind you of the point the committee had reached when it concluded its work. I would like to know your po-

sition on the recommendation we made. The committee's recommendation read as follows:

WHEREAS the Committee concludes that the medical system in Canada is not prepared for medical assistance in dying where mental disorder is the sole underlying medical condition (hereinafter MAID MD-SUMC), the committee recommends:

that MAID MD-SUMC should not be made available in Canada until the Minister of Health and the Minister of Justice are satisfied, based on recommendations from their respective departments and in consultation with their provincial and territorial counterparts and with Indigenous Peoples, that it can be safely and adequately provided [...].

Since our recommendation was published, what point have you reached in your deliberations?

With the information at your disposal, do you feel that you would be able to recommend that your respective ministers move forward?

My question is for the officials from both departments.

Ms. Gibner or Ms. Nicol, you can begin to answer those questions.

• (1900)

Kimberly Gibner: Thank you for the question.

I will reply in English, so that I can be sure to be clear.

[English]

I will repeat myself from earlier and say that I will try to be of assistance to the committee tonight, but I certainly can't provide legal advice or disclose any sort of solicitor-client privilege in terms of what recommendations they're putting forward.

What I can say is that the Government of Canada, or Parliament, has been consistent in Bill C-7, Bill C-39 and Bill C-62, in the charter statements, that the.... I just lost my train of thought. I apologize.

The government has a wide scope to legislate in the space, and whether they prohibit MAID or provide MAID, it's consistent with the charter. Either option chosen can be made consistent with the charter.

The government is still working through, as you know, Bill C-218 and is awaiting your recommendations—

[Translation]

Luc Thériault: I understand your hesitancy.

Ms. Lawley, does the same answer go for the Department of Health?

Do you have the same reservations? Are you able to answer the question?

Sarah Lawley: I can be a little more specific on the preparations and the stage the preparations have reached in our country.

Luc Thériault: Do I hear you saying that there has been some progress?

Sarah Lawley: Yes, there has.

Luc Thériault: Is it your opinion that the progress could allow us to move forward without any problems?

Sarah Lawley: Yes, we have made progress in the last two years. We are not ready yet, but most of the provinces and territories, except Alberta and Quebec, are in the process of removing the exclusion.

Allow me to add a few words about the health care system.

Since the committee's last recommendations, we have made progress on the guide for psychologists. So more doctors have access to training.

I will continue in English now.

[English]

The Joint Chair (Hon. Yonah Martin): There are about 10 seconds, so give a very brief answer.

Sarah Lawley: There has been progress on the standards of practice, on the guidelines for our psychiatrists and on increasing training for our psychiatrists so they have a better understanding of the role they would play in assisting MAID assessors.

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

We'll move now to questions from senators.

[Translation]

The Joint Chair (Marcus Powlowski (Thunder Bay—Rainy River, Lib.)): Thank you. Madam Chair.

It's my turn to take the chair now.

Senator Dalphond, the floor is yours for three minutes.

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

[English]

Maybe I will continue with what you started in answering Mr. Thériault, because I'm interested to know about the state of readiness. That was one of the main reasons last time....

I understand that Alberta and Quebec are not participating in these meetings, but they are not gearing up to be ready next year because these provinces will not be offering that service. All the other provinces and territories are working and are expecting to be in a position to offer that "health service" if the exemption were to expire next year.

Sarah Lawley: Yes.

Hon. Pierre Dalphond: When you said that you are developing the standards that are required and that training is being delivered now, what was the third part you referred to?

• (1905)

Sarah Lawley: If I may respond, we have the MAID model practice standard, which were discussed at this committee in 2024, but further to that, the MAID curriculum that CAMAP is providing...further to federal funding.

Participation has tripled over the past two years. We have seen a definite increase in those who identify as having a specialty in psychiatry and as general practitioners, with a tripling in the number of clinicians accessing that training, both those who identify with a

speciality in psychiatry and those who have completed the MAID module on mental health and MAID.

On the Canadian Psychiatric Association guidance, which I know has been discussed at this committee and was released publicly at the end of March, we had a very good conversation with provinces and territories just last week around the application of that guidance and how it will support our psychiatrists in understanding and assessing irremediability and suicidality. There is a new tool in the tool box that was not there the last time this committee was struck.

Hon. Pierre Dalphond: This may be for legal. I understand from the charter statements released before that we will engage section 15 if we prolong extending the exclusion, but that will be a test under section 1 to see if it's "reasonable" to defer because of the state of readiness. Is my understanding correct?

Kimberly Gibner: I think the government's position is, as I've said, that both permitting and prohibiting MAID can be in conformity with the charter, be it section 7 or section 15. Of course, both of those sections will be implicated, as will section 1.

I think we've been pretty consistent throughout the years. From a legal perspective, we're in the same state of affairs. The key in any sort of litigation will be in setting out the evidence you're relying on, whatever the legislature decides to do.

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

Senator Martin, you have the floor for three minutes.

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

My question is for Ms. Lawley.

I had a stakeholder in my office this morning who's living with a physical disability. He was very concerned about how many times some of his friends and people he knows living with a disability have been offered MAID. He has lost many friends.

To my first question, I'm hoping for a very short yes or no, and why. The UN Committee on the Rights of Persons with Disabilities called on Canada to halt the 2027 mental illness expansion. The government tabled the report late, said nothing publicly and 10 months later told a journalist it was still reviewing the recommendations. Can you tell this committee today whether the government has formally responded to the UN recommendation to halt this expansion, and if not, why not?

Sarah Lawley: The government has not responded to the UN Committee on the Rights of Persons with Disabilities, mostly because every individual's end-of-life journey is different. Track 2 is permitted in Canada through our Criminal Code. There are safeguards in our jurisdictions that are meant to support that. The expert panel on MAID did consider whether there should be additional legislative safeguards put in place for track 2. It did say that more guidance was needed for clinicians, but safeguards were in place.

The Joint Chair (Hon. Yonah Martin): The safeguards do not seem to be enough. People are falling through the cracks. It's a very dangerous situation for them.

My second question is related to your December 2025 report on the engagement with indigenous communities. I understand that not one indigenous partner organization has endorsed readiness for this expansion. Would you comment, please, on the status of the readiness of indigenous communities?

● (1910)

Sarah Lawley: I don't know if I can comment on the readiness of indigenous communities, but I can comment on their very active engagement with us over the course of the 18 months during which we undertook our indigenous engagement. A very robust report on our website, which we released last year, speaks to the fact that a good number of indigenous partners across the country did provide us with their perspectives on end-of-life care and the role of medical assistance in dying in that—

The Joint Chair (Hon. Yonah Martin): Did it not conclude that more consultations are needed before the exclusion expires in March 2027? Wasn't that one of the conclusions?

Sarah Lawley: We are obviously continuing to engage with our indigenous partners as part of our overall policy work and to provide recommendations to the Minister of Health and the Minister of Justice. For the purposes of this committee, there is not a standardized position across the country from our indigenous partners, just as there is not a standardized position across this country from practitioners or people who live in the jurisdictions. It's a very complex and personal issue.

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

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

Senator Moodie, you have three minutes.

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

I'd like to direct my question to Ms. Lawley. The question is around understanding the assessment of readiness that was made in the past.

MI-SUMC was extended twice, and the justification given was a lack of readiness. What metrics of readiness are you aware of that were used to make this determination? What method was used to determine whether the metrics were met or not?

Sarah Lawley: I don't want to paraphrase the work of previous committees, but I believe there were recommendations based on lack of standards of practice, lack of guidelines, lack of adequate training, concern over oversight and concern about the availability of mental health practitioners. Those really drove the recommendations from the last AMAD committee.

Hon. Rosemary Moodie: In terms of defining the scope of these various areas of deficiency or gaps, or the requirements, were there metrics assigned to these in any way, shape or form so that this time around we could assess improvement?

Sarah Lawley: There were no metrics, per se, assigned to them. There was just a general understanding that we had not yet as a country felt like we had met the bar. We are now looking at whether

the bar has moved. I do not have a baseline or an aspirational target to be achieved.

Hon. Rosemary Moodie: The Association of Chairs of Psychiatry in Canada, in preparation for March 2023, raised a number of recommendations that needed to be implemented before we could move ahead, including that we "Develop expert agreement on an operational definition of irremediability for different mental health disorders", "Develop guidelines and procedures...differentiating suicide vs. access to MAiD-SUMD", "Develop standardized education tools for training psychiatrists and other health professionals", and have robust processes for data.

Would you say we have met those things?

Sarah Lawley: I would say there is good evidence to show recent progress on that.

I would draw to your attention the Canadian Psychiatric Association guidance, which provides practitioners with tools to help assess irremediability, especially so they know it is not a yes or a no. It is a judgment by the practitioner based on multiple lines of evidence, including whether the individual has had a psychiatric diagnosis; the duration, severity and persistence of the suffering related to that diagnosis; their treatment history; whether they are in advanced and irreversible decline; and social conditions, which should not be mistaken for medical irremediability. That provides them with more direction from a clinical practice perspective to guide their work and their advice to a MAiD assessor.

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

Senator Wallin, you have the floor for three minutes.

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

I have a quick question for both Ms. Lawley and Ms. Gibner, which comes out of the discussion around jurisdiction shopping, if I can put it that way.

To your knowledge, has anyone in Canada been approved for MAiD with mental illness being the sole underlying cause, noting that today it is not yet permissible? Do you have any evidence of that?

● (1915)

Sarah Lawley: To my knowledge, no.

Kimberly Gibner: I would say the same. I'm not privy to any of that kind of information.

Hon. Pamela Wallin: Thank you. There's nothing on the record about that.

On the issue of readiness, one of the things we heard about in testimony at the last iteration of this committee was a shortage of practitioners and assessors.

Ms. Lawley, you have said that you think that has been corrected, if there are triple the number of people now taking up training and expressing their willingness to be involved.

Sarah Lawley: It's important for the committee to recognize that while there has been triple the number of practitioners involved in the MAID curriculum online and in engagement, I am still hearing very regularly from my counterparts across the country that mental health capacity is a concern, especially if you consider the Canadian Psychiatric Association's guidance that there has to be a diagnosis and there has to be treatment.

A number of things have to be met before mental illness as a sole underlying condition can be a reason for medical assistance in dying. The concern around the country is whether we have the system in place that would allow supports for an individual for the duration of their illness, and I would say we do not. That is one point where we're still having active conversations.

Hon. Pamela Wallin: Do you believe that by 2027 this situation will improve?

Sarah Lawley: The statistics show us that we aren't increasing the number of psychiatrists in our country—if I look at CIHI data—and it's still below the number of family health practitioners we are providing. It is not significant; it's like a 7% increase.

Hon. Pamela Wallin: Ms. Gibner, as we've discussed, provinces can make access more restrictive, but they can't make legal something that is illegal. From a justice point of view—the point of view of the Constitution, the law and the Criminal Code—do you think there are enough safeguards in place for MAID to become an option for those whose sole underlying condition is mental illness?

Kimberly Gibner: If it's okay, my colleague is going to take that question.

The Joint Chair (Marcus Powlowski): There are only five seconds left, but I'll give you another 15 seconds.

Julia Nicol (Counsel, Criminal Law Policy Section, Department of Justice): I don't think it's up to us to determine if there are enough safeguards; that's the role of Parliament. Obviously, you can see from other testimony that there is a debate, with some people believing fervently that we have enough, such as the expert panel and others who are questioning that. You'll have to weigh the evidence from various experts. Unfortunately, we're not in a position to advise on that.

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

Senator Wells, you have three minutes.

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

My question is for Health Canada.

Are you aware that the CPA clinical guidelines encourage clinicians to review a person's health records, which include past assessments? This is also clearly communicated in the CAMAP curriculum and was part of the expert panel recommendations.

Sarah Lawley: I do know that it is in the Canadian Psychiatric Association guidelines, because I read them myself the other night. Even though I'm not a clinician, I can tell you they're very easily understandable. They are really trying to create a holistic approach and support for clinicians.

Hon. Kristopher Wells: This question was sort of asked, but I want to ask a bit more about metrics. If we have no metrics, how

can we say we do not have enough practitioners? How do you see the metrics connecting to the practitioners?

Sarah Lawley: There's a double jeopardy issue in place here in terms of determining metrics, because we also don't know the demand.

We understand the supply. We can tell you how many psychiatrists we have in this country, where they're located and what the regional disparities are. What I can't tell you is what the demand will be should this exemption be lifted. Ergo, would there be enough demand and supply? That is an unknown in this formula that we are solving for.

Hon. Kristopher Wells: If that were the case, we wouldn't need a legal exclusion. There wouldn't be enough practitioners to even move forward for some people.

Sarah Lawley: That is an active conversation that jurisdictions are having, especially low-resource jurisdictions. For instance, Nunavut has no psychiatrists, yet it delivers MAID services to its jurisdictions.

There is a conversation around how a psychiatrist in one jurisdiction could perhaps provide advice to a MAID assessor in another jurisdiction. We allow for that across our country; we have inter-jurisdictional billing codes. How you build a system whereby you know how to find that support for you as the MAID assessor is a very active conversation at the PT level right now.

● (1920)

Hon. Kristopher Wells: I think the proposed bill in Alberta would bar assessors outside of the province from consulting with people in the province.

Sarah Lawley: That is actually a question I asked Alberta the other day. Their legislation says that their citizens cannot see MAID assessors in other jurisdictions. Their legislation does not prohibit their psychiatrists from providing advice to other jurisdictions, but we don't know if that was the intent. They're going through their legislative process right now, and it is an active question with that jurisdiction.

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

I'll turn things over to Senator Martin.

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

We'll go to round two, with three minutes for each member.

We'll begin with Ms. Jansen.

Tamara Jansen (Cloverdale—Langley City, CPC): To the comments that both Ms. Gibner and Ms. Lawley made about there being no actual cases that they're aware of, if you look in the death review committee report, there was a Mr. A who experienced suffering and functional decline. He was given MAID, and there were no pathological findings for his decline other than his COVID-19 shot. There are cases.

This goes to my question about non-compliance, and Ms. Lawley, I'll direct it to you.

If you wanted to design a system that quietly looks the other way, I'm not sure you could do it much better than what we're seeing here. In Ontario alone, the coroner tracked 428 possible Criminal Code violations in assisted dying cases over five years. There were 178 in a single year. Out of all those cases, every one involving the ending of a human life, only four were referred to a regulatory body, and not one was reported to police.

In any other area of law—financial crime, assault and even paperwork violations—hundreds of potential Criminal Code breaches would trigger investigations, headlines and consequences, but here, where the stakes are literally life and death, the system seems to do the opposite. It absorbs it, redirects it and keeps it away from the very institutions designed to enforce the law.

Then we hear something even more troubling. When we asked basic, reasonable questions of this government on which provinces have oversight, who's reviewing the cases and whether there are checks before or after a life has ended, the answer we got back from them was essentially, "We don't know; that's up to the provinces."

Let's put that together. There are hundreds of possible violations with no police involvement, no national tracking and no clear line of accountability. Now, with some of the most complex, subjective and difficult-to-diagnose cases in all of medicine—mental illness—we are being told this same system will somehow suddenly function just fine.

Canadians aren't naive. They can see when a system is built to enforce the rules and when it's built to avoid asking too many questions. Right now, this looks like a system that has been structured, intentionally or not, to keep scrutiny at arm's length and enforcement and safeguards out of the room.

Before we expand this any further, we need to be honest about what's already happening. I point to Kiano's case. He did not move to B.C. He flew to B.C.

That's why we're here in this review committee. The more testimony we hear, the more it seems clear that we're not ready, and will likely never be ready, to expand this to those whose sole underlying condition is mental illness.

Is there anything you can say to demonstrate proof that the federal government or Department of Health is dealing with the hundreds of compliance failures?

The Joint Chair (Hon. Yonah Martin): There are only about 20 seconds, so maybe give a yes or no or a brief example.

Sarah Lawley: I would say, to very valid public interest concerns around safeguards and oversight, that you are right. There is a patchwork of approaches to oversight that the federal government does not lead. It is really for the jurisdictions to set up their oversight mechanisms, and they're all slightly different.

The one thing about oversight is that the opportunities the jurisdictions have for continuous process improvement play out at our FPT working level. We are sharing that information with each other, and we are learning from each other.

• (1925)

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

Next we'll go to Ms. Tesser Derksen for three minutes.

Kristina Tesser Derksen (Milton East—Halton Hills South, Lib.): Thanks very much, Madam Chair.

Thanks to our officials here today.

I want to take the discussion about the provinces a step further. It's a discussion we've already had around the table with Mr. Lawton, Ms. Jaczek and Senator Wallin.

I want to talk about the concerns about variances in the accessibility and application among the provinces—this patchwork, as we've been referring to it. I want to examine it from a charter compliance lens, if I could, so this question might be best directed to Justice.

I'm wondering if there are legal exposures from potential charter violations due to those inconsistencies or if inconsistencies could develop between the provinces.

Kimberly Gibner: That's a very good question.

I am here to talk about the federal space as it relates to the Criminal Code and what we criminalize as a society and as a federal government. As it relates to the issues at play around MAID more generally, you will find all sorts of charter considerations in all three of the charter statements that we provided for sections 7 and 15. You certainly could look to all those sorts of considerations if you wanted to make an argument that health care is not provided consistently across the country, but that's extent of it.

I hope that helps.

Kristina Tesser Derksen: I'm thinking specifically of an example where someone who has mobility issues wants to access MAID, but their province won't allow it. They have mobility rights under the charter as well, so if they wanted to go to a different province but couldn't because of a medical condition or something else, is there a charter violation there that we could potentially be exposed to because we haven't properly set the national guidelines for the provinces?

Kimberly Gibner: If it's of assistance, since this committee has spent so many years thinking about these really complex problems, maybe you can switch to another subject where you can draw some analogies, like any other sort of health condition and how provinces deal with it differently. I don't know if that will help the committee think that through, but we are in a federation, so it's a very complex area of the law.

Kristina Tesser Derksen: I'll follow up with one more question about something that you said, Ms. Lawley, with respect to the terms and conditions of delivery being within the jurisdiction of the provinces. How would you distinguish that from the accessibility and eligibility that the provinces seem to also be using differently?

The Joint Chair (Hon. Yonah Martin): Give a very brief response.

Sarah Lawley: I think we could spend a lot of time talking about the CHA, but I would say this. There is a basket of services that must be provided—medically necessary care—but how that care is delivered, to whom it is delivered and the eligibility for it does fall within the jurisdictions. Cancer screening is a good example. Your ability to access cancer screening will change depending on which jurisdiction you're in.

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

Monsieur Thériault, I apologize, but you have two minutes, not three.

[Translation]

Luc Thériault: Thank you.

My question is for the officials from the Department of Justice.

Emeritus Professor Jocelyn Downie joined us at our last meeting. She told us that a blanket prohibition for those whose only underlying medical condition is a mental disorder would be contrary to the Carter decision because it would not allow for individual assessments. In that sense, the prohibition would be contrary to the charter.

Do you agree with that?

Julia Nicol: Thank you for the question.

As my colleague mentioned, the government's position is that the charter provides for a prohibition on medical assistance in dying in the case of mental disorders. It can prohibit one or it can allow one.

Given that the current legislation was not in place at the time of the Carter decision, the specific question is whether the legislation complies with the charter.

Luc Thériault: What legislation are you referring to?

After the Carter decision, there was Bill C-14 and Bill C-7. We are talking about the exclusion provision in Bill C-7.

• (1930)

Julia Nicol: Currently, the legislation does not permit medical assistance in dying in the case of mental disorders. The target date of March 17, 2027 must also be considered. Arguments for both issues have been put forward.

In the Carter decision, the Supreme Court stated that its position was in line with the facts of the case, in which no one was suffering from a mental disorder. That matter has not been examined by a court through the lens of current legislation.

Luc Thériault: Thank you.

Does that mean that it would be advisable—

[English]

The Joint Chair (Hon. Yonah Martin): I'm sorry, Mr. Thériault. Your two minutes have expired.

We are now going to the second round for senators for two minutes each.

The Joint Chair (Marcus Powlowski): Senator Wells, you have the floor for two minutes.

Hon. Kristopher Wells: In reference to Health Canada, do you have any evidence that there is widespread non-compliance, abuse or criminal activity in the MAID system? Isn't it true that when we hear a media story, we do not have access to the full information from the patient or the clinicians and therefore are really only hearing part of a story, which may be factual or not?

I have a question for legal. To your knowledge, has there been any situation in which there has been a six-year delay in the coming into force of legislation arising out of a successful charter challenge?

Julia Nicol: As I mentioned in the answer to the other question, the charter challenge had plaintiffs with physical conditions, so I don't think we can characterize it as a clear decision of a court on the question of mental illness. In terms of the temporary nature of the exclusions, I'm not sure, off the top of my head, if there are other examples where there have been those sorts of sunset clauses, but there are several in various pieces of legislation.

Hon. Kristopher Wells: Thank you.

What are the principles that the Supreme Court of Canada has articulated should be used to determine whether to issue a suspension on a declaration of invalidity?

Julia Nicol: I'm sorry. Can you repeat the question?

Hon. Kristopher Wells: What are the principles—and you can share this in writing if you need to—that the Supreme Court of Canada has articulated should be used to determine whether to issue a suspension on a declaration of invalidity?

The Joint Chair (Hon. Yonah Martin): Give a brief answer.

Julia Nicol: I'm not a charter expert, so I'll get back to you on that.

Hon. Kristopher Wells: Send it to the clerk, please.

The Joint Chair (Marcus Powlowski): Since you only have about eight seconds left, I guess you'll surrender your time.

Hon. Kristopher Wells: I won't try.

The Joint Chair (Marcus Powlowski): Senator Dalphond, you have the floor for two minutes.

Hon. Pierre Dalphond: [Technical difficulty—Editor] I believe that the charter issue.... I understand that sections 15 and 7 are engaged. That's what your statements have said in the past. I certainly agree with this. However, the test will have to move to section 1 to find out whether renewing the sunset provision is a reasonable decision considering the context in which the decision was made. Is that really what the question will be?

Julia Nicol: Are you saying if we extend the exclusion again...?

Hon. Pierre Dalphond: Yes.

Julia Nicol: If we extend it, we're going to have to look at the factors, the evidence, that we have in front of us: what has been done to prepare to be able to assess decision-making capacity, incurability and all of that. I think it will come down to those aspects. There is a fair amount of room for Parliament to decide—based on the risks and complexities involved and the important competing interests of autonomy, the protection of the vulnerable and the prevention of suicide—where it wants to land on those issues.

Hon. Pierre Dalphond: Thank you.

The Joint Chair (Hon. Yonah Martin): Thank you so much to our witnesses for taking all of our questions.

We will suspend for a few minutes to prepare for the second panel.

Thank you.

• (1934)

(Pause)

• (1935)

• (1940)

The Joint Chair (Hon. Yonah Martin): We will resume.

As members are taking their seats, I'll welcome our witnesses for the second panel.

Representing the Association des médecins psychiatres du Québec, we have Dr. Claire Gamache, psychiatrist, and Dr. Guillaume Barbès-Morin, psychiatrist, by video conference. In attendance in person, as individuals, we have Dr. Ramona Coelho, family physician, and Dr. Karin Neufeld, psychiatrist and chair of the department of psychiatry at McMaster University.

Thank you all for being here.

We have our first round with members. You have five minutes each. I'm sorry. We have our presentations. I'm eager to get to the questions.

We will first hear from our witnesses. We will begin with Dr. Claire Gamache.

[Translation]

Claire Gamache (Psychiatrist, Association des médecins psychiatres du Québec): Thank you very much.

My name is Claire Gamache. I am the president of the Association des médecins psychiatres du Québec, or AMPQ, representing 25% of the psychiatrists in Canada.

Since 2020, we have taken part in the discussion on medical assistance in dying where mental disorder is the sole underlying medical condition. Our main goal is to use our expertise and our experience with the most vulnerable to combat stigma.

According to the World Health Organization, the WHO, and with our experience on the ground, severe mental disorders remain misunderstood and the effects on those so afflicted are poorly recognized by the public. The experience we refer to is with patients whom we have been following for decades and who have tried many therapies and treatments.

In the presentation that I provided for you today, you can see mental disorders in the form of a pyramid. The 3% showing severe mental disorders corresponds to 3% of the population. In terms of medical assistance in dying for those with mental disorders, we are talking about a tiny percentage of the patients in that 3%. These are the patients with schizophrenia, with very severe obsessive-compulsive disorders, with recurring and refractory depression. It's a very small number. For the 20% of mental disorders currently diagnosable in patients in distress, medical assistance in dying would never be considered for someone in crisis, someone who has lost a job, or who goes to the ER. That kind of situation does not enter the equation and it is somewhat dishonest to suggest that it does.

In the document, we show the origins and the definitions of severe mental disorders. The psychiatrists in Quebec consider the suffering they cause to be the equivalent of the suffering caused by physical disorders. The only real difference is the way in which they are manifested.

Let me describe a clinical case for you in order to demonstrate a severe mental disorder.

A 67-year-old woman has had a very severe obsessive-compulsive disorder since she was a teenager. She has irrational doubts and is in constant fear of contaminating her husband, her children and her grandchildren with her bowel movements. She has been washing herself 15 times a day for several years. She has been hospitalized many times, she has received electroshock therapy, she takes huge amounts of medication and she is in therapy. One day, she announces that she no longer wants to see her grandchildren because she is too afraid of contaminating them. She refuses to go back to hospital and she is asking for medical assistance in dying.

The request causes a lot of debate because the criterion for eligibility for medical assistance in dying for those with mental disorders is the notion of grievous and irremediable. As psychiatrists in Quebec, we consider that the uncertainty surrounding this diagnosis is not reserved for mental disorders. The AMPQ suggests three major factors. These are that the disorder has been chronic for a number of years, that previous treatment options have been appropriate and generally recognized, and that treatment, discussion and assessment of the current situation has been refused. That is why, for us, appropriate psychiatric expertise must clearly be sought.

Suicidal crises also involve many challenges. But they are part of our daily practice. Assessing the risk of suicide is part of the work of interdisciplinary mental health teams. The assessment takes many forms including the planning, any previous attempts and the ability to hope for change.

Examining a request for medical assistance in dying will be done for long-term patients who have had multiple treatments and who are no longer in crisis or in an acute phase of their illness. It is very clear to us that when an illness or mental disorder is unstable, it is not the time to be discussing medical assistance in dying. A patient in a period of depression, in acute, manic or psychotic crisis will in no way be able to have a conversation about medical assistance in dying.

In conclusion, the AMPQ believes that patients with mental disorders cannot be considered as different, as citizens with no right to the same health care options.

Psychiatrists know, follow and support patients with severe mental disorders throughout their careers. They have the knowledge, the judgment and the rigour required to assess these requests.

We in the AMPQ believe that, instead of preventing those with serious mental health disorders from exercising their right to medical assistance in dying, Canadian society must enshrine that right. Psychiatrists are ready to support patients through that process.

• (1945)

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

[English]

Next we will have five minutes of testimony from Dr. Ramona Coelho.

Ramona Coelho (Family Physician, As an Individual): Thank you.

I'm a family physician, a senior fellow at the Macdonald-Laurier Institute and an adjunct research professor at Western University. I served on Ontario's MAID death review committee and have published extensively on MAID, but I speak in an individual capacity today.

For 20 years, I have cared for patients with complex disabilities, mental illness, chronic pain and extreme social vulnerabilities. These are people who live in poverty and with other forms of marginalization, such as men out of prison and refugees.

Suffering is complex and different for everyone, and it's shaped by psychological distress, trauma, poverty, isolation and a lack of supports. Addressing this takes careful assessment and time. Community life also plays a major factor in mitigating suffering, yet in Canada, some individuals receive MAID when suffering is driven by these unmet needs.

In my practice, I have observed and spoken about troubling patterns of how MAID was introduced and assessed. Some patients were referred immediately after a new diagnosis by a specialist. Others were approached repeatedly during vulnerable hospitalizations—I've brought patients on the BBC to speak about that—and some were assessed and approved quickly, without meaningful exploration of suffering or supports in place.

Ontario's MAID death review committee reports contain anonymized cases, but they are real and you should have them all. Across these cases, there were individuals with untreated mental illness, suicidality, addiction, isolation and unmet social needs. They demonstrate premature eligibility, inadequate safeguards and a failure to address suffering before ending lives.

It's not fair to say that all cases in the media are fake. That's gaslighting the disability community and their stories, and we would never do that to people who want MAID. We also can't fool ourselves that all MAID providers get it right every time.

The MAID death review committee cases exist. In particular, the stats from the MAID death review committee reveal that track 2 cases reflect high social vulnerability and untreated mental illness. Statistics show that nearly 30% of the patients lived in poverty. More were women. Many listed a lawyer, a physician or a friend as their next of kin—they couldn't list a family member—suggesting a high level of social isolation. Fewer than half of these people received mental health or disability supports before they died, and fewer than 10% received community solutions or income. These are the major solutions that my patients need in order to thrive.

Although framed as a choice, MAID can allow structural coercive influences to push people towards death. With mental illness, it is not possible to reliably determine that someone will not recover. At the same time, many Canadians wait a long time for specialized psychiatric care, and that prolongs recovery and increases suffering. Suicidality, a lack of insight and impaired judgment are symptoms of many psychiatric diseases, and they fluctuate, but recovery is possible the vast majority of the time with or without treatment.

Given the lack of evidence to guide MAID assessments for mental illness, like for my patients, bias and discrimination will inevitably determine who gets MAID and who gets suicide prevention. I invite you to read my article "Discrimination-driven deaths—Analysing Ontario Coroner Reports on Euthanasia and Assisted Suicide".

In response to claims made here that MAID professionals consistently follow guidelines and that CAMAP guidance doesn't have any problems, I urge you to read these reports. You can also read my article. Also consider the risk of expanding MAID to suicide contagion. MAID presents death as a solution to suffering and provides the means to achieve it with clinician support.

One witness cited a documentary on MAID for mental illness, noting that the individuals committed suicide when the delay was announced, and said it contributed to their deaths. Why might this have occurred? Repeated exposure to and being followed around by messaging from the government that this could be a solution to their suffering, framing it in a way that it would be dignified to let them die, can increase the resolve to end one's life and can actually worsen suicidality. We know this from suicide prevention research.

Further, the CPA's consensus statement on MAID for mental illness is an opinion. It doesn't add anything to this discussion on evidence-based medicine. It should not reassure us that we are ready to proceed, nor guide life-and-death decisions, even on a case-by-case basis.

• (1950)

In contrast, the International Association for Suicide Prevention, in December 2025, stated that MAID should not be provided solely for mental illness and that suicide prevention principles must apply to all people, including those with disabilities and those at the end of their life.

The Joint Chair (Hon. Yonah Martin): Dr. Coelho, can you wrap it up in five seconds?

Ramona Coelho: I have just one line, actually.

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

Ramona Coelho: The UN Committee on the Rights of Persons with Disabilities has advised repealing track 2 MAID and stopping the expansion of MAID for mental illness.

Thank you very much.

The Joint Chair (Hon. Yonah Martin): Thank you. I should have forewarned you.

Ramona Coelho: That's okay.

The Joint Chair (Hon. Yonah Martin): We will now have testimony from Dr. Karin Neufeld.

Karin Neufeld (Psychiatrist and Chair of Department of Psychiatry, McMaster University, As an Individual): Thank you so much for the opportunity to present before you today. I hope to convince you, with my strong urging, to delay the expansion of MAID to mental illness.

I am Karin Neufeld. I am a psychiatrist. I have practised for more than 35 years. I have cared for tens of thousands of patients.

After completing medical school in Manitoba, I went to Johns Hopkins University's school of medicine, where I did my training, and I served in a leadership capacity as a faculty member and was promoted to professor at that institution before having the honour of coming back and being asked to be a chair at McMaster University, where I am currently working. I am not, however, testifying on behalf of any institution. I am only testifying on behalf of my own opinions.

I have already prepared a written brief, which I think you have access to. Reading it to you would probably be less interesting than highlighting the case I begin to tell you about in my brief and using that as a teaching example of why I am so concerned about this expansion.

In October 2023, a middle-aged man came to my clinic in Hamilton, where I had just started practising. He was suffering profoundly. Let there be no mistake about it. He was suffering from a recurrent, major depressive illness. He had been suffering from this illness since he was a child. What this means is that he would have bouts of very severe depression—very dark and hopeless—and felt badly about himself, about his prospects and about the world around him and that he would be much better off dead. This was a

very profound feeling he had that would sometimes last months or years.

He came to me in the fall and asked me to refer him for MAID. Because it was not legal at that point, he agreed to work with me. He has worked with me and continues to work with me. It took us a long time to find a regimen that actually helped and that he could tolerate, but he got much better—so much better, in fact, that this year, after returning to university, he actually graduated with a degree and is now looking for a job in the counselling field. He has also improved his relationships with his family—his wife and his siblings—and poignantly, he has been one of the greatest supports to a niece who developed postpartum depression, because it is a condition that runs in his family.

When he came to me several weeks ago, I reminded him that he had come asking for MAID. He laughed and said it was a darn good thing it wasn't legal when he came in, because he'd be dead now. While that was a little funny, it really wasn't funny, because I think he was right. I think he would very much have qualified for MAID at the time when he presented. Let me explain why.

First of all, with the way the law stands currently, when a patient comes in to request MAID, even though I, as an experienced psychiatrist, may know there are clinical practice standards that haven't been tried yet, I can't really use that as a basis for not referring him. I must refer him. I'm compelled to refer him.

Second, I think we can all agree that he had profound suffering. There was no doubt about that. It was every bit as profound as any other kind of physical disability. The problem is that it's about grievous suffering and irremediability. I think I've demonstrated to you that it wasn't irremediable. He is back on track with his life and doing well, and he doesn't want to pursue his MAID request, so it wasn't irremediable, but at the time, I could not prove that.

The guidance document that Dr. Mona Gupta told you about on March 24, which I have here, doesn't really help us all that much. It refers us back to the model practice standard, which basically says you must use a proxy. We heard this evening that you really have to look at how people have responded to treatments. This man had had 10 hospitalizations, ECT and many treatment trials, and had not responded. Certainly, he would have qualified from that perspective.

• (1955)

His suicide was not impulsive. He just wanted to die and had wanted to die for a very long time. I think that would be considered a stable request.

How many people are we willing to sacrifice just like this gentleman? He's not rare.

The Joint Chair (Hon. Yonah Martin): Thank you, Dr. Neufeld, and thank you to all the witnesses.

We'll begin our first round with Mr. Cooper for five minutes.

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

Dr. Neufeld, in the last panel, Sarah Lawley from Health Canada cited the guidance from the Canadian Psychiatric Association on evaluating irremediability and managing suicide risk as evidence of readiness for the expansion of MAID for mental illness. As the chair of the Association of Chairs of Psychiatry in Canada, can you speak to whether this guidance represents a consensus among chairs of psychiatry?

Karin Neufeld: It absolutely does not represent any consensus among the chairs of psychiatry. In fact, the chairs of psychiatry in the majority do not support the expansion of MAID. This guidance document has just been published, on the very last day of March. It's not peer-reviewed, and certainly none of us, to my knowledge, were even asked to participate in the process. It doesn't represent a consensus.

Michael Cooper: It's my understanding that eight members worked on the guidance, all of whom were self-selected. Do I have that right?

Karin Neufeld: I can't speak to how they were selected, but we do know that some of those members, from the outset, have been very clearly interested in expanding MAID.

Michael Cooper: On the issue of consensus, would it be fair to say that to the degree there's a consensus, it's a consensus of these eight individuals?

Karin Neufeld: I would imagine so, yes.

Michael Cooper: Looking at the guidance, at the very start, there's a disclaimer that states, "This guidance is not intended to be interpreted or to be used as a standard of medical practice." What is the significance of that disclaimer?

Karin Neufeld: It makes it hard to know how one would decide on how to implement this very final solution in patients.... I didn't mean it that way—this very difficult-to-retract medical decision based on this guidance.

Michael Cooper: You noted in your brief to the committee that the "guidance offers no substantive criteria for determining irremediability." Instead, as you just noted, it copies and pastes Health Canada's model practice standard, which instructs assessors to consider prior treatment attempts, including their duration, intensity and outcomes, as well as illness severity and duration.

You cited an example of a patient. You also noted in your brief that psychiatric disorders "follow non-linear trajectories", that patients "frequently improve after years of severe [illness]" and that treatment resistance does not establish non-recovery.

Do I have that right?

• (2000)

Karin Neufeld: I think so, yes.

Michael Cooper: Okay. Given that, is it fair to say that the factors set out in Health Canada's model practice standard that are copied and pasted into the guidance are not suitable or not appropriate for assessing irremediability in the context of mental illness?

Karin Neufeld: Yes, I believe so. It's really hard to prognosticate based simply on people's history as to whether there are things that still should be tried or things that can still be helpful to somebody.

Michael Cooper: You further noted in your brief that the guidance provides "no clear instruction" regarding distinguishing between a rational request for MAID and one motivated by "suicidal ideation", and that instead of providing clarity, it could actually create "conceptual and clinical confusion". Can you elaborate on that point?

Karin Neufeld: The patient I was telling you about really illustrates that. He was not impulsive.

What I get from this document is that it's impulsivity that we're warned against reacting to with MAID, that somebody who's planning to hurt themselves in the next little while is not eligible for MAID. The problem, as my patient demonstrated, is that an enduring, stable wish to die might be part of the illness, as it was in his case, yet that would be considered an appropriate request for MAID.

Michael Cooper: To be clear, Dr. Neufeld, is it your professional position that the CPA guidance does not constitute evidence of so-called readiness?

Karin Neufeld: I don't believe it does, no. It certainly doesn't help me understand how this would be implemented.

Michael Cooper: Dr. Coelho, is your position the same on that point?

Ramona Coelho: Yes.

The Joint Chair (Hon. Yonah Martin): That was perfect timing. Thank you very much.

We will now go to Mr. Maloney for five minutes.

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

Thank you to the witnesses for being here this evening.

Dr. Gamache, I'll start with you. You started your remarks by saying that this will affect only a small number of people. Why is that relevant?

[Translation]

Claire Gamache: It is relevant because it is very clear to us that it would be for those with very serious mental conditions that have been developing for a number of years. By serious mental conditions, we mean conditions affecting 3% of the population. So these are patients that we have been following for many years.

I have been practising psychiatry for 27 years. Among my patients, I would probably not have agreed to a request for medical assistance in dying more than two or three times, although I see many new patients each week. So we are talking about very few patients.

[English]

James Maloney: Thank you, Doctor. Look, it makes no difference to me whether it's a small percentage or a large percentage. The issue we have to deal with is getting it right. It sounds to me like you said this to give me some comfort in making my decision. With respect, I think it's an irrelevant factor.

My second point is that you said that we can always determine irremediability. You made that statement very clearly and very decisively.

This question is for the other two panel members. Do you agree with that?

Karin Neufeld: No. I don't think I know how to determine irremediability. I don't know how to be absolutely certain that someone cannot be helped.

Ramona Coelho: The evidence does not show that we know how to predict irremediability in mental illness. I have seen many patients who have suffered for years and years, in hospital and out, recover, and I would never have guessed it.

James Maloney: My dilemma in addressing this issue is that I have to make a decision, along with my colleagues around this table, and make some recommendations. Those recommendations have permanent consequences. How do I do that when the three of you can't agree on the core issues? How do I make a recommendation that we can go ahead with this if the three of you, and many others in your profession, cannot agree?

Dr. Gamache, let me ask you that.

[Translation]

Claire Gamache: Yes, it is difficult to collect precise data on psychiatry, on mental health and on suffering. I would be surprised to see that physical disorders are always much more precise. In oncology, or with multiple sclerosis or Parkinson's disease, we are seeing developments that also take different paths. I find that we make a very clear distinction between mental and physical disorders. It seems to me that this does not match the patients' paths, which differ at times.

I acknowledge that this is a very difficult decision for parliamentarians. We are not saying that it is simple. It is difficult, for sure. The decision we are actually making is that medical assistance in dying is a form of care but care to which a part of the population, whom we already perceive as lacking resources, will not have a right.

• (2005)

[English]

James Maloney: Thank you, Doctor. I apologize for interrupting, but I have limited time.

Thank you for acknowledging that it's imprecise. That's my main point. Until I am given comfort that there is precision, I can't responsibly make a recommendation that we can proceed with this. That's the dilemma I'm facing. I understand your commitment to the issue, and I understand, as you pointed out, the obligation you have to patients that they should not be treated as second-class citizens, but I'm not sure everybody in the profession is held to your standard or lives up to your standard.

We've had discussions tonight and previously about doctor shopping and jurisdiction shopping. Until I can be assured that everybody is as certain about things as you are, I'm just not comfortable. Is that a fair conclusion on my part, in your opinion?

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

[Translation]

Claire Gamache: When medical assistance in dying was first offered to patients with physical health conditions, so many doctors had conscientious objections and were by no means comfortable with the idea, even for physical health conditions. The palliative care people were completely opposed—

[English]

James Maloney: You're talking about conscientious objectors. I'm talking about people who can't medically reach that conclusion. That's the dilemma.

The Joint Chair (Hon. Yonah Martin): I'm sorry, Mr. Maloney. The time has expired.

Thank you, Doctor.

We will now go to Monsieur Thériault for five minutes.

[Translation]

Luc Thériault: Dr. Gamache, Dr. Barbès-Morin, how do you see the matter of consensus or lack of consensus among your members in Quebec?

Claire Gamache: I will answer first and then my colleague can finish my answer.

A few years ago, a survey showed that a little more than 50% of psychiatrists were comfortable with preparing to offer medical assistance in dying for mental disorders. However, look how things have evolved. A lot of psychiatrists in Quebec are taking part in aptitude assessments for MAID requests or for our colleagues' complex cases.

Luc Thériault: Do you want to add anything, Dr. Barbès-Morin?

Guillaume Barbès-Morin (Psychiatrist, Association des médecins psychiatres du Québec): As you might expect, we have no figures and it is a difficult situation to assess. I am a generalist psychiatrist from a remote region. I have been living here, in my little town in the north of Quebec, for 20 years. I have been treating patients for 20 years. It is difficult for me to answer for all psychiatrists, but I am pretty sure that most of my colleagues would agree on several key points.

In terms of intense suffering, there is no doubt that our severely ill patients with chronic health problems sometimes suffer to a level of intensity that is comparable to the level that would lead to medical assistance in dying for physical health problems. In terms of irremediability, those with bipolar affective disorder will have the illness for the rest of their lives, so, yes, it is irremediable.

The impact of the illness could lead to a change. Some people find a positive path forward. As Dr. Neufeld mentioned just now, we may well find a treatment that works well and it's great when that happens. Some people have full, complete lives. Others have more difficult lives and still others have lives that are crisis-filled, despite all our best efforts.

Those people, the ones who unfortunately do less well, in spite of everything having been tried, are the ones who come to us. I have been seeing them on a daily basis for years. We can still hope for the best for them. However, just as for other health problems, we have to respect their independence, their ability to make decisions and to choose for themselves what they want to do with their lives, with their suffering and with their hope. We must continue to give them hope, but we must also be able to see and understand their situation.

I feel that my colleagues, both in Quebec and elsewhere in Canada, are able to do that. Things are not different because the illness is in the brain. Like multiple sclerosis, some people do well despite it being a grave illness, but others suffer terribly. We can recognize that when it is happening in the brain too.

Unfortunately, I find that, with the way in which the current discussion is going, we are prepared to continue discriminating against our patients, who are also suffering greatly. That's just because we have a poor understanding of the neuroanatomy of mental illness and we can't see the illness on a scanner. Clinically, I feel that the vast majority of psychiatrists in Canada are sufficiently well trained and equipped to make decisions on all the factors we are discussing here.

They may be uncomfortable doing so, perhaps because of their own personal or religious values, but we still have to focus on our patients, on the needs of those who are suffering. When they ask for something, we have to listen. We have to work hard to determine the stage things have reached. I feel that we are up to that task in a number of situations.

It's just like the rest of medicine. I don't know the figures, but maybe 2%, 4%, 5% of doctors are comfortable, perhaps more. There's every reason to expect that the same is true with psychiatrists. Some people develop more specialized expertise in assessing those things. Not everyone can do it, and that's fine.

• (2010)

Luc Thériault: Is it your impression that there is a lot of medical paternalism in psychiatry, as there once was when patients had to fight for palliative care? The sole focus at that time was on finding a cure and, basically, patients were dying because of the treatment.

Guillaume Barbès-Morin: I agree so much with what you have just said. We have tried to leave the paternalism behind us in most of our dealings with patients and it's good that we have. However, I have heard a lot of things in the speeches this evening that are moving in that direction. We must be at our patients' side to help them to make decisions and to guide them, as well as to treat them. We must stop imposing our own values and our own world view on people who are suffering. If we can do that, we are doing well.

Luc Thériault: Basically, does that mean that some patients are going to end up in palliative care for ever and ever, amen?

Guillaume Barbès-Morin: It's worse than that. Patients will take their own lives because they are not being heard. If they had ongoing support, they could regain hope and they could be supported further through treatment.

[English]

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

We'll now move to questions from senators.

[Translation]

The Joint Chair (Marcus Powlowski): Senator Dalphond, the floor is yours for three minutes.

[English]

Hon. Pierre Dalphond: My question is about what you just said. Do we have enough resources in Canada to provide proper support to those who are in need of psychiatric assistance?

Karin Neufeld: I'm not a health systems expert in the Canadian context. I can speak only about what I know in my own region.

We could do a much better job of spreading the amount of resources we have. Certainly, within the province of Ontario, I know there are many regions that don't have access. We are relatively rich in the Hamilton-Toronto area, so we should be doing better, but even there it takes very long for people to get care.

Hon. Pierre Dalphond: [Technical difficulty—Editor] Quebec, but Dr. Coelho, are you of the same opinion?

Ramona Coelho: Yes. As I mentioned, I take care of people who live in the lowest socio-economic strata in Ontario, where I work. My patients have to access food banks. All of these things play into increasing their mental health suffering. They can often get a quick consult for psychiatry if it's urgent, but it takes five years to access super specialized care, like ACT teams, for complex care, which is not good enough.

[Translation]

Hon. Pierre Dalphond: Is the situation the same in Quebec?

Do people have access to the ongoing support they need? Are the resources sufficient?

Guillaume Barbès-Morin: I feel that the situation is the same everywhere in Canada, with the exception of a few small, extremely privileged clients in some large cities. More resources for more things could be a request everywhere in Canada. I make no secret of asking you for that. I also work with young patients experiencing their first psychotic episodes and with people with borderline personality disorder. We need resources.

Nevertheless, we must acknowledge that very sick people often have access to adequate resources in Canada. The huge gap is for those who are less sick and they are often the people who need front-line care. When they go to see their family doctor, they do not have access to social workers or psychologists. That is where the huge gap lies.

In general, even in a small region such as the one where I live, we can provide treatment such as ECT or repetitive transcranial magnetic stimulation, or offer programs of specialized care for personality disorders. We do it pretty well.

People need more care, but that is the case in other areas of medicine. As you know, access to specialized care—

• (2015)

Hon. Pierre Dalfond: Forgive me for interrupting you. Given that time and resources are limited, is there not a danger of resources being used for assessments and other studies when they should be used for ongoing support?

Guillaume Barbès-Morin: It's all about how much can be handled. I couldn't give you a precise figure. I don't know how many assessments of MAID requests are expected. But, as Dr. Gamache told you, my impression is that it would be a very small number, just those in the 2% of the sickest patients that psychiatrists deal with. So my impression is that there will not be many each year.

The Joint Chair (Marcus Powlowski): Thank you very much, Senator Dalfond.

[English]

We'll go to Senator Martin for the next five minutes.

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

Earlier in the previous panel, we heard that the government has not responded to the UN Committee on the Rights of Persons with Disabilities, but there's another report, from the International Association for Suicide Prevention, which released a statement against MAID for mental illness. It's the leading global body dedicated to suicide prevention research and policy.

I'm wondering about this December 2025 report. Is there anything that we should be aware of as we're looking at expansion? Has the government responded in any way? Are you aware of that?

Ramona Coelho: The IASP statement in December 2025 said that there is an interlap between assisted suicide and suicide—we can't forget that—particularly outside the end of life. They emphasize that we can't know if mental illness suffering is truly irremediable, that hope always remains, that prognosis is inherently uncertain and that MAID should never replace mental health care.

The UN CRPD statement was that we should repeal track 2, as I mentioned, and not expand MAID for mental illness. They warned that what we're doing is basically putting people's lives at risk when we're offering them death in the context of not good psychosocial care or community solutions.

They also emphasized that autonomy alone is not a sufficient safeguard. People wanting something doesn't mean that it's good for them, and it can very much reflect therapeutic nihilism: "I am suffering so much with this patient that I think it's better that we

just end it for them." Am I just complying with their suicidal demand? Is that really accompaniment, or is it actually an abandonment?

The other thing that was raised and I'd like to address is that some people might be very careful and only approve two cases, but will they be right in those two cases? They may well be wrong. That's a big problem even if you have somebody who's trying to do their best. The government has not responded to it either.

The Joint Chair (Hon. Yonah Martin): That was actually what my second question was about: trusting the judgments of all physicians. I know that you've been part of the Ontario MAID death review committee, so whether it has been your experience that mistakes can happen and—

Ramona Coelho: I'm very disappointed with privileged commentators who say that the disability community trying to share their stories in the media is fake. That's not acceptable. We don't do that. On top of that, we have government-audited cases where we have reviewed their health care charts and have come up with.... The cases are from the coroner. They're not from us. If you want to question our analysis, fine, but the cases are from the coroner.

Just last month, CMAJ published a research paper by Pesut et al. from the MAID community talking about inter-assessor variability. It is wide. I'll give you one example. For reasonable and foreseeable natural death, some people consider it for weeks and months, but some people consider it for five years. That shows there's no standard.

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

Senator Moodie, you have three minutes.

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

Thank you for your anecdotal example, Professor. That's what it is. It is an example of a single patient. That bears no relationship to generalizability.

If I were to ask you a question that relates to that—it's a yes-or-no answer—are you saying, then, that you believe all individuals have the potential to get better from mental illness? That's the impression you give us.

It's a yes-or-no answer: Are you saying yes or no that you believe all patients can get better?

• (2020)

Karin Neufeld: I am saying that I cannot predict who will get better.

Hon. Rosemary Moodie: Thank you.

I'll also ask you if you come to this table as a person who supports providing MAID for mental health as a single diagnosis, or are you opposed to it?

Karin Neufeld: Are you asking me?

Hon. Rosemary Moodie: Yes.

Karin Neufeld: I said very clearly to begin with that I am opposed to it.

Hon. Rosemary Moodie: I'm making it clear for the record, because you made the statement that others who sit on the committee for the development of guidelines were clearly for it. I want us all to be clear about where we stand.

Dr. Coelho, as you walked through your examples, you mentioned a number of incidents, which you described, that are quite outrageous if they are factual. In fact, they are a clear violation of law.

Ramona Coelho: They are, Senator Moodie—

Hon. Rosemary Moodie: Excuse me. I would like to ask the question, if you don't mind. Please wait. Thank you.

If they are clear and factual, then they're a clear violation of law. Have you reported directly to the police or to your college any of the individuals who were involved in these cases?

Ramona Coelho: There are some cases the coroner is aware of that were investigated and taken over once I pointed them out. There are some cases where my patients did not go through with MAID even though they were approved, because I helped them put supports in place, so I didn't feel that there was any need to report. That's what we're doing with the MAID death review committee: trying to have quality assurance and safety.

Hon. Rosemary Moodie: Just as a point, MDRC case reviews are used to generate recommendations for MAID practice and oversight, not to determine wrongdoing. You don't examine things to the level and degree in which you would be—

Ramona Coelho: It's advisory only.

Hon. Rosemary Moodie: Yes, exactly.

Can you then say, in the cases that you have reviewed—

The Joint Chair (Marcus Powlowski): Senator Moodie, your time is up.

Senator Wallin, you have three minutes, please.

Hon. Pamela Wallin: Thank you, Mr. Chair.

I'm going to ask our two witnesses here a question. Are you familiar with the studies “What drives requests for MAiD?” and “Is Structural Marginalization Driving Medical Assistance in Dying (MAiD) in Canada?” by Dr. Downar?

Ramona Coelho: I've written a response to that.

Hon. Pamela Wallin: Okay.

Through the anecdotal testimony that you've provided tonight, the evidence is to the contrary. It's not for lack of access to services, advice or palliative care—

Ramona Coelho: Actually, the response was signed by—I can't remember the exact number—tens or maybe hundreds of doctors contradicting the findings.

Hon. Pamela Wallin: I think this study had 16,000 people, and there were 14 cases where better services could have been provided.

Ramona Coelho: I could be getting the study mixed up. I'm sorry.

Hon. Pamela Wallin: In some sense, it's counterintuitive, but what the studies are saying is that the level of income or access to services is not a driver for MAID. We've heard this evidence from others as well. It's more the well-to-do who have access.

Let me go back to Dr. Gamache and perhaps Dr. Barbès-Morin.

I want to follow up a bit on what Mr. Maloney was inquiring about: certainty. Of course, we'd all like to have 100% certainty in any diagnosis of any illness, whether it's physical or mental, but that is not likely in the human being and in the human condition.

Do you have confidence and certainty in yourself that the decisions being considered...? We don't have any real evidence, of course, for the question of mental illness being the sole underlying cause, because it doesn't exist yet, but in the work of MAID, do you feel that doctors and people in your position are balancing that?

● (2025)

[Translation]

Claire Gamache: Absolutely. That is why we generally consult with colleagues and have committees to discuss complex cases where patients are in unique situations. We do that very regularly in psychiatry. We consult our colleagues and we discuss complex cases together. We will do the same for these patients without a shadow of a doubt. In any event, a way of assessing patients who request MAID has been proposed in Quebec.

I would like to say that, when a patient requests MAID, it is very often a cry for help and we will treat it as such. When the patients are those whom we have known for a long time, we will discuss the reasons that have brought them to that point and we will examine those situations very thoroughly.

There are cases where it has not been deemed possible, because it wasn't; then we propose other solutions. The first step is to start the discussion. If all patients with mental disorders are told that it's out of the question—

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

[English]

The Joint Chair (Hon. Yonah Martin): Are we going to round two?

The Joint Chair (Marcus Powlowski): No, it's Senator Wells, your colleague.

The Joint Chair (Hon. Yonah Martin): Yes. I apologize.

Hon. Kristopher Wells: Thank you for not forgetting about me.

I would like to pick up with Dr. Gamache on the point that was being made in the last question.

We've heard that some individuals say that clinicians often disagree among themselves on whether a person has decisional capacity. Can you walk us through what happens if two assessors don't agree that a person with a mental disorder requesting MAID lacks capacity?

[Translation]

Claire Gamache: Is that question for me?

[English]

Hon. Kristopher Wells: Yes.

[Translation]

Claire Gamache: If two assessors do not agree, the case will have to go to a committee and different people will have to be called on. We will deal with these complex cases as we currently already do for physical disorders.

[English]

Hon. Kristopher Wells: To follow up, what will happen if a person who requests MAID has not had adequate treatment?

[Translation]

Claire Gamache: In Quebec, the thought was to consult psychiatrists who specialize in that type of illness and to make sure that the patient is receiving adequate treatment. For someone with severe refractory depression who absolutely refuses electroshock therapy, the decision will have to be that, in that situation, he is probably not eligible for medical assistance in dying. Before any agreement to offer medical assistance in dying to such patients, an available treatment has to have been tried for a number of years.

[English]

Hon. Kristopher Wells: That would be a clear safeguard that is in place.

[Translation]

Claire Gamache: In our view, yes, it would be necessary.

[English]

Hon. Kristopher Wells: Do you think the clinical recommendations developed by the Canadian Psychiatric Association reflect good practice?

[Translation]

Claire Gamache: In my view, yes. I can let Mr. Barbès-Morin answer the question but we find the recommendations to be very appropriate.

[English]

Hon. Kristopher Wells: Some individuals say psychiatrists cannot distinguish between suicidality and a MAID request. How would you respond to that?

[Translation]

Claire Gamache: That seems to show me a lack of familiarity with what a psychiatrist does every day. We are constantly assessing suicidal thoughts and discussing the situation with patients to see whether the request is maintained over time. Evaluating plans for suicide, previous attempts, hope and the situation with loved ones is a daily task for us.

We really want a request for medical assistance in dying to be made at a time when people are more stable and calm, not when they feel they can no longer tolerate the situation.

[English]

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

We'll go to round two.

We have three minutes for Ms. Jansen.

Tamara Jansen: To quickly follow up on what Dr. Gamache just said—this is for the other two witnesses—is there anything that says someone has to have had adequate treatment before MAID can be acquired?

● (2030)

Karin Neufeld: No. In fact, it was my understanding that if the patient does not agree with or is not willing to consider a treatment, a patient does not have to be compelled to try something.

Tamara Jansen: Dr. Coelho.

Ramona Coelho: In the MAID death review committee's second report of 2024, there is a case of a gentleman who received MAID even though he went to a psychiatrist, who suggested he could get MAID because he had a disability. He died from MAID with his mental health and addictions largely untreated, as documented in the case.

Tamara Jansen: We've been told that refusing to expand MAID to mental illness is discriminatory, yet in the cases you've reviewed, there were many recipients living in poverty who were isolated and without proper support. I have to ask, is not offering death to people who need compassionate care a discriminatory response?

Ramona Coelho: It's a very weird way to frame medicine, because MAID has been placed in medicine. Population- and evidence-based medicine is based on risks and harms to everybody and patient safety.

For example, for an amputation, you couldn't just demand an amputation. You'd have to have clinical indications that met the criteria. It's not discrimination to not give someone an amputation. Even if they're in terrible pain, if they would do better with compression stockings, revascularization or something else, we wouldn't give them an amputation. We wouldn't give them an amputation if it had no benefit to them at all medically, even if they wanted it, so this whole framing is—

Tamara Jansen: I'm sorry. We're so short on time.

I would like to pass my last minute over to my colleague Andrew.

Andrew Lawton: Dr. Gamache, Senator Wallin said earlier that we can never have 100% certainty on this. We have some disagreement even on the panel here today, as Mr. Maloney pointed out.

In your view, what would an acceptable margin of error be for misdiagnosing and misclassifying something as irremediable if mental illness is the sole qualifying criterion for MAID?

[Translation]

Claire Gamache: I can't talk to you about probability and margins of error. I am sorry but we cannot specify—

[English]

Andrew Lawton: Is the acceptable margin of error higher than zero?

[Translation]

Claire Gamache: It would certainly be acceptable if it were zero. We must be sure that we have done all we can for the patients before we agree to provide medical assistance in dying.

[English]

Andrew Lawton: If we have disagreement here, does that not prove that there is going to be a margin of error greater than zero if we proceed with this?

[Translation]

Claire Gamache: It is true that there are degrees of suffering and of severe, chronic psychiatric problems. A human being is a very complex being. We all agree on that. As a result, there would probably be a small margin of error.

[English]

Andrew Lawton: This is a life-or-death—

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

I will now go to the co-chair. You have three minutes.

The Joint Chair (Marcus Powlowski): I have to put my other hat on now.

Dr. Gamache has said that she thinks MAID for mental illness will be very rare. We've heard that from other people. Dr. Gupta talked about the requirement that you would have to talk to the family beforehand, you would have to talk to all treating physicians beforehand and you would have to have tried all forms of treatment. Quebec may want to implement a system that has those things.

Maybe I can ask you, Dr. Neufeld, about this first. Are all those safeguards required under the current legislation?

Karin Neufeld: They are not, to my understanding.

The Joint Chair (Marcus Powlowski): Dr. Coelho and Dr. Neufeld, you both work, as I did, as doctors, with a lot of other physicians.

Dr. Neufeld, you are a chair of psychiatry. You train a lot of psychiatrists. Are all psychiatrists the same? Are all equally careful? Are all going to insist on all of those precautions before acting?

It seems to me that there are some psychiatrists who very much believe this is the autonomous right of an individual, and they feel that not only do they not have to talk to the family, but if the patient refuses consent and they cannot talk to the family, there isn't a requirement for other forms of treatment. Do you think, in practice, that all treating doctors administering MAID would be that careful?

Karin Neufeld: I think there's going to be a great deal of heterogeneity, just as you've seen at this committee tonight.

The Joint Chair (Marcus Powlowski): In your opinion, Dr. Coelho and Dr. Neufeld, are there some doctors who, very much as part of their living, make their living by administering MAID?

• (2035)

Ramona Coelho: I would say a lot of MAID clinicians are very careful and very good, but you have a group of MAID providers who do very high numbers and actually say in public they have a very broad approach and take cases no one else would, and that is concerning to me.

The Joint Chair (Marcus Powlowski): Dr. Coelho, I hear there have been cases referred by the coroner to the College of Physicians and Surgeons of Ontario. Have any of them resulted in disciplinary hearings against the doctors involved?

Ramona Coelho: I think only one, and that was at the beginning, when a doctor made up their own MAID protocol and didn't bring a MAID kit. Actually, there have been no ramifications for any of these other cases, that I'm aware of.

The Joint Chair (Marcus Powlowski): To your knowledge, have there been other cases referred by the coroner to the College of Physicians and Surgeons of Ontario?

Ramona Coelho: No. Being part of the MDRC, we don't have the privilege of knowing every case that's been referred. We trust that they have been referred, but we haven't been hearing of any findings, despite these cases being public. Most of us feel that these are very concerning, even those from the MAID community.

The Joint Chair (Marcus Powlowski): Why have the colleges—I think Tamara brought this up—not pursued any of these cases?

Karin Neufeld: That's a very hard question.

Ramona Coelho: Yes, it's a very hard question.

The Joint Chair (Hon. Yonah Martin): The time has expired, so we have to go to Monsieur Thériault.

Monsieur Thériault, you have two minutes.

[Translation]

Luc Thériault: Thank you, Madam Chair.

Dr. Gamache and Dr. Barbès-Morin, you said just now that it's not only a matter of therapeutic obstinacy or patients ending up in palliative care for ever and ever, amen. At some point, nothing works any more. And at that point, because you are not able to make a clear and precise diagnosis, you tell patients that you are going to do your best to ease their suffering but that you have no cure. You tell them they will have to suffer. You are saying that the danger is that, instead of a peaceful death, those patients will take their own lives.

Moving forward, if medical assistance in dying were broadened to include MAID MD-SUMC, would that be helpful because you could then do some early screening?

Someone may put their hand up because they feel they are eligible for medical assistance in dying. Even if that is not the case, we at least know that they are suffering from some disorder because they raised their hand. As a result, they can be looked after.

Guillaume Barbès-Morin: That's an excellent question.

Starting a dialogue is, in a way, the approach that the Association des médecins psychiatres has begun to put in place. It's been our priority from the start. It means that, if patients are suffering, if they are overwhelmed by it all and need help, psychiatrists can start a dialogue. They can evaluate everything that has been done, do what has not been done, and then see what happens.

I have listened to a number of recent discussions. There is a desire to establish a considerably higher standard for psychiatry than for the rest of medicine. In all areas of medicine, assessments can differ from one doctor to another. But we are being told that patients must be assessed by perfect clinicians, with no possible disagreement, before this type of care is offered. In my view, that's not an option at all.

In psychiatry, we are trying to improve ourselves and, like everyone, to rely more and more on probative data. But let's not deceive ourselves. All medicine is imprecise. We are trying to do better, but it is imprecise, for us and for all the other specialties.

[English]

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

This is the second round, for two minutes.

The Joint Chair (Marcus Powlowski): For the senators, it's right back to you, Senator Martin.

The Joint Chair (Hon. Yonah Martin): My question is for Dr. Coelho.

In terms of the Ontario MAID death review committee, which you served on, and the lack of safeguards, what concerns you about expanding MAID for mental disorders?

Ramona Coelho: Someone asked before about MAID for mental illness. I am also very concerned about track 2 MAID.

As for the gentleman from the AMPQ.... I'm sorry; I've forgotten your name. There is a lot of uncertainty, even in disability, at the end of life. These psychosocial factors really impact suffering. If someone can't work anymore, they're thrown into poverty and lose their social circle, and then those things actually increase despair, drive hopelessness and increase wishes to die.

I'm really concerned that the safeguards for all people outside the end of life are just not sufficient, especially because we don't have an oversight, which I was asked about, that's actually enforcing the standards and preventing drift among a potentially very small group of MAID clinicians. They're very dangerous, because every life matters.

• (2040)

The Joint Chair (Hon. Yonah Martin): Dr. Neufeld, do you have concerns regarding the lack of safeguards if we were to expand the MAID regime?

Karin Neufeld: Yes, I do, Senator Martin. I have grave concerns if we expand it to include mental illness, because of the lack of safeguards.

The Joint Chair (Hon. Yonah Martin): I don't have enough time to ask a third question per se, but I'll use the rest of my time simply to say I met with a stakeholder from B.C. He suffered an injury and became disabled. He didn't apply right away, but what he is facing legally and medically, and the fact that he's so concerned about others who are being offered MAID and are choosing MAID.... There's a lot of mental health involved in what they're going through.

I agree with your concerns regarding the lack of safeguards.

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

Dr. Moodie, you have two minutes.

Hon. Rosemary Moodie: My question is for Dr. Coelho.

You raised the question of track 2, so I was wondering if you are aware of the following statistics. I'm talking about statistics, not language like "many" and "a lot".

Are you aware that "While MAID cases continue to rise, MAID cases for people whose natural deaths are not foreseeable (Track 2) actually fell in 2023, and remains extremely rare", at 0.09% of deaths?

Are you aware that "95 percent of those in Track 2 with a self-reported disability received supportive services"?

Are you aware that "Only four (3 percent) Track 2 recipients had previously been found ineligible for MAID, and there is no evidence that 'doctor shopping' lay behind these cases"? This is as opposed to an example with a change in a person's condition being the cause.

Are you aware that "The prevalence of isolation or self-perceived burden among MAID recipients is either the same or lower than the prevalence of these reports in community-dwelling or terminally ill people who do not seek MAID, suggesting that these factors are not driving MAID to any substantial degree"?

Finally, are you aware of this? "MAID recipients are much more likely to live in private residences, and less likely to be in residential care/long-term care than those who die naturally. Many older MAID recipients live alone, but at rates that are very similar to the population average for their age, again suggesting that this is not a factor driving MAID."

The Joint Chair (Hon. Yonah Martin): There are only 15 seconds left.

Ramona Coelho: I would just say that being white, wealthy or privileged doesn't mean you're not vulnerable at the end of your life. The Health Canada reports by MAID providers....

I'm sorry?

Senator Rosemary Moodie: The 15 seconds are finished.

The Joint Chair (Hon. Yonah Martin): She did have a few more seconds.

Did you finish your last sentence?

Ramona Coelho: It's fine.

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

With that, thank you so much for your testimony this evening and for taking all our questions.

We will suspend very briefly and go into the third panel.

● (2043) _____ (Pause) _____

● (2045)

The Joint Chair (Hon. Yonah Martin): Colleagues, let's begin.

As people make their way back to their seats, I will introduce those who are appearing in our third and last panel.

Thank you so much to our witnesses for being here so late.

We have two witnesses joining us as individuals by video conference. We have Dr. Harvey Max Chochinov, distinguished professor of psychiatry at the University of Manitoba, and Dr. Pierre Gagnon, psychiatrist.

I will invite you to provide your opening remarks. You each have five minutes.

We'll begin with Dr. Chochinov.

Harvey Max Chochinov (Distinguished Professor of Psychiatry, University of Manitoba, As an Individual): Thank you. I appreciate the opportunity to be here this evening.

My name is Harvey Max Chochinov. I'm a distinguished professor of psychiatry at the University of Manitoba and a senior scientist at the CancerCare Manitoba research institute. In 2015, I chaired the federal government's external panel on options for a legislative response to *Carter v. Canada*.

For over 35 years, I've studied psychosocial dimensions of palliative care, matters related to personhood, and dignity in the health care setting. What I bring to the MAID conversation is my work on human suffering and research exploring why people might want to die.

Based on that body of work, I cannot support the expansion of MAID for mental illness as the sole underlying medical condition. I have cared for patients struggling with chronic suicidality, patients whose suffering seemed irremediable and patients I worried might one day take their lives.

I recall a woman with mind-numbing depression who teetered precariously between life and death. One day, after years of countless drug trials, hospitalizations, ECT and various psychosocial in-

terventions, she arrived for her appointment three weeks into starting a new antidepressant with a grin on her face. "The door is purple", she declared. I told her the door had always been purple, to which she replied, "I know—but now I care."

Before that moment, no one—not me, not her friends or family, not anyone on this committee and not any MAID assessor—could have predicted her recovery. The cornerstone of her care, and of suicide prevention more broadly, was the steadfast commitment to connectedness.

The key ingredient of any successful psychological intervention is the therapeutic relationship. There is good evidence showing that the strongest predictor of suicidality, even among patients with advanced cancers, is the strength of connection with their health care providers. Our studies demonstrate that connectedness aligns with a sense of dignity and that a loss of dignity correlates with suicidality and desire for death.

Our publications on dignity-conserving care and intensive caring are adding to the lexicon and scholarship of human suffering. Such interventions as dignity therapy, which is based on considerations of personhood and legacy, have been shown to target the psychological substrate of suicidality and MAID requests, including loss of dignity and autonomy, loss of control, feeling like a burden and loss of meaning and purpose.

Some witnesses have told this committee that there's a professional consensus that Canada is ready to introduce MAID for mental illness. This is simply wrong. What it really means is that there's a small, unrepresentative group of MAID providers prepared to step forward and say they stand ready. While the paper developed by the Canadian Psychiatric Association's MAID guidance development committee is meant to provide guidance, it does not, unfortunately, solve the riddle of how to identify which patients have irremediable suffering, nor how to distinguish MAID from suicidality.

Another form of readiness you need to consider is that of Canadian psychiatrists, family physicians, psychologists, social workers, mental health counsellors and pastoral care professionals—in other words, people who care for patients with chronic mental health challenges, which often include suicide, self-loathing and marginalization. Adding MAID for mental illness into the mix will alter the therapeutic chemistry in every clinical encounter. It removes the vital guardrail from the therapeutic contract, which is to value patients' continued existence, to affirm that their lives matter and to maintain steadfast connection.

This, as much as anything we do with patients burdened with suicidality, is what keeps them alive. It's no wonder that fewer than 30% of psychiatrists support MAID for mental illness, and fewer for treatment-resistant depression or personality disorders. These patients live with chronic suicidality and are sustained by long-term care and caring.

I know that some suggest that keeping the gate to MAID for mental illness closed will see some patients continue to suffer and even contemplate suicide, especially those unwilling—or unable, I should say—to avail themselves of proper care, but there is no neutral position. If we wrongly tell patients that they will never get better and open the gate to ending their lives for them, many who would have recovered will walk through. How many will line up at the gate? According to Dr. Scott Kim, extrapolating from Dutch data, we can expect 2,500 to 5,000 annual requests. About half will receive MAID for serious mental illness.

Limited prognostic accuracy means that at least half slipping past that gate would have gotten better, and it likely would be more considering that most patients with serious mental illness experience substantial recovery or long-term improvement over the course of their lifetime.

• (2050)

With the Artemis II mission currently top of mind, it feels apropos to say, “Ottawa, we have a problem.” For all those reasons I've outlined, this mission, MAID for mental illness, should not proceed.

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

Next we'll hear from Dr. Gagnon.

[Translation]

Pierre Gagnon (Psychiatrist, As an Individual): Good evening.

It's a pleasure to be here to be part of your discussions on this study.

I have been a psychiatrist for 35 years. My specialty is psycho-oncology in palliative care. I am a full professor in the Department of Psychiatry and Neurosciences at the Université Laval, where I was the director for eight years, from 2017 to 2025. I was also involved in palliative care research as director of the Réseau québécois de recherche en soins palliatifs et de fin de vie, a division of the Fonds de recherche du Québec en santé.

You have seen in my brief that I began with a clinical picture of the type of patient often described in articles. The patient has had borderline personality disorder for two decades, has attempted suicide on many occasions and is considered refractory to all treatment. The patient expresses the wish to die but the path changes in a quite unexpected way. The patient has a physical illness, cancer, and realizes that they do not actually want to die. The patient develops a very close relationship with a volunteer in the palliative care centre, a relationship that completely changes the patient's perception of their illness and their life.

That, I feel, is what we as psychiatrists are trying to say. We have gained a lot of experience of suffering in the course of our careers.

In the face of that suffering, medicine has developed a whole arsenal of therapy, technology and medication. However, in psychiatry, we also have the opportunity to provide relationships that can completely change the course of a life. That is what makes a wish to die an intrinsic symptom of psychiatric illness.

It is very difficult to establish a supposedly independent wish for medical assistance in dying as a genuine desire. As this case shows, uncertainty with regard to the prognosis is also integral to psychiatry. Even for an extremely severe case like the one I have described—and maybe for others—an unexpected change can sometimes occur. So we must remain open to that and maintain hope. With mental illness, therefore, the irreversibility criterion is not met.

Refusing treatment is also an intrinsic feature of the illness. We very frequently have to treat patients against their will, and they get considerably better. It comes with the illness.

It is often said that, if euthanasia is opened to patients with mental disorders, the only cases would be rare and extremely complex. By contrast, studies seem to show that there are a lot of current psychiatric cases of depression, of personality disorders, of social difficulties, or of socio-economic poverty. That also plays a major role. Perhaps that is even what led Quebec to restrict the option.

It also becomes very complicated for caregivers, for patients and for families alike. Suffering and drama have been going on for years and a degree of compassion fatigue can set in. Everything becomes confused and it is very difficult to see things clearly in those situations. So making such a critical decision also becomes extremely difficult as a result.

In addition, experimental treatments in psychiatric palliative care are not highly developed, as they are in physical medicine. They should be developed to a greater extent. I am talking about pharmacological innovations that are currently being studied, such as psilocybin or ketamine, and various techniques of neurostimulation. As director of the department, I was able to see many potential developments being left aside.

Broadening seems inappropriate, even dangerous. These decisions are irreversible and fatal. They also go against the physician's code of ethics, which requires every possible treatment option to be offered.

• (2055)

It is also a break with modern medicine. This is why a number of provinces and territories, Quebec included, have chosen to close the door to euthanasia. I believe it should be the same all over Canada.

Thank you for your attention.

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

[English]

Thanks to both witnesses.

We will go into our first round, and the first five minutes will be for Mr. Patzer.

Jeremy Patzer (Swift Current—Grasslands—Kindersley, CPC): Thank you very much to both witnesses. I really appreciated your testimony.

I'm going to start with Dr. Chochinov.

Could you elaborate a bit more? You have a tremendous amount of experience. I think you said you have spent 35 years studying human suffering and developing interventions specifically targeting the desire to die. I'm wondering, though, for a patient whose suffering feels irremediable and who has lost all sense of dignity and purpose, what does the evidence say can actually be offered, and what results have you seen in your 35 years of experience?

• (2100)

Harvey Max Chochinov: It's a wonderful question. I'll confine my responses to the work that I've contributed, although there are colleagues worldwide who are working in this area trying to understand human suffering in the whole field of psycho-oncology and trying to figure out how we can attend to the psychological underpinnings of a critical illness.

We have developed something called dignity therapy, which is a way of helping patients to reclaim their narrative thread, tell their story and preserve their legacy. Originally, this was designed in palliative care. It has also been used for patients with mental illness. There was recently a randomized control trial of dignity therapy in patients with major depression, and the results were that giving people this opportunity actually increased their level of hope.

I've also been developing something that I refer to as intensive caring. This was published in the *Journal of Clinical Oncology*. The framework is now being published in multiple languages and is being disseminated worldwide. Essentially, it's a paradigm shift and describes a paradigm shift for health care providers.

In life and medicine, we're often faced with things that really aren't fixable, but that doesn't mean we don't have a role to play in being attentive. Intensive caring describes some basic stances that health care providers can take with their patients to engage them in a way in which they can feel less helpless and the patient can feel appreciated—for example, by just showing up, committing to non-abandonment, being present and being attentive.

It's hard to summarize 35 years' worth of work briefly, but when I wrote an article objecting to MAID a couple of years ago, a young man wrote me back who was very angry with me. He was experiencing severe mental illness, and basically what he was trying to say was, "Chochinov, piss off. This is my decision. This is something I want. I'm suffering, and who are you to get in the way?"

I wrote back, thinking again about this idea that we need to be respectful, we need to engage in relationships, we need to be kind and we need to validate his experience. I said, "Thank you for reminding me of the anguish of critical mental illness." At the end of the correspondence, I just about fell off my chair. Almost immedi-

ately, he wrote me back and said, "Thank you. Even by corresponding with you, you have given me hope, maybe not that my illness will get better but that there are doctors out there who actually care."

When Dr. Gagnon was talking about relationships and connectedness, there's good evidence, even in oncology, that the degree of connectedness between the patient and the care provider is the most ardent predictor of suicidality. There is this idea that we have nothing to do for somebody. We need to commit to saying we do have something to do with them. We may not be able to fix them, but we are committed to showing up, and when we show up, we know that we can offer comfort that can change their experience.

Jeremy Patzer: I think you hit the nail right on the head.

When we look especially at the numbers in Canada, we're around or maybe even over 100,000 people who have already ended their lives with MAID. You talked about some of the other numbers, looking at the Dutch model.

Do you have any other concerns about what we're seeing in statistics around the world that might give us some forewarning if we were to proceed down the path of track 2 expansion?

The Joint Chair (Hon. Yonah Martin): Respond very briefly, Dr. Chochinov.

Harvey Max Chochinov: I like to follow the evidence. Scott Kim has extrapolated the number of people we can expect based on the number of requests that we're seeing in Holland. Even though some people said this is a very tiny number, we're talking about 2,500 to 5,000 Canadians with severe mental illness each year who are going to line up, about half of whom are going to then receive MAID.

I have grave concerns, and that's setting aside the fact that there's collateral damage.

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

Next we'll go to Ms. Jaczek for five minutes.

• (2105)

Hon. Helena Jaczek: Thank you. I will be sharing my time with Mr. Maloney.

Thank you to both witnesses. You've made your positions extremely clear.

Here in Canada, obviously, neither of you would ever be required in any way to participate in medical assistance in dying, should it be approved at the end of the day for the sole purpose of a mental illness. However, having said that—as I said, you've made your positions very clear—if that should occur and it becomes legal in Canada, can you think of any safeguards or particularly stringent positions that you would want to see before MAID was applied and accepted for patients? Can either of you think of any?

Harvey Max Chochinov: Look, although we could sit here and say that maybe there's a certain amount of time that someone will have to live with a critical illness before they are eligible or maybe there's a certain number of treatments they will have to receive before they are eligible, the fact is that none of those things have been proposed. There's been great opportunity to say that we need to make sure the bar is very high, but nobody has stipulated anything about trying to define how high the bar should be.

In spite of how high the bar is placed, there are two things we can't resolve. We don't have a crystal ball. Even with somebody like the patient I described, that was after years, so we can't predict who will get better, and we know that over time, the vast majority do improve.

Finally, we cannot distinguish MAID from suicidality in patients with chronic mental illness who have chronic suicidality.

Hon. Helena Jaczek: Would you have any possibility of suggesting some safeguards should this be allowed? Dr. Gamache gave us some in the previous panel. Do you think there could be some conditions that could be applied?

Harvey Max Chochinov: If we want to be serious about trying to meet the needs of patients with mental health issues, then we need to think about the totality of their suffering. For us to talk about MAID as—

Hon. Helena Jaczek: My question was actually for Dr. Gagnon.
[Translation]

Pierre Gagnon: As Dr. Chochinov said, there is a fundamental difference between psychiatric disorders and physical disorders. The wish to die and suicidal ideation are integral to psychiatric illness. In my experience, and with what I see in the scientific literature, there is no real way to distinguish between a genuine request for medical assistance in dying and a request from a suicidal patient whose condition is going to improve. I have a lot of difficulty understanding how we could come up with guidelines or indicators that could completely reassure us.

Of course, it's tragic. That would be my answer for now.
[English]

Hon. Helena Jaczek: Thank you.

The Joint Chair (Hon. Yonah Martin): Mr. Maloney, you have one minute and 10 seconds.

James Maloney: Thank you.

This is for either of you. Would you agree with me that the guardrails that would be put in place should be applied equally and consistently from city to city within a province?

Harvey Max Chochinov: They should, yes.

James Maloney: Do you have concern that they may not be?

Harvey Max Chochinov: Yes.

James Maloney: If you take that across the country, province to province, does your concern increase?

Harvey Max Chochinov: Yes.

James Maloney: Are you concerned that people are going to be doctor shopping or, in the case of going from one province to an-

other province, forum shopping to get the answer they want to receive?

Harvey Max Chochinov: Yes.

James Maloney: In both of your opinions, are those good reasons not to proceed with the expansion of MAID for mental health as the sole underlying medical condition?

Pierre Gagnon: That's part of the reason.

Harvey Max Chochinov: They're some of many.

James Maloney: I'm pretty much out of time. I'll stop there.

Thank you.

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

We will now have Monsieur Thériault.

You have five minutes.

● (2110)

[Translation]

Luc Thériault: Thank you.

Dr. Gagnon. I imagine that you are familiar with the report from the group of experts chaired by Dr. Gupta. It was tabled during the last Parliament and was very enlightening for the committee.

I imagine that you know the recommendations. In the recommendations from that report, were there not some principles, guidelines and caveats that made it possible to respond elegantly to what you are hoping for?

Accepting that psychiatry cannot predict with any certainty whether a patient will or will not recover, and accepting also that the patient has been suffering for decades, you are nonetheless able to establish the patient's capacity for decision-making. The report indicates that a conversation on medical assistance in dying can never be started with a patient in a suicidal crisis or when the assessor considers that structural vulnerabilities may cause harm. Nevertheless, some statements and refinements were expressed that accommodate your fears. That report had not yet been tabled when Quebec decided against moving forward.

In light of what is in the report, is there no way you can find some comfort with it? Basically, are you totally opposed to medical assistance in dying?

Pierre Gagnon: Once again, the issue that concerns us, in terms of psychiatric disorders, is the inherent difference between physical and psychiatric illness. Even though there may be reference points, we have seen cases where patients do not appear to be in crisis but who are nevertheless in a state of morbidity that greatly affects their judgment. They can still come out of it. Just now, I gave you one example from my brief.

Luc Thériault: We will read it, but we have not yet received it.

Pierre Gagnon: The case I was referring to is that of a woman who had borderline personality disorder for decades and who wanted to die. Suddenly, something happened in her life. She said that she had wanted to die for 20 years but, all of a sudden, her health status changed.

People's status may change, even though they may not seem to be in crisis. It's because of such experiences that we have doubts about those kinds of criteria. The criteria are there, but they do not really address the basic distinction between psychiatric disorders and physical ones.

• (2115)

Luc Thériault: If we say that there is no question of opening that door and that we are closing the file, aren't we actually dooming some people? The number is small, but it still can't be overlooked.

I imagine it's somewhat like the small number of people who have slipped through your hands in the years you have been practising. The ones who committed suicide.

Are we not condemning people to stay in palliative care for ever and ever, amen? By that I mean that we can adjust the medication or treatment. We can care for their pain and suffering, but we will never be able to cure them. We keep them suffering for ever.

Is that not the case in psychiatry?

Pierre Gagnon: It's somewhat like Dr. Chochinov explained. We have medication, but we also have many other possible approaches on a human level. Establishing a relationship is one. To reduce suffering, we have the technical aspects, medications, ECT and magnetic stimulation, but other approaches are possible, such as establishing relationships, psychotherapy, art therapy and a lot of other things we do not provide for our patients.

That's not all. If we work in both physical palliative care and in psychiatry, we can see that psychiatry is the poor cousin in terms of the variety of approaches. We provide them, often routinely, to patients in physical palliative care; why not provide them in psychiatry? You will not often see music therapy or art therapy in psychiatry departments, but you will often see them in physical palliative care.

There are so many things that can be done beyond trials in pharmacology and neurostimulation. Psychotherapy already exists; why is it not offered enough?

[English]

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

We will now move to questions from senators.

The Joint Chair (Marcus Powlowski): Senator Dalphond, I think this time I'll try to keep people to two minutes, because we're trying to get out. There's an absolute cut-off at 9:45.

Hon. Pierre Dalphond: Thank you.

There are two things you're saying. First, there is the irremediability of the illness. You said it's difficult to predict who is in this irremediable situation and who is not, or won't be at one point. The second point, if I understand well, is that the particular nature of the

therapeutic relationship between the patient and the provider, the psychiatrist, is different from "normal" medicine to an extent.

Could you expand on that, or am I wrong to understand that's what you're saying?

The Joint Chair (Hon. Yonah Martin): I'm sorry. Senator, you will have three minutes in total.

Harvey Max Chochinov: Well, I began by saying that there are two significant problems. The problem that won't be resolved, even if there's a further delay, is that we can't predict who will get better and who won't get better. The other thing I said is that we can't distinguish between suicidality in the context of chronic mental illness and bona fide requests for MAID.

From there—and I think you're asking me to say a little more about the therapeutic relationship—we know, when we look at the efficacy of any psychological intervention, that it comes down to the therapeutic alliance. The strength of that alliance is the thing that seems to be most helpful in predicting a successful outcome.

Oftentimes, though, people forget about that, and we hear people saying, "There's nothing more we can do." These words should be expunged from the repertoire of anyone doing medicine with chronically ill patients, because what we can always do is show up. We can be present. We can be attentive. You might say, "Well, that sounds very lame. That doesn't sound very profound." Again, there are studies that show, in the absence of showing up, that the rate of suicidality increases.

Hon. Pierre Dalphond: Isn't there a shortage of resources to provide that? In psychiatry, we have a shortage of psychiatric....

Harvey Max Chochinov: I think you're asking if we can afford to do this. I guess I would flip that on its head and say, "Can we afford not to do this?"

If we don't do this, what are we left with? We're left with people who feel abandoned, who feel alone and who feel that no one cares. Those are the things that lead to hopelessness, and our studies show that hopelessness is the most ardent predictor of suicide outcome.

Hon. Pierre Dalphond: I've noticed.

Thank you.

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

Senator Martin, you have three minutes.

Hon. Yonah Martin: My question is for Dr. Chochinov.

You mentioned in your response to Senator Dalphond the therapeutic relationship you have with your patients and its importance and said that it's built on the clear commitment that the clinician believes the patient's life has value and is worth fighting for. I'm trying to imagine psychiatrists and medical professionals having to offer MAID or talk about MAID and what it does to that relationship. I think you've already given us some examples, in that we should expunge just saying, "There's nothing else we can do."

How important is that relationship? Also, then, when you talk about MAID as an option, what does that do to the profession itself?

Harvey Max Chochinov: This fundamental commitment to continuing to be involved is vital. If you remove that guardrail, as I said in my statement, you change the therapeutic chemistry.

That's not something that the 200 or 500 or so psychiatrists who are willing to say they're prepared to step up need to be comfortable with. There are tens of thousands of mental health care providers out there who.... I mean, there are people who have spoken to me who are saying they are frightened that the minute those guardrails are lifted, patients they've worked with for years or for decades are simply going to choose MAID.

The other thing I thought you were going to ask is, what happens if we are obliged to ask for MAID? Asking someone if they would have considered MAID, I would point out, isn't a benign communication. It's like discovering that hemlock is being placed on the menu in what you thought was your friendly family restaurant. No one is saying that you have to order it, and no one is saying it should rank among your top choices, but you are being told that the servers are prepared to bring you hemlock, that they have made peace with the possibility that you might select it and that the choice is entirely yours.

Being forced to broach the option of MAID for mental illness really affirms patients' deepest anguish that perhaps their lives really are worthless, that their lives are devoid of meaning and that being served up death is an appropriate option.

• (2120)

The Joint Chair (Hon. Yonah Martin): There's nothing more for me to add other than to say how ironic it seems that this is what we're talking about: psychiatrists having to or choosing to talk about MAID as a potential option. That this is something that would be happening seems to me to be one of the most impossible situations for the profession itself.

I've run out of time. I will move to the next questioner.

The Joint Chair (Marcus Powlowski): Thank you.

Senator Moodie, you have three minutes.

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

Dr. Gagnon, I believe I heard you express the opinion that it is impossible for psychiatrists to say whether someone with a mental disorder has a grievous or irremediable medical condition or that in fact they're not suicidal. However, the Canadian Psychiatric Association has developed guidance on how to assess such matters. The AMPQ also holds the view that such assessments are possible, suggesting that the impossibility you have expressed does not in fact reflect the state of knowledge in psychiatry.

Would you comment on that?

Pierre Gagnon: Yes.

[Translation]

These reports and documents do not always come from pure science. They come from the consensus achieved by groups of psychiatrists who are particularly interested in the topic. When we spoke

to our colleagues as we prepared the first briefs we sent, it was easy to find other colleagues—department heads, for example—who would say that it was not possible. The topic is always being discussed. Some groups of psychiatrists said it was possible but other groups said it was not.

[English]

Hon. Rosemary Moodie: Thank you very much.

Dr. Chochinov, have you ever asked a patient in your care if they have considered suicide? We call it suicidal ideation.

Harvey Max Chochinov: Have I asked patients if they've considered suicide?

Hon. Rosemary Moodie: Yes.

Harvey Max Chochinov: Absolutely.

Hon. Rosemary Moodie: In your experience, did that lead to an attempt of suicide or that particular patient wanting to commit suicide? You made the association that a discussion about MAID will lead to a person wanting MAID.

Harvey Max Chochinov: Yes, but you're making the mistake of thinking that my asking about suicide—

Hon. Rosemary Moodie: Personally, I'm not making any mistakes. I'm asking a question.

Harvey Max Chochinov: I'm attempting to respond.

What you're saying is that in asking about suicide, I am giving a person an opportunity to share their thoughts. In asking if somebody has considered MAID, I am saying to them that this is a possibility. This is an option that they might consider. There's a vast difference between those two.

Hon. Rosemary Moodie: I'm not sure I agree with you. I think there is quite an association between suggesting to a patient that they may be considering suicide based on your assessment of them and where you think they're at. MAID is no different. MAID is a therapeutic option that is being offered to individuals who are deemed to be at that place in their therapy, in their clinical situation, when they may not have considered any others.

The Joint Chair (Marcus Powlowski): Your time is up, Doctor.

Mr. Chochinov, do you want to offer a very brief response to that?

Harvey Max Chochinov: Yes.

When you ask somebody about suicide, you're giving them an opportunity to share their thoughts about self-harm. When you're asking them if they've considered the option of MAID, you're saying something about your willingness to consider that as an option that you will give to them. It's not something that they will do to themselves.

• (2125)

The Joint Chair (Marcus Powlowski): Thank you.

Senator Wallin, you have the floor for three minutes.

Hon. Pamela Wallin: Thank you.

Dr. Chochinov, are you opposed to MAID in all circumstances, even with irremediable physical conditions?

Harvey Max Chochinov: I like to follow the evidence. I have an ambivalent relationship with MAID.

What I see happening in palliative care concerns me, because there are many instances where instead of responding to what's causing somebody suffering, people get into a very legalistic stance and ask, "Do they meet criteria?"

Hon. Pamela Wallin: There are situations in which you'd consider that, like if somebody had an irremediable stage 4 cancer.

Harvey Max Chochinov: My opposition to MAID for mental illness is based on the data.

Hon. Pamela Wallin: I was talking about something else, but I'll move on.

The Supreme Court ruled on this matter in 2016 and again in two subsequent decisions. The court laid it out in its simplest form, saying that this should be a question of choice. It's a matter that a doctor and patient should have a discussion about, and families should be included in all of that. Nobody is forcing this. It's not mandatory in any way.

You've suggested that you feel very comfortable usurping a patient's right to choose an end-of-life option. You discussed something you've written about called intensive caring. You would be comfortable imposing your view and your intention that they should carry on at all costs, regardless of their own views and their own willingness to choose a different option.

Harvey Max Chochinov: Look, we're talking about MAID for mental illness. Let's be clear what this topic is about.

Patients who are mentally ill have self-loathing and chronic suicidality and feel that their lives are worthless. We have to be mindful of that and understand that expressions of suicidality in the context of somebody who has a chronic mental illness can't be distinguished from a bona fide request for MAID.

Hon. Pamela Wallin: No, you're saying that all questions of people with all forms of mental illness.... If they begin to discuss or want to choose the option of MAID, you're saying that's instantly a question of suicidality. I don't think there's evidence of that.

Harvey Max Chochinov: I happen to have the document that was created from the Canadian guidance on medical assistance in dying. If you give me a moment.... You have to give me two moments. I thought I had it all here.

Hon. Pamela Wallin: I think we should just carry on with the discussion here. You seem comfortable with—

The Joint Chair (Marcus Powlowski): We're out of time, Senator Wallin.

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

Hon. Kristopher Wells: Dr. Gagnon, do you practise in the field of MAID actively?

Pierre Gagnon: No. I'm a psychiatrist. Psychiatrists don't—

Hon. Kristopher Wells: You don't make any assessments. You haven't gone through any training.

Pierre Gagnon: No.

Hon. Kristopher Wells: I'll ask the same question of Dr. Chochinov.

Harvey Max Chochinov: I have seen patients who have requested MAID who have been referred to me for dignity therapy. That is the extent to which I've been involved with MAID.

Hon. Kristopher Wells: You haven't gone through any specialized training, or any of the clinical guidance.

Harvey Max Chochinov: I went through four years of postgraduate training as a psychiatrist. I would say that—

Hon. Kristopher Wells: You have not gone through the current practice that's been established or the current training.

Harvey Max Chochinov: No, but I have read the guidelines.

Hon. Kristopher Wells: Neither of you has gone through all the hours of workshops. Is that correct?

Harvey Max Chochinov: No. I have just four years of psychiatry residency and post—

Hon. Kristopher Wells: Thank you.

Dr. Gagnon, is it possible to predict with certainty the future of all physical conditions?

Pierre Gagnon: No.

Hon. Kristopher Wells: From my perspective, we're seeing a false dichotomy start to happen between mental and physical illness. People with mental disorders make life-and-death decisions all the time in health care. By the logic we're hearing today, they should be excluded from making life-and-death decisions about their health—refusing treatment for cancer, stopping dialysis, requesting "do not resuscitate" orders.

From the perspective we're hearing, it seems like a patient is never allowed to say they've had enough treatment, because there's always more treatment they should be going through, and we're never going to give them a choice.

• (2130)

[Translation]

Pierre Gagnon: That is what we were saying. Suicidal thoughts are inherently part of mental illness, and that is not the case with physical illness. That's the difference, right there.

[English]

Hon. Kristopher Wells: Do you mean all the time? Is suicide ideation always a part of mental illness or a mental disorder?

[Translation]

Pierre Gagnon: No, but when a patient has—

[English]

Hon. Kristopher Wells: Are you saying that a psychiatrist can't separate the two?

[Translation]

Pierre Gagnon: If we as psychiatrists have a patient in front of us with a major psychiatric illness, who is suicidal and tells us that he wants to die, we consider suicidal ideation for sure. It is not a genuine request for euthanasia.

[English]

Hon. Kristopher Wells: My last question is for both of you.

I just want to be clear, Dr. Gagnon, that you're speaking from your own perspective and experience, not from the perspective of the Canadian Psychiatric Association.

[Translation]

Pierre Gagnon: That's correct. They are a group of psychiatrists who think differently.

[English]

The Joint Chair (Marcus Powlowski): Senator Wells, your time is up.

Hon. Kristopher Wells: He didn't answer the question.

The Joint Chair (Marcus Powlowski): It doesn't matter. You haven't given him time to answer the question.

Hon. Kristopher Wells: Do I have no more time?

The Joint Chair (Marcus Powlowski): You have no more time. I'm sorry.

The Joint Chair (Hon. Yonah Martin): We'll go to round two, and we have three minutes now for Mr. Lawton.

Andrew Lawton: Thank you very much.

My questions are going to be for you, Dr. Chochinov. We only have a few moments, so if you could be as brief as possible, I would appreciate it.

There are good doctors and bad doctors. There are doctors who go out of their way to keep current and others who don't. There are doctors who are more diligent than others. They're humans, and I understand this.

Do you believe there are doctors who are more philosophically or ideologically inclined to view MAID as not just something that should be available but something that is desirable for patients?

Harvey Max Chochinov: Yes, I believe there are doctors who are philosophically bent in that direction.

Andrew Lawton: What are the implications of that in a mental health context where you have patients who may be very impressionable or vulnerable, or who may not know what their trajectory is or could be?

Harvey Max Chochinov: First off, I'm suspicious of doctors who, when they express their expertise, do so in the legal realm rather than in the medical realm. If a doctor were to stand up and say, "This is about autonomy; this is about choice", I'd say, "Let's talk about medicine. Let's talk about the psychology of suffering."

It's kind of ironic. When you have a provider who says, "I'm willing to provide MAID", sometimes initially what happens is that the patient feels that they're understood. It's this collusion around a sense of hopelessness: "I'm finally understood." Unfortunately, where that therapeutic relationship leads, literally and figuratively, is a dead end, so the disposition of the doctor has a profound influence. As one of my supervisors said, if two people are in a room, it's helpful if one isn't hopeless.

Andrew Lawton: I speak from experience here as someone who's been very outspoken about his own struggles with mental ill-

ness. It is a years-long battle for many people, and there are psychiatrists I know who have had therapeutic relationships with patients that have lasted decades. Improvements can be incremental over time.

There is something called compassion fatigue, and I'm wondering if you could, in the 30 seconds I have left, speak to how that could affect physicians and their patients in the context of MAID for mental illness.

Harvey Max Chochinov: When you're dealing with somebody who has a chronic, serious mental illness, it is overwhelming. It's overwhelming to the person who's afflicted, it's overwhelming to their family and it's overwhelming to the health care provider.

Hopelessness is contagious. When people start to feel hopeless, they begin to look for solutions, and MAID, when it arises, appears as if it's a solution. As I said, it's a solution only in that it ends the life of the sufferer. What happens is—

• (2135)

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

We're now going to Ms. Lapointe.

Viviane Lapointe (Sudbury, Lib.): Dr. Gagnon, I'm going to build on the questions that were asked by my colleague MP Jaczek when she asked about what safeguards and measures would need to be in place within the health care system to have MAID for mental illness be allowable.

My question is for both of you. What metrics would you use to determine whether the health care system is ready for MAID for mental illness?

[Translation]

Pierre Gagnon: That's difficult to imagine at the moment because we have not found a way to distinguish between a suicidal thought and a genuine desire for death. I am sorry, but we always come back to the same thing.

It is a concern that studies from the Netherlands or Belgium, where MAID is allowed, show that the scope already seems to be widening. Those countries had guidelines too, but we are already seeing all kinds of reasons put forward, the death of a pet, for example, that are pushing depressive patients towards medical assistance in dying.

So that is a concern. Theoretically, we are finding that it is difficult to come up with guidelines and, practically, we can see that the guidelines are weak anywhere they are used.

[English]

Viviane Lapointe: I want to build on the response you just gave, where you referenced Belgium and the Netherlands. In showing expansion beyond these rare cases, what concrete policy design do you think would prevent scope creep in Canada if MAID were ever extended to mental illness?

[Translation]

Pierre Gagnon: I have a hard time seeing why we would be so superior to other countries that are ahead of us. For them, the situation has actually deteriorated or has become very ill-defined. I have a hard time seeing it, and it's the same with physical illnesses.

I was in Quebec, where MAID was offered only at the end of life, basically euthanasia for a physical health problem. It broadened so quickly.

There are two experiences, of euthanasia for physical health problems, which is broadening quickly, and of euthanasia for psychiatric cases in countries where MAID is already available, which has also broadened. Neither is very reassuring.

Viviane Lapointe: What kind of policies would we have to put into place to avoid the examples you have described?

Pierre Gagnon: Honestly, I have a hard time thinking of any. I couldn't give you any, mostly because we have no way of telling the difference between a genuine suicidal idea and a genuine request for MAID. We are not able to make that distinction.

[English]

The Joint Chair (Hon. Yonah Martin): Monsieur Thériault, you have two minutes.

[Translation]

Luc Thériault: Thank you.

Are you saying that you are not able to establish the decision-making capacity of a patient who asks for medical assistance in dying, for no other reason than a mental disorder?

Have you never had cause to determine a patient's decision-making capacity?

Pierre Gagnon: I have established decision-making capacity before, but not with a patient with a psychiatric disorder.

Luc Thériault: Psychiatrists who come to provide evidence to the committee tell us that they do it all day long. It could happen in situations of medical assistance in dying, for example.

You have never established the decision-making capacity of a patient who is asking for medical assistance in dying?

Pierre Gagnon: No, for a patient with a psychiatric disorder, I have not.

Luc Thériault: Have you done it for patients other than those with psychiatric disorders?

I am asking the question for the third time.

Pierre Gagnon: Yes, I have done so for patients other than those with a psychiatric disorder, because suicidal ideation is not part—

Luc Thériault: Have you done it before?

Pierre Gagnon: Yes.

Luc Thériault: So you feel that it is easy to establish that suicidal ideation is not linked to a person's state of health.

Is that the case?

Pierre Gagnon: Most of the time, it can be done.

Luc Thériault: So, in terms of mental disorders, you consider that the expert report contains no guidelines on the precautions needed. I have certainly seen passages saying that we need to be careful. There is no way a discussion about medical assistance in dying can be started if the clinician recognizes a concern about suicide ideation. In a case like that, he would have to decide whether he should impose a treatment against the patient's will, or propose other approaches.

This is in no way about agreeing to MAID requests. Just because it's requested does not mean it will be available. But you see one easily leading to the other. You see the slippery slope as something inevitable.

● (2140)

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

[English]

We'll now do the second round for senators.

The Joint Chair (Marcus Powlowski): Very quickly, we'll have Senator Wallin for two minutes.

Hon. Pamela Wallin: I just want to make sure I've understood the exchange properly, which is that we've agreed that suicidality is not present in every person who wants to choose MAID.

Harvey Max Chochinov: I'm trying to imagine an instance where you—

Hon. Pamela Wallin: Dr. Gagnon, go ahead.

He was just having this discussion.

Harvey Max Chochinov: I'm sorry.

Pierre Gagnon: It's not the suicidality of psychiatric patients, where suicidality is part of the illness.

Hon. Pamela Wallin: No, what I'm asking is.... I think we were discussing this a bit earlier with Dr. Chochinov. A person's request for MAID, or their willingness to want to discuss it or have it presented as an option, is not necessarily an indicator of suicidality.

Would you agree with that, Dr. Gagnon?

Pierre Gagnon: Do you mean outside of mental illness?

Hon. Pamela Wallin: I mean either way. It's just a more general statement.

Pierre Gagnon: That's what you have to look at—if there's mental illness. If you have depression—

Hon. Pamela Wallin: In mental illness, do you think anybody who wants to discuss other options, like end of life, or who is refusing treatment is expressing suicidality?

Pierre Gagnon: So far, we're not able to differentiate what is suicidality or "real"—

Hon. Pamela Wallin: Is it that you're not able to distinguish it as a professional, or do you mean the patient isn't able to? I'm not clear on that.

Pierre Gagnon: I mean as a professional.

The Joint Chair (Marcus Powlowski): We have Senator Wells for two minutes.

Hon. Kristopher Wells: Dr. Gagnon, I'm still a bit confused by what you've said, so I'll ask this question. Have you ever consulted on a patient with a mental disorder who wanted to make a life-and-death decision about their physical health by, for example, refusing dialysis or cancer treatment?

Pierre Gagnon: Yes.

Hon. Kristopher Wells: Were they all suicidal, or in some cases, was the patient considered capable of making their own decisions?

Pierre Gagnon: In some cases, they could. Yes, they were able.

Hon. Kristopher Wells: Okay, you've answered my question. Thank you.

The Joint Chair (Marcus Powlowski): Do you have any more questions, Senator Wells?

Hon. Kristopher Wells: No.

The Joint Chair (Marcus Powlowski): I don't know what to make of that.

Some hon. members: Oh, oh!

The Joint Chair (Hon. Yonah Martin): With that, on behalf of the committee, I'd like to thank our panellists in this final grouping. Thank you for your testimony and for your time this evening.

Thank you, colleagues. We have reached the end of the more than three hours. I appreciate all of the work you are putting into this.

We are finished with this committee meeting, so we are adjourned.

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