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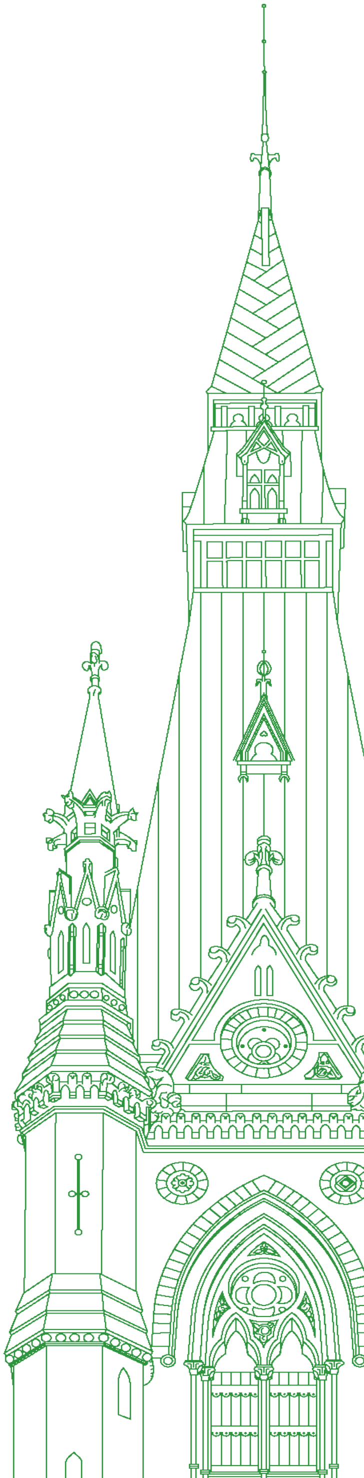

Co-Chairs: Marcus PowlowskiYonah Martin

Special Joint Committee on Medical Assistance in Dying

Tuesday, April 21, 2026

● (1830)

[*English*]

The Joint Chair (Marcus Powlowski (Thunder Bay—Rainy River, Lib.)): I call this meeting to order.

Welcome to meeting number four of the Special Joint Committee on Medical Assistance in Dying.

Pursuant to the orders of reference of the Senate adopted on February 26, 2026, and the order of reference of the House of Commons adopted on February 13, 2026, the 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 do see some people out there. I'd like to confirm that sound tests were made successfully.

Before we continue, I would ask all in-person participants to consult the guidelines written on the cards on the table. These measures are in place to help prevent audio and feedback incidents, and to protect the health and safety of all participants, including the interpreters, whom we thank. You will also notice a QR code on the card, which links to a short awareness video.

I'd like to make a few comments for the benefit of witnesses and members. 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're not speaking. For those on Zoom, at the bottom of your screen, you can select the appropriate channel for interpretation: floor, English or French. For those in the room, you can use the earpiece and select the desired channel.

This is a reminder that all comments should be addressed through the chair, which is me, for this meeting. For members in the room, if you wish to speak, please raise your hand. For members on Zoom, please use the “raise hand” function. The clerk and I will manage the speaking order as best we can. We appreciate your patience and understanding in this regard.

I'd like to welcome our witnesses for the first panel today. I think they are all virtual.

We have Dr. Christopher Lyon, visiting research fellow, Centre for Death and Society, University of Bath. We also have Dr. John Maher, psychiatrist, Ontario Association for ACT & FACT.

John, when you have your speaking time, you may want to explain ACT and FACT.

I'll try to get your attention when you have about 30 seconds left. You can go a bit over the time. If you find that you're running out of time, you might try to get everything in on time, but you will probably have a chance to come back to it when there are questions if you don't get through everything.

Dr. Lyon, if you'd like to commence, you have the floor for five minutes.

Dr. Christopher Lyon (Visiting Research Fellow, Centre for Death and Society, University of Bath, As an Individual): Thank you very much for the invitation to appear, Chair and committee members.

My name is Christopher Lyon. I'm Canadian, a family witness to MAID, academic staff at the University of York and a visiting fellow at the Centre for Death and Society at the University of Bath.

Since my father's death, I've researched and published on MAID. I speak as an individual. My dad, John Lyon, lost his life to a MAID provider in Victoria, B.C., in July 2021, one week after he moved into an assisted living apartment. With a low income, he was very anxious about how much assisted living would cost. The day he moved in was the first day of the record-setting but transient heat dome event that hit B.C. Five days later, potentially affected by the extreme heat wave, he fell in his new apartment. On day seven, as the heat dome broke, my dad received a lethal injection.

When he found out about MAID, he told me a doctor told him he should have it. He was approved for track 2 MAID for rheumatoid arthritis, frailty, recent falls, chronic pain and conditions he often coped with. Halfway through the mandatory 90-day assessment period safeguard for track 2, his providers labelled him track 1, foreseeable natural death, three days before he was killed. His medical certification of death indicates this track change was for early sepsis NYD. NYD is medical shorthand for “not yet diagnosed”. However, the Criminal Code for both tracks first requires a person to have a grievous and irremediable medical condition, stating they must have a serious and incurable illness, disease or disability. Track shifts like this won't be easy to see in the data Health Canada uses.

When he first applied, I sent the local MAID coordinator a family document of collateral information detailing his history of mental health issues, including bouts of strong suicidal ideation during life transitions like moving homes. The heat crisis, combined with the move to assisted living, was absolutely in keeping with when he would struggle with his mental health the most. A few months before he died, my family arranged a call with the suicide prevention hotline, and he seemed to back away from this ideation, which was a recurrent pattern for him. The day he was killed was also the birthday of a family member who was present. I cannot begin to describe the horror.

Dad's provider permitted him to drink wine both the evening before and the day of his death. At the same time, he was prescribed prednisone, eszopiclone, trazodone and hydromorphone, all of which have severe psychotropic capacity-impairing effects and can mimic early sepsis markers and mental disorders. He had trouble remembering when or if he scheduled his death, or even if he had been assessed. “Get me out of here” was the flimsy assent interpreted as his final consent.

I pressed for a last-minute psychiatric assessment and was told the psychiatrist would just agree with the provider. They were right. The assessment was full of errors. It denied suicidality, minimized his history of depression, denied he was a smoker and claimed he'd been living in his assisted living flat for a month, not four or five days. His provider told me he'd probably just kill himself anyway, and that she knew she was good at MAID because she'd never lost sleep over her deaths and later told me not to raise my concerns.

Attempts by his executor and me to file complaints and access his medical records, which might confirm or refute non-compliance, proved mostly futile. We obtained only a somewhat redacted copy of his psychiatric evaluation and his medical death certificate.

B.C.'s system is a pinball machine of deflection among colleges, police and coroners, with records protected by privacy law that extends to deceased persons, though this does not seem to apply to the MAID providers, who may use them for self-promotion and commercial ventures. If this is already the de facto standard of care for MAID when mental illness and psychotropics are involved, what will happen if sole mental illness is permitted?

In my research, I found evidence that the charity lobbyist and constitutional litigant, Dying with Dignity, or DWD, cares little for safeguards around people's mental health status, historically and now. A large body of archived evidence from DWD sources suggests that it ran a—so far—unprosecuted scheme of payment-based pro-suicide counselling, assisted suicide and homicide of adults in the decades up to Carter and Bill C-14, and potentially, children. It hosted open-access workshops on suicide methods amenable to assistance, homicide and concealment from investigators. Its public website still describes alternatives for those who are ineligible for MAID, like stopping eating and drinking, refusing treatment and options in Switzerland. This web page is accessible to all, including those with mental disorders and children.

Last year, Philip Nitschke, the inventor of the Sarco pod, who gives speeches alongside CAMAP founders and DWD leaders at the World Federation of Right to Die Societies conferences, claimed to the British press that he provided material support to Kenneth Law. After facing first-degree murder charges, Law had just agreed to plead guilty to aiding suicide in 14 deaths. Nitschke claims to have met him at a more recent suicide workshop he ran in Toronto. Law's alleged victims were typically teenagers and adults with mental illness.

● (1835)

I find myself forced to ask very uncomfortable questions about what happens in those secret encounters with patients, despite all the MAID laws and safeguards meant to protect them from negligent care or unlawful death.

● (1840)

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

Dr. Maher, you have five minutes, please.

[*Translation*]

Dr. John Maher (Psychiatrist, Ontario Association for ACT & FACT): Good evening.

Thank you very much for inviting me to appear before you.

[*English*]

I am chief of psychiatry at an Ontario hospital, a medical ethicist, editor-in-chief of the Journal of Ethics in Mental Health and president of both the Ontario and the global associations of tertiary care ACT teams. They are the teams that take care of the very sickest mentally ill patients.

For the last 23 years, I have treated patients that other psychiatrists told me could not get better, yet they get better. Suffering can always be reduced. With dozens of validated psychotherapy modalities, hundreds of medication combinations and myriad psychosocial interventions, there is absolutely no such thing as “everything has been tried”, despite what some patients say and despite what some psychiatrists who lack skill, knowledge or perseverance say. Death is being falsely presented as the only option.

You seek my evidence because I have particularly relevant experience and knowledge. How do you know who is right when my statements conflict with others? Tragically, ableism and stigmatization are never defeated because of clear logical points made about social fairness. Ideology pays lip service to reason while amplifying misinformation.

I presented on this same issue at a Senate hearing in 2021. My rage has since given way to profound sadness because the same misrepresentations keep being repeated by the same players. The issues have not changed in five years. The facts, however, have been made clearer. People are getting MAID for psychiatric reasons under the guise of flimsy medical excuses. Prolific MAID providers are happy to assist with suicides while people are on wait-lists for effective treatment. MAID is being offered to veterans, disabled people and people with very treatable illnesses. Irremediability is clearly known to be impossible to predict for mental illnesses. Patients will doctor-shop until dead.

Orwellian doublethink has been rampant. MAID activists say MAID is not suicide, that “irremediable” means you can't get better right this minute, that suffering is best relieved by death and that the health care system cares about you so much it will help you kill yourself. People need lifeguards, not someone to push them under.

Only one in three adults and only one in five children in Canada have access to the mental health care they need. The general public is not aware of this appalling and intentional lack of services. The Mental Health Commission tells us we could save billions by paying for upstream services that we know work. Instead, we let people get sick downstream, and it costs us billions more than necessary.

Why don't we provide care that we know works and is extremely cost-effective? Why are any of you supporting suicide instead of the care that prevents suicide?

The answer is stigma, ableism, false economic claims and a distorted view of autonomy. Please stop pretending that autonomy is some detached, rational enterprise. Very sick people are actually driven by fear, desperation and hopelessness borne of the illnesses we undertreat and don't treat. If you have to help someone kill themselves, then they are not acting autonomously. I am tired of the farcical news stories citing people who have been trying to kill themselves for decades and are demanding that a doctor help them.

There is a laughable conceptual distinction put forward by MAID activists that MAID is well thought out and true suicides are impulsive. Decades of suicide research put the lie to this. Eighty per cent of suicide attempters thoughtfully plan their suicides. MAID is suicide par excellence, like having a wedding planner to make it all as easy as possible, even with same-day service.

The Harvard school of public health showed that 90% of people who attempt suicide do not go on to complete suicide following treatment. With the right treatment, suicidal thinking disappears. The rates of suicide in jurisdictions that have MAID—specifically Oregon, Switzerland, the Netherlands, Belgium and Australia—rose much faster after it was legalized than before. Suicide contagion is a well-proven reality. Don’t pretend it won’t happen in Canada.

● (1845)

Seventy-two per cent of Canadians oppose MAID for mental illness. Over 90% of psychiatrists are opposed. You should listen, but mostly, you should stop and try to imagine what it is like to be given up on. If you have never tasted raw, hopeless despair, then stand boldly behind the claim that we should all be entitled to suicide facilitation, but if you have known suffering, the suffering of those you are inviting to death, then you can’t pretend that this planned social travesty is anything but accursed ignorance.

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

For the first round of questioning, I will go to Mr. Lawton for five minutes.

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

Thank you, witnesses, for your testimony.

I'd like to start with you, Dr. Maher. Just to put a fine point on this, the MAID regime we have in Canada did not exist as a health care policy. It is an exemption to murder in the Criminal Code. When you describe mental health as already qualifying people for MAID in the eyes of some assessors and practitioners, you're describing criminal misconduct, are you not?

Dr. John Maher: I absolutely am. I had a patient with schizophrenia who was approved for MAID on the basis of a skin condition that a dermatologist said could be treated by cream and with a sore ankle following not co-operating with physiotherapy after a broken ankle. I had a fierce argument with the MAID provider, who said that was sufficient. My patient had schizophrenia and was psychotic and delusional at the time. That is what's happening. These are already happening.

Andrew Lawton: From your understanding of the case of Kiano Vafaeian, which was reported in media, would that fit the bill of what you're describing, of someone who was dealing with only a mental illness and who had a very flimsy physical condition appended to justify MAID?

Dr. John Maher: I won't comment on that particular case. All I know is from the media, but I do stand by my statement. I and other colleagues are experiencing this. People are clearly getting MAID for reasons that are frankly illegal.

Andrew Lawton: We have heard a variety of views from psychiatrists before our committee thus far. Somewhat counterintuitively, we have psychiatrists saying that there's a general consensus that mental health conditions can be irremediable, at the same time as other psychiatrists are saying this isn't the case, which would prove that there is no consensus on this.

Explain to me how you view irremediability in the context of mental illness.

Dr. John Maher: I certainly don't view it the way MAID activists have argued, which is that if you can't get a cure or relief in the moment, that should qualify you.

The Benelux countries, which at least require that standard treatments be tried first, has a fine safeguard, but then it begs the question of what “standard treatments” are. I'm a subspecialist psychiatrist. I'm a psychiatrist's psychiatrist. People get referred to me whom other psychiatrists say can't get better and they don't know what to do, and those people get better. Irremediable... We're not talking about a cure, although I have patients we could easily say are cured in the sense that diabetes is cured if you take your medications for the rest of your life; it will have no significant impact on the quality or longevity of your life. That certainly happens all the time in psychiatry.

Do I have patients for whom symptom persist? Absolutely. Do I have patients for whom symptoms can never be ameliorated? Never, not once.

I stand here representing the 70 ACT psychiatrists who do subspeciality work in Ontario. There are always ways to reduce suffering. I don't mean to break the rules of the club, but not all psychiatrists are subspecialists. Not all cardiologists are cardiac surgeons.

Andrew Lawton: Thank you.

When you talk about suicide contagion, I want to make sure I understand the point you're making. Are you saying that just by the act of permitting this—what Parliament already has done—if that's what proceeds, that will basically normalize or legitimize suicide as an option for people who might not avail themselves of MAID but may just commit suicide on their own because the government has basically said that this is a legitimate answer to mental illness? Is that what you're saying?

Dr. John Maher: Yes, it's the Werther effect, a well-known phenomenon, which is why newspapers agreed not to publish articles about famous people and how they killed themselves, yet we have MAID articles in the press daily. I had a patient today with schizophrenia very cavalierly saying that if he didn't get a job and a girlfriend, he's going to request MAID. It's been normalized. Suicide contagion is a well-established phenomenon.

Interestingly, we didn't start looking at this data until the MAID legislation euthanasia program started emerging in some countries. The rates of the countries I named where their rates have gone up and those of the countries around them have gone down is a very legitimate, significant concern. It's modelling. Not only—

● (1850)

Andrew Lawton: Thank you, Dr. Maher.

Very briefly, Dr. Lyon, when you talk about conversions and people going from track 2 to track 1, the lack of Health Canada having adequate data on that would, in and of itself, indicate that there is no readiness to expand track 2. Is that correct?

Dr. Christopher Lyon: It's a good question. No, I don't think there is any readiness to expand track 2. I think right now, based on my own experience, if we're able to track-shift like that and record deaths that have been moved for reasons such as undiagnosed illnesses, and those are showing up as track 1 in the data, we don't know what is really a track 2 case and what is really a track 1 case. It would be very difficult to expand under those circumstances.

The Joint Chair (Marcus Powlowski): Thank you.

Dr. Jaczek, you have five minutes.

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

Thank you to both witnesses. You've certainly made your positions exceptionally clear on where you stand. As has been referenced, of course, we have heard from other psychiatrists and experts in ethics and so on who feel differently.

From your point of view, Dr. Maher, if MAID were to be approved in our country for the sole underlying condition of a mental illness, what kinds of safeguards could you envisage might be reasonable in such a situation, or are you completely saying that it's impossible to have any safeguards?

Dr. John Maher: I am saying that safeguards are going to fail because the cultural ethos, the suicide contagion, is already permeating our society. My teams are pulling their hair out over people planning to refuse medications so that they can get MAID. These are people who have healed and recovered. We're doing suicide prevention, and people are being presented with "suicide is coming".

As for safeguards and standard treatments being tried, which the Benelux countries do, it begs the question of what counts as a standard treatment. I do subspecialist care. I have literally limitless options. It's because of this that my patients get better. It's because we can continue to try. The average treatment time for me to help people recover from severe schizophrenia is three years. It's not a short process. It's like a long chemotherapy protocol for people with certain types of cancer. How do you maintain hope in the face of that?

I have a patient, and in the middle of treatment, a family doctor came and offered her MAID. She said, "Oh, thank goodness my family doctor cares enough about me to relieve my suffering." I wanted to relieve her suffering by treating her. She was 35.

Are there safeguards? The fundamental value question here is that you either support suicide or you don't. If you're opposed to suicide, if you think the suicide taboo provides protection, and if you think there's merit in supporting life, then clearly this is my fundamental argument here: Provide the basic services. I work in an ACT team, one of the subspecialist teams caring for the sickest. There are 80 in Ontario. There should be 150 by population. Right now we have 5,000 people with degenerative illnesses waiting for care. They're going downhill. They're waiting up to five years. If I asked you about the cancer field, would you be okay with funding 60% of the cancer centres and letting everybody else kind of flounder and hopefully live?

I think safeguards are fanciful, given the clinical reality. This is my great frustration. I can stand here and tell you that you don't get what it's like on a daily basis. I don't know if I'm the only person in the room who spent yesterday listening to a patient in emergency tell me why she took an overdose. I don't know if I'm the only person in the room who's listened to thousands of people after the fact tell me why they wanted to kill themselves and about the help they wished they'd had.

Offering suicide before they get the help—I don't know how you can do it.

Hon. Helena Jaczek: Dr. Maher, I'm sure you're an extremely compassionate physician, but have you not had your own patients commit suicide?

Dr. John Maher: Of course I have.

Hon. Helena Jaczek: What happened—

Dr. John Maher: The suicide rate for schizophrenia is 10%. The suicide rate when people are in ACT teams is under 2%. What does that tell you?

As I said, there's the Harvard stuff and there's Canadian research from the Canadian suicide prevention society. We know that treatment prevents trying again. Four thousand people in Canada will kill themselves this year. Those four thousand are only 7% of all the people who tried. That means 93% of people didn't try again. Why is that? When you're in crisis, you get the help, which frustrates me profoundly. You should get the help long before you get to that crisis point. When I say—

● (1855)

Hon. Helena Jaczek: Excuse me.

We had a psychiatrist here who absolutely agrees with you that MAID should never be allowed or this considered irremediable unless the person is not in crisis. Obviously, if the person is in crisis, this is not the time to make any such request.

Do you think that's at least a reasonable position?

Dr. John Maher: Rational suicide is absolutely a thing that occurs—there's no question. Most people have capacity. They're able to make their own treatment decisions.

If you're making a decision at a point in time when you are still suffering and can't get help, when you don't believe that help is going to be possible or when you're fed up with and tired of it, I understand that. When you look at the 4,000 suicides in Canada this year, you will see that 90% will be people with a mental illness.

Yes, there's rational suicide, but why do we have to help people kill themselves if they can do it themselves? I don't mean to be callous—

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

[*Translation*]

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

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

Dr. Maher, I understand your frustration. Mental health and mental illness have often been the poor relations of health care systems for years. While I sympathize with your frustration and the suffering you witness every day, I question your testimony tonight, because you seem to suggest that people who don't think like you are incompetent and that psychiatrists who disagree with you are incompetent.

I am neither a psychiatrist nor a specialist in mental disorders. However, things need to be sorted out.

I have here a document from the Canadian Psychiatric Association. I imagine that not everyone in this association is incompetent. They've gone so far as to make clinical recommendations on medical assistance in dying. I have this document in front of me. It is titled "Canadian Clinical Recommendations on Medical Assistance in Dying (MAID): Assessment of the 'serious and irreversible' eligibility criterion in people with mental disorders who request MAID and the management of suicide risk during the eligibility assessment process for all MAID requests."

These people claim they can provide training on the sensitive issues you've raised. They do indeed claim that structural vulnerabilities must be taken into account when they are the primary reason for the request. This is clear in the expert panel's report. I imagine they aren't all incompetent. The expert panel's recommendations state that there is no question of continuing the discussion on medical assistance in dying with a patient in a suicidal state.

You have surely read this report. I get the impression that there are several safeguards in place precisely to address the concerns you have and avoid the situations you are denouncing tonight.

So, who should I believe? Are all those who disagree with you incompetent, as you said?

[*English*]

Dr. John Maher: My translation was set up at the initial point of contact, but it has not been working.

[*Translation*]

I'll try to answer you. If I am—

Luc Thériault: Excuse me for interrupting. Please wait a moment.

Madam Chair, the witnesses should be told that there is a way to hear the French interpretation. I demand that my time not be wasted on witnesses who were not provided with the necessary assistance prior to the hearing so that they can hear what I have to say.

This is the first time this has happened here, but it has happened before. I would like us to take the time to tell the witnesses how to hear the interpreters. We cannot have a discussion on issues as sensitive as these if we cannot hear each other and if we do not understand each other.

I expect you to stop the clock. I want the interpretation to take place.

● (1900)

The Joint Chair (Marcus Powlowski): I will stop the timer, and I will explain this to Dr. Maher.

[*English*]

Do you want to briefly suspend to go through this, or do we get the...?

Dr. John Maher: I understand there's a—

The Joint Chair (Marcus Powlowski): We're going to give Luc his time back so he can ask his question again.

Just so you fully understand, at the bottom of your screen, you can select the appropriate channel for interpretation.

Do you see that?

Dr. John Maher: Is it under "audio"?

The Joint Chair (Marcus Powlowski): We'll suspend for a moment.

● (1900)

_____________________(Pause)_____________________

● (1900)

The Joint Chair (Marcus Powlowski): Welcome back.

[*Translation*]

Mr. Thériault, I will give you the floor again. You may ask your question again.

Luc Thériault: Since Dr. Maher says he understands my question, we will begin a five-minute discussion.

The Joint Chair (Marcus Powlowski): Yes, we will start with five minutes.

Luc Thériault: Agreed.

Dr. Maher, since it seems you have understood the gist of my statement, you may respond. If that is not the case, I will let you know.

Dr. John Maher: Certainly, feel free to correct me if necessary.

[*English*]

I didn't use the word "incompetent" in describing colleagues. What I said was colleagues "who lack skill". A young psychiatrist would, as residents do, lack knowledge. I'm not an expert in anorexia. I'm an expert in schizophrenia and bipolar disorders. We all lack knowledge, to some degree, in some areas of the broad areas of medical psychiatric care.

I also said those who lack "perseverance", and that, I think, is a key point to be made here. I am a subspecialist psychiatrist, and like a subspecialist in any area.... If I have a complicated cancer, I'm off to Princess Margaret hospital in Toronto. I'm not at my local hospital in Barrie. That's partly what I'm talking about.

● (1905)

[*Translation*]

Luc Thériault: I understand. So you believe that others lack your expertise.

I referred you to the document from the Canadian Psychiatric Association.

Have you ever had to assess a patient who requested medical assistance in dying?

Have you taken training from that association on assessing eligibility criteria?

Do you consider this document to be incompetent?

Do you believe that, from the outset, it is impossible to assess a patient? In your opinion, is it impossible to conduct such an assessment?

[*English*]

Dr. John Maher: I think there's a fundamental understanding of the capacity assessment you're talking about. You're not assessing whether someone is eligible for MAID. You're assessing whether they understand and appreciate the consequences of refusing psychiatric care. If they understand that, they're free to do whatever they want. If they want MAID, they're free to request MAID.

The capacity—

[*Translation*]

Luc Thériault: Excuse me for interrupting. That is not what the expert panel's report says.

The expert panel's report makes it very clear that just because someone raises their hand and says they want medical assistance in dying does not mean they will be eligible. To determine whether people are eligible for medical assistance in dying, the report sets out a series of principles and precautions that must be considered. As such, it is not true that simply refusing treatment is sufficient to qualify for medical assistance in dying. This report tells us the opposite.

I imagine that if you are an expert on schizophrenia, or, in any case, if you have cured everyone struggling with schizophrenia, you are truly qualified to receive the Nobel Prize in Medicine. However, schizophrenia is also a disease that is not easily treated. It is possible that you might lose a patient. It is possible that after 30 years, a patient might have had enough, because their suffering has not been alleviated.

What we are saying here is that there is no question of considering that a patient who is in a suicidal state should have access to medical assistance in dying. Assessing decision-making capacity seems to be a specialty of psychiatrists, and some of your colleagues tell us that it is entirely possible to do things by the book, which you claim is not possible.

I agree with you that we need more resources to treat people and that we need to be even more proactive and provide care early on, but these are two completely different issues. Here, the question is whether we should continue to keep someone who is at the end of their rope in palliative care indefinitely—which is all you are capable of doing, since you do not cure the person.

[*English*]

The Joint Chair (Marcus Powlowski): Dr. Maher, you have 15 seconds.

Dr. John Maher: You said two things that I didn't say. I didn't say that if you're found capable, you're eligible for MAID. I did not say that.

I am an absolute expert in capacity assessment, so the logical distinction I make is valid. I am saying that the CPA has some things wrong about capacity. If you look at the capacity literature, you'll get only about 75% agreement. If you have 25% of psychiatrists saying "capable" or "not capable", that's a problem. That's an operational problem.

Then when the CPA says we can do this, it's a claim that is not defensible because if you're mistaken here and if you say someone is capable and they're not.... Lots of people pretend to be quite rational and can manage it for a while, which is why expertise matters and why relationship matters.

You've said two things I didn't say. In terms of long-term suffering—

The Joint Chair (Marcus Powlowski): Thank you, Dr. Maher. We have to go on.

[*Translation*]

Senator Dalphond, you have the floor for three minutes.

[*English*]

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

Dr. Maher, I'm interested in data. You referred to some data, but I would like you to provide support for that. You said that 93% of psychiatrists are opposed to MAID for mental illness.

Where did you get the 93% number?

● (1910)

Dr. John Maher: That was from an OMA survey, wherein 90% oppose it without standard treatments being attempted first, at least. As far as I can tell, there is no recent data saying what the absolute opposition is, because there have not been continuing surveys.

The data I provided on Canadians being opposed was from an Angus Reid survey.

Hon. Pierre Dalphond: However, you said that it was 93% of psychiatrists, not Canadians. It's people who are supposed to be able to evaluate or assess capacity.

Did you say that number came from a survey?

Dr. John Maher: Yes, it was from the Ontario Medical Association survey.

Hon. Pierre Dalphond: Could you provide—

Dr. John Maher: A survey is never of everyone. There would be hundreds of people responding.

Hon. Pierre Dalphond: Okay. Could you provide a link so we can have access to that survey?

Dr. John Maher: Certainly.

Hon. Pierre Dalphond: I understand, from your answer, that the survey asked whether they should not have access to MAID unless they have tried other things.

Isn't that what you said?

Dr. John Maher: Yes, it was unless standard treatments have been provided.

Hon. Pierre Dalphond: Were the psychiatrists asked whether they would still be opposed to access to MAID if, at that time, standard care and treatment had been provided for a few years?

Dr. John Maher: No, it wasn't asked. The question asked was how many people supported MAID for mental illness, and the answer was only 3%.

Hon. Pierre Dalphond: Okay. That's without treatment. You also said that the rate of suicide is increasing in jurisdictions providing access to MAID for mental illness.

Which data are you referring to?

Dr. John Maher: There have been about five studies published at this point. Jones would be one of the obvious authors who has done research on this. It's recent research, because it was prompted by MAID and various countries starting euthanasia programs. It's solid data.

Hon. Pierre Dalphond: Would you mind providing us with copies of these five studies you rely on?

Dr. John Maher: I'm certainly happy to do that.

Hon. Pierre Dalphond: Thank you.

Do I still have time?

The Joint Chair (Marcus Powlowski): You have 24 seconds left.

Hon. Pierre Dalphond: Thank you very much for your answers.

The Joint Chair (Marcus Powlowski): Senator Martin, go ahead for three minutes.

The Joint Chair (Hon. Yonah Martin (Senator, British Columbia, C)): Thank you, both, for your testimonies.

My first question is for Dr. Lyon.

You explained what happened to your father. I think it's important for us to understand what happened. You said that your family had difficulty getting a MAID clinician to consider the collateral information you tried to share about your father's mental illness.

Based on this direct experience, can you tell us what that revealed to you about how the current system handles mental health evidence, and why that should concern this committee as it examines whether to expand MAID to those suffering from mental illness as a sole underlying condition?

Dr. Christopher Lyon: My impression from that experience was that I received conflicting answers from the providers in question.

His MAID provider seemed to suggest that his suicidality was a reason for MAID. In the conversations we had, as I mentioned, she suggested that he might just kill himself without MAID—that suicide was more plausible now, and things like that. Then, when I broached the prospect of his depression, she told me that if he had depression, he would be ineligible for MAID. I didn't quite understand the conflict in those comments: “If he has depression, he can't have MAID, but it's okay to be suicidal.” If you look at the way the right-to-die movement frames this, they have this idea of rational suicide and will start to make a separation there.

His provider said that the psychiatrist would just agree with her when it came to a psychiatric assessment. The psychiatrist's assessment talks about his depression and quotes my father saying something to the effect of.... It's very minimizing language, and it goes on from that. The assessment itself has been described as global to me, and subpar. There is almost a conflict between what the psychiatrist was exploring and the different statements his provider said to me. It was very confusing.

If we look at MAID for mental illness, we're going to get divergent views among individual clinicians. As the law is written, as I understand it—if it comes to pass in 2027—it wouldn't be psychiatrists doing the assessments for mental health cases. It would be the same nurse practitioners, general practitioners or medical practitioners doing these assessments without any training as it is. When we move into that space, we won't have any coherence.

● (1915)

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

Thank you.

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

I would like to welcome Senator Loffreda to our committee.

You have the floor for three minutes.

Hon. Tony Loffreda (Senator, Quebec (Shawinigan), ISG): Thank you, Mr. Chair.

Thank you to the doctors, our experts, for being here this evening.

My question is on defining “incurability” in mental illness. Dr. Maher, you went deeply into that. I would like to have Dr. Lyon's expertise on this, if we have time.

There remains significant disagreement as to whether and how a mental disorder can be considered incurable. That's a very important question.

Maybe I'll elaborate on that. Does the current clinical or legal definition provide sufficient clarity to ensure consistent assessments, or does it risk subjective interpretations that could lead to uneven or unsafe application?

I put that question forward because, Dr. Maher, you made some serious claims with respect to suicide and mental illness—whether they are to be allowed or not allowed. I come from an industry where integrity is never negotiable. I've said that a million times. We don't have any doctors who were reported, or what have you. Maybe I could have your opinion on that, or your judgment on that, more importantly.

Dr. John Maher: Are you asking me?

Hon. Tony Loffreda: Yes. Dr. Maher, go ahead.

Dr. John Maher: I tried reporting a doctor to one of the provincial colleges and was told that until the patient is dead, there has been no malpractice.

I said that the doctor had come to a conclusion that was flat-out illegal. There were no criteria, by any stretch of the imagination, that would qualify this patient for MAID. Both the family doctor and I told the MAID provider this. The college said that until the person is dead, it's not malpractice. I said that this person is being induced to a suicide plan, has been given the belief that they will be killed and they were offered their date to be killed. The college said that it would do nothing.

I have tried, colleagues have tried and that's what we hit our heads against.

Hon. Tony Loffreda: You believe the tools, protocols and safeguards in place are faulty or that they could be improved in making a distinction.

Dr. John Maher: I am aware of murders that have taken place in Canada for which there was no follow-up. The police have the door shut because the hospitals say it's confidential medical records. From the college—I won't say all colleges—in my experience and that of other colleagues, there is not action. There is not a taste for this.

Yes, I'm aware of homicides.

Hon. Tony Loffreda: That's very concerning—

The Joint Chair (Marcus Powlowski): I'm sorry. You only have about two seconds left.

Hon. Tony Loffreda: I work hard every day, but I don't have that much talent.

The Joint Chair (Marcus Powlowski): Unless you drink lots of of coffee, you're not going to get it in there.

Senator Wallin, you have three minutes.

Hon. Pamela Wallin (Senator, Saskatchewan, CSG): My question is for Dr. Lyon.

I read from your professional credentials that you are with the department of environment and geography, and you also work in the field of biodiversity. Is that correct?

Dr. Christopher Lyon: That's correct. That's one side of my job.

Hon. Pamela Wallin: Do you have any formal legal training or training in policing or constitutional law?

Dr. Christopher Lyon: No, I don't.

Hon. Pamela Wallin: The reason I'm asking is that you've authored and published a paper called “Canada's Medical Assistance in Dying System Can Enable Healthcare Serial Killing”.

That is a very serious allegation, to accuse medical professionals of being serial killers. What was that professional opinion based on when your area is neither medicine or law?

● (1920)

Dr. Christopher Lyon: It was several things. One thing I am is a researcher. What I can do is research. When we look at the definition of serial killing that law enforcement services put out, it's quite simple. It's usually something along the lines of killing two to three people in sequence on separate occasions or separate events. That's serial killing.

Hon. Pamela Wallin: You think that's applicable in the medical profession.

Dr. Christopher Lyon: The difference between, let's say, criminal serial killing and MAID is that we've created a carve-out in the Criminal Code for medical professionals who engage in discrete homicide.

Hon. Pamela Wallin: No. There are standards and eligibility requirements for the provision of MAID. There's no such situation for serial killers. I mean, let's be realistic here.

Dr. Christopher Lyon: What you're speaking about there is basically a definition in law. Criminal serial killing is killing outside the law. When you're killing with MAID—

Hon. Pamela Wallin: Right, and this is not outside the law, which is the distinction I'm trying to make clear here for people.

Dr. Christopher Lyon: You are creating a legal form of serial killing in MAID because—

Hon. Pamela Wallin: MAID is actually legal according to the Supreme Court. Do you understand that?

Dr. Christopher Lyon: Yes, it is. I'm saying that you're creating a legal form of serial killing. What I'm not saying right now in MAID is serial murder, which would be illegal. MAID is still a form of serial killing, so if you kill two to three or more patients sequentially, you are still committing serial killing within a legal parameter, so by that method—

Hon. Pamela Wallin: If they misdiagnose a person or if the cancer moves more quickly, or if the mental illness can't be diagnosed, you're saying that any medical professional could actually be accused of this. That's your position.

Dr. Christopher Lyon: That's not my position.

Hon. Pamela Wallin: Well, MAID is actually legal in Canada. It was—

Dr. Christopher Lyon: I know. That's why I'm saying—

Hon. Pamela Wallin: — declared legal by the Supreme Court and by Parliament.

Dr. Christopher Lyon: If you take the basic definition that law enforcement uses for serial killing, before you add whether it's within the law or not, you're talking about the difference between a culpable and a non-culpable homicide. MAID legally is a non-culpable homicide, so a series of MAID deaths that are within the law are a series of non-culpable homicides.

The Joint Chair (Marcus Powlowski): Thank you, Dr. Lyon and Senator Wallin.

Senator Wells, you have the floor for three minutes.

Hon. Kristopher Wells (Senator, Alberta, PSG): I'm going to continue what my colleague has just been talking about. Both of our witnesses today have made some pretty serious accusations of doctors being murderers. If this is so extreme, the committee needs to see proof before those accusations can be part of the public record. I'm just going to put that out there.

Dr. Maher, are you aware of the 2026 Environics poll for support of MI-SUMC? The poll question states:

> Under Track 2 safeguards, do you support or oppose allowing an adult with the capacity to provide informed consent to seek an assessment for MAID, and, if eligible, receive MAID, when their only medical condition is a severe, treatment-resistant mental illness...that causes enduring and intolerable suffering?

Are you aware of that poll?

Dr. John Maher: I'm not.

Hon. Kristopher Wells: Okay.

Dr. John Maher: I'd like to clarify. I didn't call anybody a murderer. I said homicides.

Hon. Kristopher Wells: That's not my question.

Right now, 80% of those polled agree with that statement. That's public opinion. That's actually on the record.

In your May 2022 testimony before this committee, you stated, “We have yet to find a case where treatment and recovery were not possible,” yet we've heard from multiple witnesses at this committee that we should treat persons with a mental illness similarly to how we treat persons with a disability. Understanding that, is it your professional opinion that all people with mental illnesses will get better?

Dr. John Maher: No. It's my understanding that all people with mental illness can have their suffering reduced—

Hon. Kristopher Wells: Thank you.

Dr. John Maher: —and can be supported to the point where they're no longer suicidal.

Hon. Kristopher Wells: My time is limited, unfortunately.

The Joint Chair (Marcus Powlowski): I think you posed a very lengthy question. I would give the witness a brief opportunity to reply to the question.

Hon. Kristopher Wells: It was a yes-or-no question, Chair. Are you going to—

The Joint Chair (Marcus Powlowski): We are not going there.

Hon. Kristopher Wells: I have a point of order.

The Joint Chair (Marcus Powlowski): Dr. Maher, you have 10 seconds or so to answer the question.

Dr. John Maher: Thank you. I'll just repeat my answer. Suffering can be reduced, and people can receive treatment that can reduce their suicidal thinking, goals and plan. They can find meaning and purpose with support, and, yes, that's true of 100% of people.

● (1925)

Hon. Kristopher Wells: Can I continue?

The Joint Chair (Marcus Powlowski): Yes.

Hon. Kristopher Wells: Thank you.

Dr. Lyon, my question is this: Have you ever personally assessed a person for MAID?

Dr. Christopher Lyon: No.

Hon. Kristopher Wells: What you're sharing is your personal position, which seems to emphasize protecting vulnerable individuals. How would you respond to concerns that denying access to MAID for competent adults is inherently paternalistic and undermines their autonomy and dignity?

Dr. Christopher Lyon: I've never made that argument here.

Hon. Kristopher Wells: I'm asking how you would respond to those concerns that we've heard before this committee.

Dr. Christopher Lyon: MAID came about through Carter, so it's a constitutional decriminalization, basically. Then we had this lower court ruling in Quebec. Within those parameters set out in the legislation, provided those are met, there's not much room for argument on that.

I have a personal opinion on what I think is happening, if that's what you're asking me for.

The Joint Chair (Marcus Powlowski): Thank you. I'm sorry, but we don't have time for that personal opinion.

Mr. Cooper, you have the floor for three minutes.

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

Dr. Maher, just to follow up, you indicated that a 35-year-old patient who had severe mental illness was offered MAID by a family physician proactively. What happened to that patient?

Dr. John Maher: She died of an unexpected medical condition before the MAID date.

Michael Cooper: Okay.

Now, I want to follow up on—

Dr. John Maher: However, she had purchased her ticket and was ready to travel, and her parents were going out of their minds.

Michael Cooper: You indicated that you are aware of and you have reported homicides that were carried out under the guise of MAID. Can you elaborate on that?

Dr. John Maher: I haven't approached the police. I have dealt with one college in particular.

I also sought the assistance of my professional association's lawyer, and I was surprised to discover that the Canadian Medical Protective Association now has four lawyers whose only work is to deal with MAID issues that doctors keep bringing up for them. The restrictions on what we can do, given the limits of confidentiality, are extreme. The best I could do was to go to a college.

Michael Cooper: When you went to the college, what happened?

Dr. John Maher: As I said previously, I was told that, until the patient is dead, there can be no malpractice. The clear tone of the conversation was, “We're not going to do anything about MAID because the legislation is so broad that it really is a matter of individual clinical judgment whether or not someone thinks that the criteria are satisfied.” Because it's a subjective standard, there is no objective standard. If someone says they've suffered enough, that's enough.

Michael Cooper: We've heard in this committee documented cases of abuse under the MAID regime that have been cavalierly dismissed as anecdotal. What do you say in response to that?

Dr. John Maher: I'm not talking about anecdotal experiences myself. These are direct experiences with MAID impacting my patients and my teams. It's not even legal for mental illness yet, and it's already had a profound disruption in terms of undermining our efforts to maintain hope and to provide treatment for recovery. It gives people the message that we've given up.

Michael Cooper: Can psychiatrists accurately distinguish between suicidality and a rational request for MAID, yes or no?

Dr. John Maher: No. MAID is suicide. It's taking steps to arrange your own death. It's an artificial distinction.

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

Next is Ms. Koutrakis for three minutes.

Annie Koutrakis (Vimy, Lib.): Thank you, Mr. Chair.

Thank you to our witnesses for appearing before us this evening. My question is for Dr. Lyon.

My understanding is that you also do research internationally. From your research on how assisted dying has developed across different countries, could you walk us through a specific example where eligibility expanded over time? What drove that change in practice?

● (1930)

Dr. Christopher Lyon: I don't do research across jurisdictions on MAID. I focus mostly on Canada.

There's been some work in the Netherlands, for example, and in Belgium. I think people like Trudo Lemmens or Scott Kim might be better placed to answer questions about how those systems evolved.

Annie Koutrakis: In your research in Canada, have you heard any professionals talk about safeguards that may have looked strong on paper but didn't potentially do what they were intended to do when put into practice?

Dr. Christopher Lyon: I think quite a few of them have come before this committee.

Annie Koutrakis: Dr. Maher, do you have something to add to that? In your experience and your practice, what have you seen through your patients, research or data?

Dr. John Maher: Is that in terms of expansion to other countries?

Annie Koutrakis: Yes.

Dr. John Maher: I've been involved in many conversations with people in other countries looking at these issues. If you're asking why it is expanding, these are some of the more interesting questions: Why doesn't it happen in any of the Asian countries because of the values and perspective they have there? Why was it recently overturned in Slovenia? Why did the Scottish Parliament object? Why have we seen the chaos in the British discussions over this issue?

It's a values question. Fundamentally, you either support suicide prevention and helping your citizens live, heal and recover, or you don't.

I'm sorry. I have little more to offer than that.

Annie Koutrakis: I was touched personally by someone's story about their parent going blind and deaf and requesting.... This had a huge impact on their mental illness. They had asked for MAID, and it was rejected. As a result, this person took matters into their own hands, and they jumped off a balcony.

Would you agree that every Canadian deserves a dignified death?

Dr. John Maher: Yes, but we have different definitions of dignity. The greatest dignity is to have your autonomy restored and be able to continue to live.

The argument that somehow a messy death justifies supporting suicide misses the point completely. What it justifies is treatment to prevent getting to a messy death or MAID in the first place.

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

[*Translation*]

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

Luc Thériault: Dr. Maher, in the bioethics literature, there is a history of end-of-life care in a biomedical context. Remember that we have moved from futile medical treatment to the recognition of the right to die. Indeed, before palliative care, the recognition of the right to die was called passive euthanasia, and we heard virtually the same arguments regarding passive euthanasia as those I am hearing tonight.

We have thus moved from medical paternalism, which imposed futile medical treatment, to the recognition of a patient’s right to die through palliative care. We have therefore recognized that patients can avail themselves of comfort care, and, a little later, we arrived at medical assistance in dying, respecting the autonomy that you wish to restore to your patients. That is indeed the goal. A patient can decide on their own death in a situation of end-of-life care, isn’t that right? I hope you support that.

This respect for the autonomy and self-determination of the person, of the suffering patient, has led to what we now call good medical practices. I imagine you are not opposed to these good medical practices, which consist in recognizing the refusal of life-sustaining treatment and the cessation or withholding of treatment when it becomes futile.

I would like to know where you stand on the issue of end-of-life care and the medical paternalism you seem to exhibit—perhaps justifiably—in the field of psychiatry.

● (1935)

[*English*]

Dr. John Maher: I'm one of the earliest formally trained bioethicists in Canada, so I know the literature well. I've watched the pendulum swing around paternalism, and I have the greatest respect and gratitude for that. We should be free to make our own decisions.

Here's what it comes down to: I am free to kill myself. Why am I entitled to ask anyone else to do it for me? If you say we have to provide compassionate care and support, I know patients who bring their families to their homes with planned suicides, and they don't need a doctor to do it.

There's some sort of artificial claim here that when we bring a doctor in, it makes it better or prevents errors or all of these things. The paternalism here is saying you have to have a doctor to do it, but let me make this critical point: If you're not willing to kill yourself without a doctor helping you, that means the doctor is responsible for suicide inducement. It is facilitation.

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

Senator Martin, you have two minutes.

The Joint Chair (Hon. Yonah Martin): Okay. That's not much time.

You were talking earlier about the concerns that what gets called autonomy can sometimes be a response to abandonment, poverty, isolation and a lack of support.

This is a question for Dr. Maher.

If assessors are already being trained to focus narrowly on consent and capacity, how can Parliament trust the system to safely handle cases where mental illness will be the sole underlying condition? Would you further expand on what is happening right now with the system?

Dr. John Maher: Certainly. It's a nuanced discussion.

We treat people like they're Mr. Spock in the literature and in our discussions of capacity. They're not. They're messy. They're driven by emotions and despair and hopelessness. The very offering of MAID is a message at that point in time that we don't have anything else for them.

The undermining of the clinical relationship by the very offering of MAID is profound. Unless you're living it and experiencing it, I'm not sure how to communicate what it means to rob people of hope, especially when they're having to struggle over time.

Monsieur Thériault talked about whether I am going to make somebody suffer for 30 years. If they've lived for 30 years, they've been living a life. What has that life been for them? To say that they shouldn't have had those 30 years.... They made a choice to live.

Autonomy is my choice to do what I want with my body. I can kill myself. That can sound callous, but it's not. People thoughtfully plan their own deaths. I can tell you stories of how people plan their suicides. If you have some fantasy that everybody does this horrible, impulsive thing, it's uncommon. It's about 10% of people. To be clear, the impulsivity is not genuine impulsivity. They have rehearsed it in their heads for months. We have research showing that. That's autonomy: I can do what I want.

I'm objecting to the system being set up to induce, to seduce, to invite and to rob people of hope. That's not what we, as a country, should be doing to the vulnerable.

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

Last of all is Senator Loffreda for two minutes.

Hon. Tony Loffreda: Thank you.

Dr. Maher, thank you. We don't want to rob people of hope. We all need hope.

My question for you and Dr. Lyon, if you'd like to bring in his expertise, if we have the time, is this: Given the inherent uncertainty in these assessments, would you agree with an additional national safeguard, such as a mandatory specialized second opinion, to ensure consistency and to protect vulnerable individuals?

Data oversight and public confidence are so important, and public trust in this regime depends on transparency, consistency and the ability to monitor outcomes in real time. The current data collection, from what I gather and what I've heard this evening, is not sufficient to capture the complexity of these cases, including the unsuccessful requests, the reasons for refusal and indicators of vulnerability, such as a lack of access to care or social supports.

What's your experience with that and your judgment of that?

Dr. John Maher: Psychiatrists have biases. There are reasons some psychiatrists are strongly in favour of and are ready and happy to do MAID assessments. We come with biases.

If you're asking what the data says about capacity assessments, it's very easy to sort out who's extremely psychotic or profoundly depressed. It's very easy to sort out who's doing really well and is quite capable and rational, which would be the majority of people. What's complicated is the grey zone, and the grey zone is substantial. The data says that about 75% of psychiatrists will agree on what they're seeing, and if you have 25% disagreeing, that's pretty significant.

I frankly view the capacity issue as a red herring. I've thought this for a long time. People are focused on the idea that we have to decide whether they're able to decide. That stuff is done every day in psychiatry, and it's called a capacity assessment for treatment decisions. Insofar as you're calling MAID a treatment decision, then this fits into that category.

To say it's somehow special or different does not, in fact, reflect the reality of the day-to-day work of mental health care. Are some people better at doing capacity assessments than other people? Absolutely. If I have 40 years of experience, I'm going to see things differently than if I were a fresh grad.

● (1940)

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

Thank you both, Dr. Lyon and Dr. Maher, for your time.

We'll briefly suspend while we bring in the next panel.

● (1940)

_____________________(Pause)_____________________

● (1945)

The Joint Chair (Marcus Powlowski): I call the meeting back to order.

Andrew Lawton: I have a point of order.

Mr. Chair, I think we lost about 11 minutes in the first panel because of the technical issue. We're about 20 minutes over now. I was hoping you could confirm when we have resources until and whether we'll have time for all our rounds with all the remaining panels.

The Joint Chair (Marcus Powlowski): We have resources up to 9:45, and we'll try to be done by then. I think we might want to curtail the last panel a bit to get all the testimony in.

Is everyone in agreement on that? I think we all want to finish as close to 9:30 as possible.

Annie Koutrakis: It has been a long day.

The Joint Chair (Marcus Powlowski): Hopefully everyone will be in agreement on cutting some time from the third panel if necessary, but we have up to 15 minutes—

Hon. Kristopher Wells: Could we not cut back on both panels instead of shortchanging the third panel? I think that's fair.

The Joint Chair (Marcus Powlowski): We could, if everyone's in agreement on that. We could cut everybody short by 10 seconds, say, for the next panel as well.

Is everybody in agreement on 10 seconds right across the board?

An hon. member: Yes, keep it equal.

The Joint Chair (Marcus Powlowski): Is everyone okay with that? We'll take 10 seconds off everybody, and hopefully that will get us closer to getting in on time.

Some hon. members: Agreed.

The Joint Chair (Marcus Powlowski): I've been asked to quickly read this again, because someone misunderstood the translation process in a question previously.

I'd like to confirm that sound tests were made successfully.

Before we continue, I would ask all in-person participants to consult the guidelines written on the card on the table. These measures are in place to help prevent audio and feedback incidents and to protect the health and safety of all participants, including the interpreters. You will also notice a QR code on the card, which links to a short awareness video.

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

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're not speaking. For those on Zoom, at the bottom of your screen, you can select the appropriate channel for interpretation—floor, English or French. For those in the room, you can use the earpiece and select the desired channel. I'll give a reminder that all comments should be addressed through the chair.

With that, I would like to welcome our second panel.

We have Gabrielle Peters, co-founder of Disability Filibuster, as well as Catherine Frazee, professor emerita, school of disability studies, Toronto Metropolitan University. They're going to be sharing five minutes. We also have Dr. Michelle Hewitt, board chair for Disability Without Poverty, and Krista Carr, chief executive officer of Inclusion Canada.

We'll start off with five minutes to Ms. Peters and Dr. Frazee.

Ms. Peters, I think you're going to go first, and my understanding is that because of some medical problems and problems with breathing, we may have to go beyond the allocated five minutes, so we'll give you a bit of leeway.

If you'd like to start, Ms. Peters, I believe you have a video—

● (1950)

Gabrielle Peters (Co-Founder, Disability Filibuster): No, I'm speaking live.

The Joint Chair (Marcus Powlowski): Okay. Dr. Frazee is going to have a video.

Ms. Peters, go ahead.

We're trying come as close as we can to fitting you both into five minutes. Please go ahead.

Gabrielle Peters: I'll do my best. I appreciate the disability accommodation. Thank you.

One of the hats I wear is that I sit on Providence Health Care's psychiatry lived experience research advisory committee. I am always struck by the urgency accorded to the expansion of MAID for mental illness versus that of providing funding for comprehensive mental health care, supports, services, a livable income and housing for those with mental illness. Injustice can often be measured in time.

We know that neither people nor policy are islands unto themselves, yet MAID is discussed as if it exists inside a vacuum, free of influence from or consequence to society. In the little time I have, I am going to address a couple of persistent myths that constantly derail and impede rather than build understanding.

Myth one is the claim that people oppose expanding MAID because they believe mental illness is less real than physical illness, and they treat it as less significant and less worthy of support. This claim is false. The division between physical and mental illness is asserted and maintained by the medical model and the Canadian state. A two-tier health care system has been built around mental health due to the exclusion of many essential elements from Canada's public health care system. The average provincial and territorial mental health care funding lags behind that of many peer countries. Proportionally, Canada's public spending on mental illness is lower than its occurrence among all illnesses. People with mental illness face particular threats to their civil rights and higher levels of police interactions and incarceration.

Stigma requires power. Without power, stigma is just someone's bad opinion. When it comes to claims asserted by the myth, the call is coming from inside your house—not ours. As disabled people, we understand disability as one large tent. The experience of oppression is not the same, but the cause of it is. Please remember that the majority of disabled people have more than one disability. Co-occurrence of chronic illness and mental illness is common.

Myth two is that failing to expand MAID is discrimination. This claim is also false. This and other assertions made by proponents of MAID reflect a profound lack of understanding of disability, disability rights history and the causes and consequences of—and solutions to—the discrimination and injustice disabled people experience. Those eager to offer aid in accessing death to an autonomy-deprived population are certainly making a choice, but why?

At least one study has found that support for euthanasia on the basis of mental illness was positively correlated with holding attitudes of stigma towards people with mental illness. Further, a forthcoming chapter by Trudo Lemmens and Scott Kim demonstrates that parity arguments logically lead to absolute autonomy—death on demand for anyone.

This aligns with disability analysis that for years has asked, why us? The co-opting of or, at best, the outdated and incorrect understanding of disability rights invoked in the name of expanding MAID is evidence of the absence of disabled knowledge and understanding. MAID is, among many things, authored by epistemic injustice and must be repealed, not expanded.

Thank you.

● (1955)

The Joint Chair (Marcus Powlowski): Dr. Frazee, I understand you have a video. We'll go to your video.

Dr. Frazee has made a video because of her trouble in communicating.

Dr. Catherine Frazee (Professor Emerita, School of Disability Studies, Toronto Metropolitan University, As an Individual): [*Transcription of video presentation:*]

I want to begin by acknowledging both the nature and the limits of what I bring today. I speak as someone who has moved through the world for seven decades with significant physical disability. I've spent a career analyzing that experience within the frameworks of law, policy and culture.

I want underscore that your work on this committee must be grounded in the authority of what the law calls “mental illness”, authority earned through neurodivergence, psychiatric survival, intersectional identity and mad scholarship. Seek out persons who have not only lived these realities, but worked them into deep understanding.

That's a different undertaking from finding individuals who will speak about their own desire for MAID. First-person accounts have a place here, but they are not a substitute for epistemic authority, and this committee must be clear about the difference.

Between 2021 and 2023, I was part of a working group on the MAID practitioner training curriculum. My full account is published this month in the Canadian Journal of Disability Studies, and it's appended to my written testimony.

What I encountered there was a culture immune to the self-reflection and humility that ought to attend any decision to authorize death. My questions about whether a MAID applicant's despair arose from a life without validation or support were rejected as threats to autonomy. Vulnerability was narrowed to irrelevance. What remained in the curriculum trains assessors to, yes, verify capacity and consent but to look no further, as if the law’s demand for conscientious scrutiny had never existed.

In Carter v. Canada, Justice Smith staked this regime's legitimacy on trust in medical judgment—on physicians applying, in her words, the “very highest level” of scrutiny, the safety of their practice contingent upon “the skills and commitment of the physicians who are responsible”. I have watched that commitment up close in a curriculum designed to make practitioners look away. The trust that the court and Parliament placed in medical judgment has not been honoured.

On that evidence, this committee cannot responsibly contemplate expansion of a regime that has not learned to be accountable for the power it already wields.

Thank you.

● (2000)

The Joint Chair (Marcus Powlowski): Thank you.

Next is Dr. Michelle Hewitt. We'll try to hold you to five minutes.

Michelle Hewitt (Board Chair, Disability Without Poverty): Thank you.

My name is Michelle Hewitt. I'm the chair of Disability Without Poverty. As the chair of DWP, I want you to know that research from UBC will tell you that 75% of the people living in Vancouver's Downtown Eastside have mental illness. These people don't want MAID. They want supports to live their lives in dignity and to be able to thrive.

Today, I want to tell you about my husband, Victor Enns, who used MAID to die on December 9, 2025. Victor did not want to die. Victor was a poet and a writer. Along with listening to music, he enjoyed life. He had a wicked sense of humour, he cared for everything that was going on in the world, and he had a deep love for his family.

Victor was diagnosed with chronic depression in his twenties, and he was 70 when he died. Around 30 years ago, he got good support from psychiatrists and found a cocktail of drugs that managed his depression well. If MAID for mental illness existed earlier, Victor might have accessed it during a prior depressive episode. Instead, with more time and good care, his depression was under control.

The most disabling part of Victor's life was chronic pain from severe osteoarthritis, but he had good control with an opioid. In 2022, he lost his family doctor. This precipitated a series of events that led to his losing access to that opioid and being prescribed too much of something else, which led to respiratory depression, hypoxia and a week in a medical coma. After that, he was prescribed Suboxone. Victor wanted his original opioid back, as it worked better. However, ironically, he was told he couldn't have it in case he had another respiratory depression and died.

Early in 2025, Victor requested psychological testing, as he felt something wasn't right. The testing said that he had some cognitive changes, but there was no way of knowing how much the drugs that he took for his pain control or the events surrounding his week in a coma played into this. He was diagnosed with early dementia.

Victor then started to comment that he thought MAID would be in his future. The possibility of dementia scared him. He was also rapidly reaching the limit that he would be prescribed Suboxone. In May 2025, Victor submitted the paperwork, still thinking of it as something for the future. When we got a date for the assessment, Victor prepared by writing a list of reasons that he thought he should qualify. Within 10 minutes of arriving, including introductions and explanations of what MAID is, Victor was told that the assessor had already decided he had qualified and that he could have either track 1 or track 2. As Victor had no intention of using it in the short term, he'd put track 2. Within 25 minutes, the assessor was gone.

The second assessor arrived, telling us he agreed with his colleague. The whole time was spent filling in paperwork. He also said that he'd be happy to assess Victor as track 1 or track 2, and he'd follow his colleague's recommendation for track 2. He left after 30 minutes, telling us when his holidays were so that Victor could plan his death around them.

Victor was no more likely to die in the foreseeable future than I am from my MS. There was never any attempt, as designated in the legislation, to try to see whether other options would help him. They never saw us again until his life ended through MAID.

From that time onwards, Victor's mental illness worsened as his paranoia increased, his pain increased and he reached the limit of the Suboxone. The sum total was that, with no support and no pain control, he chose MAID.

Do not believe that MAID provides choice and dignity in death. We were told that we could have Victor die only before the provider started his working day or at the end of it, so we chose 4 p.m., only because it was easier than 8 a.m. We had said that Victor could spend only a small amount of time lying on a bed because it caused him so much pain. He'd not slept in a bed for two years. That was ignored, as he was told to get on the bed far too early.

With the late arrival of the doctor and with Victor lying in a bed with no painkillers—because we didn't think he'd need another dose, but everything was running so late—led to him screaming for them to kill him. The IV was poorly placed, meaning they had to switch arms, and I could not be at his side as he died. We were shouting at each other across the room to say goodbye.

● (2005)

I don't think Victor's experience is an outlier. The current MAID program is severely broken, and it doesn't do what you think it does. Victor was not in control. The only thing he is is dead, and he didn't want to die. He felt he had no other option.

The current program clearly has such major issues that you should not consider an expansion, particularly for something as controversial as mental illness as the sole condition. Track 1 needs some careful attention, and track 2 needs shutting down.

I've come here today to share the most painful aspects of my husband's death, which is not easy to do, so please ask me questions.

Thank you.

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

Ms. Carr, you have five minutes.

Krista Carr (Chief Executive Officer, Inclusion Canada): Mr. Chair and members of the committee, my name is Krista Carr, and I am CEO of Inclusion Canada. We are the national federation representing people with an intellectual disability and their families, with 13 provincial and territorial member associations and more than 300 local associations across the country.

Every day, we advocate, educate and deliver programs in the area of disability and human rights. We work to ensure that people with an intellectual disability have the same access, dignity, opportunity and equality as everyone else.

We also live the harsh reality of legislated poverty and failed support systems, housing shortages, inadequate home care and insufficient disability and mental health supports. We confront systemic discrimination and historical disadvantage. We watch as people are made vulnerable by the very systems that are supposed to be providing support. We navigate systems that regularly send messages to persons with disabilities that they are broken, that they are a burden to their families and to society, and since 2021, because of track 2 MAID, that their lives are not worth living.

We live the consequences of this MAID regime every single day. We see a pattern in which individuals choose assisted suicide not out of a genuine desire to die but because the supports needed to live with dignity are simply not made available. We answer calls weekly from individuals with a disability who were offered MAID when they attempted to access the health care system for everything from a bruised hip to pneumonia.

Across this country, persons with disabilities are being steered toward death when what they seek is help. This is the human side of MAID, and it is not rare. When I tell you this is happening, I ask you to believe me and to believe them. Please do not dismiss these experiences as anecdotes. They are people whose lives are directly affected by the laws you have written.

MAID is a human rights issue, and it's an equality issue. Track 2 MAID applies only to persons with disabilities who are not dying. This disability-based access to assisted death constitutes discrimination contrary to section 15 of the charter. It devalues the lives of persons with disabilities, reinforces harmful stereotypes and deepens historical disadvantage. No amount of additional safeguards can change that.

Canadians without disabilities who experience poverty, isolation or social suffering are not offered death. They are offered suicide prevention, treatment, housing and support. Persons with disabilities are entitled to the same response. However, we are offering people with disabilities MAID instead of help.

Track 2 is incompatible with Canada's domestic and international human rights obligations. In 2025, the UN Committee on the Rights of Persons with Disabilities expressed extreme concern about track 2 and recommended that Canada repeal it, including the planned expansion to mental illness as the sole underlying condition. The committee linked MAID requests to failures in poverty reduction, health care, housing and community mental health services.

I will briefly address arguments this AMAD committee has heard.

It has heard that the disability organizations do not represent the disability community on this issue. This claim is inaccurate and deeply offensive. Disability organizations are governed by and accountable to persons with disabilities. Our organizations are recognized by Canadian courts and international bodies as representative organizations of persons with disabilities. We speak as voices shaped by lived experience and a history of discrimination.

You have been asked to give equal weight to end-of-life advocacy organizations. Respectfully, they don't represent people with disabilities as a class. On matters of disability law, Parliament must give the greatest weight to organizations rooted in the disability community itself.

Parliament is now being asked to add mental illness to track 2. There is no professional consensus on this. In 2022, the heads of psychiatry at all 17 Canadian medical schools called for the delay, warning that there is no accepted way to distinguish a MAID request from suicidal ideation. The American Psychiatric Association opposes physician-assisted death where mental illness is the sole condition.

Treat people with disabilities the same. If others in crisis are met with suicide prevention, meet people with disabilities with suicide prevention. If other Canadians with mental illness are met with treatment, meet people with disabilities with treatment. If people with disabilities are poor and isolated, meet that poverty and isolation with housing, income and support so they can live with dignity.

● (2010)

You cannot call it equality when everyone else receives help and people with disabilities receive death.

Committee members, maintain the exclusion for mental illness, repeal track 2 and do not write one law for everyone else and another one for us. You cannot reverse death.

Thank you.

The Joint Chair (Marcus Powlowski): Thank you.

Next up is Mr. Patzer for four minutes and 40 seconds.

I would suggest, since I think we're all eager to try to get out of here by 9:45, that you're certainly welcome to make it less than four minutes and 40 seconds.

Jeremy Patzer: That's a tough ask of a politician, Mr. Chair.

Any which way, thank you to all the witnesses for coming today. I really appreciate the stories that you are all willing to share.

I'm going to start with Ms. Carr.

Before this committee even considers expanding MAID to mental illness alone in 2027, can you give us a flavour of the kinds of calls that Inclusion Canada receives from people and families about the existing MAID framework? What do these stories tell us about the risks of expanding it further?

Krista Carr: Thank you for the question.

We receive calls weekly, and we get them not just from people with intellectual disabilities and their families. Because we have been vocal on the issue, we also get them from people with all different types of disabilities.

They fall into two categories: people with disabilities who reach out to us in a last ditch attempt to find someone to help them, because they have tried so hard for so long to get the help they need; and people with disabilities who have accessed our health care system for regular, ordinary, everyday things and been offered MAID along the way for everything, as I mentioned, from a bruised hip because of a fall out of a taxicab to treatment for pneumonia. One thing they have in common is that none of them wanted to die.

We have had people call us such as a person with a disability who was a victim of intimate partner violence and had no access to income to get out of that situation because she was on disability income support who felt like if she couldn't get out of that situation, it would be better to be dead, or she may be killed. We had a person with muscular dystrophy who was living with a parent who died of cancer and had been providing a significant amount of support. Once that support was gone, they could not get the support they needed to live in their own home and were going to be institutionalized. We've had people on waiting lists for three years for chronic pain management specialists.

The list goes on and on. We have a binder of examples.

Jeremy Patzer: Thank you for that.

The question before this committee is about MAID where the sole underlying condition is mental illness. Based on the data we already have, what does that tell us about who is receiving MAID now and why they are receiving it? Why should that make Parliament cautious about expanding MAID for mental illness?

Krista Carr: Often we're quoting the track 1 data on MAID, but the data we have on track 2 MAID tells us that the people accessing track 2 MAID are disproportionately women, indigenous, living in poverty, low income and isolated, and they feel they're a burden on their families.

● (2015)

Jeremy Patzer: We're being told this next expansion can be done safely, but if we expand MAID for mental illness as a sole underlying condition, what conditions would that actually include, and what would that mean for suicide prevention in Canada?

Krista Carr: The definition that will be used comes out of the DSM-5, which is the definition of “mental disorder”. There are 290-some different labels that fall under that distinction. That includes intellectual disability, autism, trauma, eating disorders and gender dysphoria, and the list goes on and on. We're talking about a hugely wide expansion to a significant number of people.

Jeremy Patzer: Thank you very much, Chair.

I will leave it at that.

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

Dr. Ramsay, you have four minutes and 50 seconds.

[*Translation*]

Jacques Ramsay (La Prairie—Atateken, Lib.): I would like to thank all the witnesses very much.

Ms. Carr, you introduce the concept of social determinants, such as hardship, poverty, lack of housing and isolation. In life, everyone suffers from some kind of health problem. We don’t live in a vacuum. We may have a health issue, which is often linked to other factors or determinants. I completely agree with you. These determinants should be analyzed during a discussion with the individual.

However, what bothers me is that if we deny a person the right to access medical assistance in dying based on such determinants, we are engaging in reverse discrimination—that is, I could argue that because the person is poor, they do not have the right to medical assistance in dying.

I would like to hear your thoughts on this.

Next, in what ways are social determinants more closely linked to a mental health issue than to a physical health issue?

I would say they are more closely linked to physical health issues than to mental health issues.

I would also like to hear your thoughts on this.

[*English*]

Krista Carr: Thank you very much for the question.

To your first point around the social determinants of health, you're correct. That applies equally to everybody in the population, much like track 1 MAID applies equally. If you have a terminal illness, it doesn't matter what socio-economic conditions, disability supports, any other kinds of supports or anything you have in your life; you qualify for track 1 MAID. Track 2 MAID is a completely different story.

We have singled out one group of charter-protected individuals—persons with disabilities—and that is the definition that is met under track 2 MAID: It's if you have a disability and you are not dying. There's a fundamental equality issue at play here because we only offer track 2 MAID to one particular group of people. The people we are offering it to—persons with disabilities—tend to have multiple forms of intersecting discrimination, such as poverty and lack of access to supports, etc.

When someone is in the general population, suffering is equal across the board. Anyone can suffer intolerably. It's part of the human condition. When someone else is suffering intolerably, we do what we can to alleviate that suffering or provide the supports and services necessary. That's not the case when it comes to people under track 2 MAID who are experiencing those same conditions.

To your second question on whether the social determinants of health apply less to people with mental illness than to people with a physical disability, I believe—

Jacques Ramsay: Or at least no further—

Krista Carr: Right.

What I would say to that is that people with mental illnesses are in a situation where they are persons with a type of disability who are not dying, and they often do not have access to the supports they require as far as mental health goes.

I look at the population I serve. I serve people with an intellectual disability, 40% of whom have a co-occurring mental health issue, mental illness, etc. Even if they could access specialist services, very often those specialists are not trained to deal with people who have an intellectual disability or autism, and a mental illness, so they are not getting the support and treatment they require to live a good life. I would say the social determinants apply.

If you layer on the situation they're in, poverty.... When you can't pay for mental health services, when you can't pay for counselling and when you can't pay for psychiatry that isn't provided through your health care system, then you are multiply disadvantaged.

I would say that the social determinants apply just as much, if not more, to people with a mental illness as they do to people with physical disabilities.

● (2020)

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

[*Translation*]

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

Luc Thériault: Thank you very much.

The Joint Chair (Marcus Powlowski): Excuse me. You have the floor for four minutes.

Luc Thériault: I thank all the witnesses for their testimony.

Ms. Carr, if I understand your presentation and reasoning correctly, you are saying that there is systemic discrimination, that people with disabilities are treated poorly, and that this would have an adverse effect. Indeed, this would mean that the system’s inability to properly care for these individuals would leave them with only one option: medical assistance in dying.

Regarding track 2, I understand that you are opposed to expanding medical assistance in dying to individuals whose death is not imminent—that is, in all scenarios under track 2.

Don’t you think it would be systemic discrimination if the Supreme Court had ruled, in general terms, that any person living with a disability would never have access to medical assistance in dying, simply because they fall into the category of people with disabilities?

[*English*]

Krista Carr: Thank you very much for the question, Mr. Thériault.

What I would say to that is that the Supreme Court didn't say that. As a matter of fact, the Supreme Court didn't even say that it would apply to people with a mental illness. The Supreme Court ruled on the facts of the case before it, and it was very clear about that—

[*Translation*]

Luc Thériault: I’m sorry, but the Supreme Court did say that a blanket exclusion is contrary to an individualized assessment. We cannot consider that belonging to a category of people justifies excluding them from access to medical assistance in dying. Assessments must therefore be made on a case-by-case basis. However, if we end up saying that people with disabilities would not have access to medical assistance in dying simply because they have a disability, we are engaging in systemic discrimination.

You may disagree with me on this, but that is what I understand from what you are saying. You are saying that medical assistance in dying should not be a solution and should not appear to be a solution. Indeed, it is not a solution. We must be able to treat people properly, which is an absolute right.

Before the Superior Court of Quebec, Ms. Gladu said she wanted to have that option, that choice. She was disabled; she lived a full and complete life, but she wanted the possibility of accessing medical assistance in dying. If she had been denied that, it would have been systemic discrimination.

[*English*]

Krista Carr: You are correct that I do not agree with you. On the systemic discrimination, if that were the argument, then we would offer MAID to anybody who was suffering and wasn't dying, but we don't do that. We offer MAID to people with terminal illnesses, equally across the board, who are dying, but track 2 MAID is only for one particular group of people. It's for people with disabilities who are not dying.

If we are going to say that we are somehow not creating systemic discrimination, why wouldn't we be offering MAID to everybody? We would be offering it to everybody who wanted it who said they were suffering intolerably, but we don't. We don't do that. I don't think anybody around this table would think that's a good idea. Why, then, is it okay to offer MAID to people with disabilities who are not dying? Is it because their lives are somehow less worth living than everyone else's?

● (2025)

[*Translation*]

The Joint Chair (Marcus Powlowski): Thank you very much, Mr. Thériault.

[*English*]

Senator Dalphond, you have three minutes.

[*Translation*]

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

[*English*]

Ms. Carr, you said that your organization receives calls every day. How many of these people who were offered MAID were assessed?

Krista Carr: With regard to the people who have been offered MAID, to my point, I was talking about people who go to the health care system for other typical things that anybody else would go for and who are asked about MAID: Have you considered MAID? Are you interested in MAID? Perhaps you should go down this route.

As was mentioned in the panel—

Hon. Pierre Dalphond: I'm sorry. My three minutes move fast.

I understand, from the beginning of your answer, that they will call you, but you don't know what happens after. You don't know if they went to the assessment. You don't know if they were assessed as, yes, they could have it.

Krista Carr: Those particular calls I was referring to are from people who have been offered MAID, persons with disabilities, not dying—

Hon. Pierre Dalphond: In discussions with a doctor or—

Krista Carr: —in discussions with a doctor, when they were not asking for it and when they were not there for that reason.

Hon. Pierre Dalphond: Okay. They call you to know what to do.

Krista Carr: When they call us, it's because they are fundamentally traumatized and wounded by the experience.

Hon. Pierre Dalphond: I understand. I appreciate the comfort you provide.

You have 300 local associations. How many members do you have across Canada? How many people are within this organization?

Krista Carr: Individual members total over 40,000.

Hon. Pierre Dalphond: Are all these 40,000 members opposed to MAID and opposed to what Ms. Gladu and Mr. Truchon did? Do they all think these two people were wrong and that MAID should not be accessible by track 2?

Krista Carr: These are the individuals we work with on a daily basis and our local and provincial organizations work with on a daily basis. What they feel is that the availability of track 2 MAID and the further expansion of it embeds stereotypes and is discriminatory about their lives and their lives not being worth living or being worth saving.

Hon. Pierre Dalphond: I'm sorry to interrupt again. From your answer, I understand that all your members are not opposed to track 2.

Krista Carr: No. What we are saying is that, yes, our organization and its members are opposed to track 2 and further expansion of track 2, as is the United Nations. That is what I am saying.

Hon. Pierre Dalphond: Thank you.

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

You have two minutes and 50 seconds, Senator.

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

My question—or questions, potentially—will be for Ms. Gabrielle Peters or Dr. Frazee, maybe one for each.

I'll start with you, Ms. Peters. Some witnesses speak about the expansion of MAID for people suffering from mental illness as a sole underlying condition as a natural next step to respecting rights. From the disability community's perspective, does this feel like equality?

Ms. Carr has talked about concerns about expansion, but that is one of the positions we have heard, that it's about equality and respecting the rights of individuals, and that for mental illness that expansion is important. What are your thoughts on that?

● (2030)

Gabrielle Peters: Just in listening to this last conversation, and in general in the committee, it's very clear that there's a fundamental lack of understanding of what disability is, first of all.

Also, you can't equate someone's personal opinion in any moment with disability analysis. Disability rights have evolved from a period of time when people were largely institutionalized, so the focus was on independence and the right to live independently. Then we entered the universities and we entered the community, and the analysis has evolved. It's an actual area of scholarship and study.

You're taking somebody like Nicole Gladu, saying, “Oh, I want this,” and you're equating that with actual analysis—given the history, looking at our situation, looking at our lives and understanding all of these things in context—and making a judgment on how this will impact a community. These are not the same discussions that we're having, so it absolutely is not adding to disability rights.

One of the things that needs to be understood is that disability justice.... A McGill law professor has written very well and eloquently about this evolution from disability rights to disability justice. One of the things he observed was that we went in thinking that if we just fought for inclusion and integration into the existing systems, that would lead somewhere. However, people consistently come back saying policy-makers are not getting it, and they're still not getting that they're not getting it.

The Joint Chair (Marcus Powlowski): Thank you, Ms. Peters. We've run out of time.

Senator Loffreda, you have three minutes.

Hon. Tony Loffreda: My question is for Ms. Carr.

A central concern that I'm hearing in the debate this evening is the protection of vulnerable individuals. I take from your view that the current safeguards are not sufficient to identify and protect individuals who may be experiencing this structural vulnerability or these external pressures.

Are there any specific safeguards that are missing that you think could correct those issues? What level of support do you have for additional requirements, such as mandatory multidisciplinary assessment or enhanced oversight in these complex cases?

Krista Carr: Thank you very much, Senator, for the question.

The first thing I would say is that the current safeguards are flimsy at best and have gaping holes in them. I would also go on to say, as many others have testified in front of this committee, that when you have a fundamental equality issue, there is no safeguard that is going to fix that.

What we have here is a situation where we have singled out one group of people for death instead of support. One hundred per cent of the people who have called and are calling our office are saying they do not want to die. We have a fundamental disability rights equality problem, and there are no more band-aids we're going to be able to put on that to change it.

I would also say that with the "safeguards"—and I'm putting that in air quotes because they, as I mentioned, are flimsy at best—that we do have, there's no oversight to even make sure they're followed. You just have to look at the death review committee in Ontario and what they're finding to see there's really no oversight on whatever safeguards might be in place to start with.

Hon. Tony Loffreda: Thank you.

Thank you, Mr. Chair.

The Joint Chair (Marcus Powlowski): Thank you.

Senator Wallin, you have two minutes and 50 seconds.

Hon. Pamela Wallin: Thank you very much.

I am sorry to hear the stories that we hear from people at this committee. I happen to have experienced in my own life, as I know many of my colleagues have, knowing close friends or family who have chosen MAID and have done so willingly. It was not something forced upon them. It was not something they chose because they had some kind of disability, either mental or physical, or because of social determinants. This is available under the law, and they have chosen it.

While I think we all agree on one issue, which is that discrimination is not a good thing in any way, what I'm hearing from many of you here tonight is that your choices or your situations mean that you're willing to see those who want access to MAID discriminated against.

I'll start with Ms. Carr.

Are you in favour of medical assistance in dying in any situation at all?

● (2035)

Krista Carr: Thank you very much for the question, Senator.

First of all, I think we've made our position really clear. We are talking about track 2 MAID, not track 1 MAID.

Hon. Pamela Wallin: That's why I'm asking what your general view of this is. It influences this other side, which is people who are not being discriminated against but who want to access something that is legally available under the law.

Krista Carr: It is legally available under the law to only one particular group of people who are not at end of life and who are not dying. We are not offering this choice to people who are not dying equally across the board to anyone. We've singled out one group of people whose lives we have decided, because of our fear of disability or because of how we perceive it, are not worth living. Part of the reason people experience the difficulty they experience is the chronic ableism and lack of supports.

Hon. Pamela Wallin: Many people who have lives worth living but who are ill or, through some physical condition or illness—it might be cancer, or perhaps they've had mental illness most of their life—have come to the conclusion that this is not quality of life and want dignity in the way they live and end their lives.

Should they be allowed that?

The Joint Chair (Marcus Powlowski): Answer briefly, Ms. Carr.

Krista Carr: People who have terminal cancer, to your point, under track 1 have the right to access that.

We're talking about expanding this law, first of all, to people who already qualify under track 2 and expanding it even further to a whole other group of people who are even more vulnerable based on the fact that mental illness is predicated on a lot of suicidal ideation. What we are saying is no.

We talk about this—

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

Ms. Jansen, you have two minutes and 50 seconds.

Tamara Jansen (Cloverdale—Langley City, CPC): Ms. Hewitt, I live about an hour outside of Vancouver, and every time I drive down East Hastings, I see hundreds of poor souls living in squalor, danger and deep pain. You said that UBC did a study of the population there and found that 75% are living with mental illness, and they want support, not death.

What are we doing if we expand MAID in that reality? Are we treating suffering, or are we giving up on the sufferer?

Michelle Hewitt: I think we're giving up on the sufferer. Previous witnesses talked about the social determinants of health. If we have not put in place everything that we can possibly do as a society to build people up to where they want to live so they can move beyond surviving to thriving, then we haven't done our job as a society. Offering them MAID is the easiest way out, because it doesn't cost us any money and we don't have to do anything extra.

I find that absolutely appalling. If Victor were here now, he would tell you that his assessment for MAID was the easiest medical assessment he'd been through in his life, and it should not be like that.

Does that answer your question?

Tamara Jansen: Yes.

You said there was no real attempt to explore alternatives that might have helped Victor live. If those safeguards are already failing in today's system, why should anyone believe they're going to work in far more complex cases where mental illness alone is the reason for the MAID request?

Michelle Hewitt: As I said, many of us with disabilities don't exist in a single state of disability. My husband had chronic depression. In his twenties and thirties it was particularly unstable, but ultimately he got it under control. We didn't meet until after that. If MAID had been around then, I would never have met and married my husband.

I think the safeguards that are currently in place are insufficient. I went through a process where I thought I understood what a track 1 MAID patient looked like and what a track 2 MAID patient looked like. My husband has died, and I still don't know whether it was under track 1 or track 2.

● (2040)

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

I have to apologize to Senator Wells. I forgot him.

You have two minutes and 50 seconds.

Hon. Kristopher Wells: Great. Thank you, Chair.

My question is for Ms. Carr.

Thank you for the concerns you've raised today about people feeling driven towards MAID because of poverty and inadequate supports.

Would you agree that the core issue is not MAID itself but the failure of social systems, and that the solution should be to strengthen those supports while still preserving MAID as an option for competent adults experiencing intolerable suffering?

Krista Carr: No, and that is not what we are doing. We are offering MAID to people with disabilities who are not at end of life. That is the only group that is being offered track 2 MAID, and now we're looking at expanding that to 297 more labels under the definition of mental disorder in the DSM-5.

Hon. Kristopher Wells: Would restricting MAID in these cases remove a legitimate choice from individuals who are not being driven by poverty but are making a considered and autonomous decision?

Krista Carr: I guess my question back to you, Senator, would be this: Why then are we not offering...?

If that is the premise, that we're taking this particular special right away from this particular group of people.... If we were worried about that, we would be offering MAID to people not at end of life across the board. It wouldn't be designated for a particular group of people and then further expanded to people with MAID for mental illness.

We would be saying anybody who suffers intolerably and is not at end of life has access to MAID and can go to their family doctor, an assessor or a medical practitioner and request it. That is not what we are saying.

Hon. Kristopher Wells: With respect, that's not what we're studying right now. I can appreciate the concerns.

Do I have any time left?

The Joint Chair (Marcus Powlowski): You have 35 seconds.

Hon. Kristopher Wells: I think I have a second round of questions.

The Joint Chair (Marcus Powlowski): Yes.

Hon. Kristopher Wells: Thank you. I'll cede my time.

The Joint Chair (Marcus Powlowski): Thank you.

Ms. Tesser Derksen, you have three minutes.

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

Thanks so much to our witnesses who are providing testimony tonight, particularly those who are bringing us their lived experiences. Those are really important. We appreciate your sharing those.

I'm going to ask what I hope is a practical question, because I think it's important that we get this on the record with respect to provincial health care system readiness.

I'll address Dr. Frazee first.

A decision to expand MAID to those with mental illness was delayed to give provinces and territories time to analyze their capacity to assess and administer MAID for mental illness safely and in accordance with the law. That's really the core scope of this sitting of our special committee.

I'd like you to comment on your understanding of the current state of readiness of the provinces and territories to do this work.

Dr. Catherine Frazee: Thank you for the question.

The best way for me to respond is from my direct experience and observations working on the curriculum through which MAID practitioners receive their instruction.

My work on that group, when you read my testimony and my article, is that the medical profession has not risen to the gravity of the decisions that we have entrusted them with. They are unable or unwilling to disentangle those structural forces—I believe you're referring to them as social determinants of health. They're unable to disentangle that kind of suffering in cases involving stable physical disability.

I therefore conclude that there is no basis on which to be confident that they will do so when mental illness is the sole underlying condition. In other words, if they cannot or will not apply the very highest level of scrutiny to these assessments and the moral seriousness that these decisions require, they can't be entrusted with greater power and greater authority over the lives of people who are very vulnerable to harm.

● (2045)

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

[*Translation*]

Mr. Thériault, you have the floor for one minute and 50 seconds.

Luc Thériault: Ms. Frazee, the report by the Expert Panel on Medical Assistance in Dying and Mental Illness highlights concerns and outlines a number of principles related to safeguards, particularly regarding systemic inequality. It states: “In the course of assessing a request for MAID—regardless of the requester’s diagnoses—a clinician must carefully consider whether the person’s circumstances are a function of systemic inequality. ”

Recommendation 6 states that it is necessary to “ensure that all requesters have access to the fullest possible range of social supports which could potentially contribute to relieve suffering […].”

This refers to safeguard measure 241.2(3.1)(g), which requires ensuring that the person has been informed of the means available to alleviate their suffering, particularly when indicated.

We must therefore be able to address structural vulnerabilities.

Wouldn’t these guidelines be sufficient, in your view, if they were applied correctly?

[*English*]

Dr. Catherine Frazee: No, with respect, they are not. Thank you for the question.

Perhaps I can best answer with reference to just one case among the many that I speak of in my paper. That is a case of a young man in his twenties who wanted MAID because he was desperately lonely and felt that he would never find a loving relationship and have what he considered a normal family.

I would suggest to you that the roots of this problem, the roots of the suffering that MAID is being deployed to address, are very deep. How on earth can we safeguard against heartbreak, which was what motivated this man to request MAID? He did die, by track 2 MAID, of a broken heart, frankly, and desperate loneliness. We can't safeguard against that.

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

Next is Senator Wallin for one minute and 50 seconds.

Hon. Pamela Wallin: Thank you.

I guess I just feel that we should put on the record here tonight some balance. We are in the process of declaring an entire profession—doctors, MAID providers, mental health professionals—incapable of understanding matters of life and death and that this entire group of people is inclined to break the law and risk their licences from some desire to provide MAID to people who don't want it.

I guess I'll ask Dr. Frazee that question: Are there no other kinds of doctors in Canada?

● (2050)

Dr. Catherine Frazee: They're not breaking the law. That's the problem. They're interpreting the law liberally. They have—

Hon. Pamela Wallin: Certainly they would be breaking the law if they were providing MAID to those with mental illness as a sole underlying cause, which many of you seem to be suggesting.

Dr. Catherine Frazee: I'm not sure any of us did suggest that.

What I'm suggesting is that they're in a position where much of the suffering that their patients are speaking of is not medical in nature, yet under the MAID regime, as long as there is a significant physical disability to which this suffering can, at least in part, be attributed, then the requirements for eligibility are met and it's a legal death. However, that isn't, surely, what this Parliament or the court intended.

The Joint Chair (Marcus Powlowski): Thank you.

Last of all we go to Senator Wells for one minute and 50 seconds.

Hon. Kristopher Wells: Thank you.

Dr. Frazee, the committee received a letter from the president of the Federation of Medical Regulatory Authorities of Canada, signed by the medical regulatory heads from across Canada, all saying that medical regulatory authorities in Canada are ready for the expansion of MAID for persons with a mental illness.

Based on what you've shared with us today, what additional evidence should Parliament consider before expanding track 2 MAID for persons with a mental illness, knowing that the regulatory bodies have clearly said they have a duty to be ready?

Dr. Catherine Frazee: I would request that you pay close attention to the evidence and the arguments being advanced right now in the constitutional challenge to track 2 MAID that I'm sure you're aware of as it works its way through the courts. You have heard and you will hear from many of the organizational plaintiffs representing people with disabilities across the country. I hope our voices will be heard.

Hon. Kristopher Wells: Would you say we should leave this decision up to the courts rather than Parliament?

Dr. Catherine Frazee: No, I'm sorry. I didn't mean to imply that. I meant that you will find well-reasoned evidence ready for your review and for you to weigh and to give weight to in appropriate measure, and not just what the provinces are saying.

Hon. Kristopher Wells: Thank you very much.

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

With that, we conclude the second panel. I would like to thank all the witnesses for coming today and for their very important testimony. We certainly have heard from you. Thank you.

We will suspend.

● (2050)

_____________________(Pause)_____________________

● (2055)

The Joint Chair (Marcus Powlowski): I call the meeting back to order for the third and last panel.

In this panel, we have Dr. Kerri Froc, associate professor at the University of New Brunswick; Daphne Gilbert, full professor at the University of Ottawa's faculty of law; and Isabel Grant, University Killam Professor, University of British Columbia, who will be sharing her time with Elizabeth Sheehy, professor emerita of law at University of Ottawa, by video conference.

I'll start with Dr. Froc, followed by Dr. Gilbert, followed by the two on video.

Each of you has five minutes. With about 30 seconds to go, I will try to indicate that fact.

Dr. Kerri Froc (Associate Professor, University of New Brunswick, As an Individual): Thank you very much. Good evening. I very much appreciate the invitation to appear.

I'm a constitutional law professor at the University of New Brunswick. My teaching and research focuses on the charter, equality rights and the interaction of equality and section 7. I publish extensively in those areas.

At the outset, I want to be clear that the charter does not require extension of MAID to mental illness as a sole underlying condition. Carter does not establish that requirement and section 15 does not compel it.

I'd like to make three points. The first is that Carter does not constitutionally require the extension of MAID to mental illness. The second is that any group advancing a section 15 equality claim must demonstrate that partial decriminalization transforms an exemption from criminal liability into a benefit under federal law. This would be a novel claim with no authoritative precedent. The third is that even if that hurdle is overcome, substantive equality under section 15 does not require full decriminalization. Truchon assumes that equality requires identical treatment as between groups with disabilities. It does not.

Turning first to Carter, it was a section 7 decision grounded in causation. The claimants had to show that state action caused the deprivation of life, liberty or security of the person.

The violation of the right to life depended on the Supreme Court's acceptance that the law caused premature death. It accepted that some individuals with “grievous and irremediable” conditions would take their own lives prematurely for fear that they would be incapable of doing so when their suffering became intolerable. This “cruel choice”, in the court's words, also imposed psychological suffering.

At the point of physical incapacity, the prohibition engaged liberty and security of the person because it precluded autonomy over one's life and it prolonged suffering. Carter did not mandate the extension of MAID beyond that defined class.

The court accepted that the state has a legitimate objective in protecting vulnerable persons from being induced to commit suicide and that carefully designed limits are permissible. It says that drawing lines is justifiable through “stringent limits that are scrupulously monitored and enforced.”

I will now turn to Truchon and section 15. Truchon is often relied upon to support an equality argument, but the case is less stable doctrinally than is sometimes suggested. Section 15 is engaged when the state provides a benefit or imposes a burden unequally. Parliament is not providing MAID as a benefit. It has created a limited exemption from the criminal law. Characterizing that exemption as a benefit would be a significant and novel extension of section 15, not supported by existing Supreme Court jurisprudence, such as Auton, or any other lower court decision. Parliament, under the Criminal Code, is not providing access to MAID to anyone.

Moreover, even if the “benefit” framing is accepted, section 15 prohibits distinctions that are substantively discriminatory—those based on prejudice, stereotyping or that perpetuate disadvantage. Here the distinction reflects the recognized limits of medical knowledge, the inability to reliably determine irremediability in mental illness and the difficulty of separating suicidality from MAID requests. Treating those differences as material is not stereotyping or perpetuating disadvantage. Section 15 requires evidence about the claimant group, and differential treatment that corresponds to their circumstances is not discriminatory—

● (2100)

The Joint Chair (Marcus Powlowski): You have 30 seconds left.

Dr. Kerri Froc: Okay.

Truchon did not address the benefit problem and equality is not about the ability to make choices exclusively. It's only when limits on autonomy are linked to stereotyping or the perpetuation of disadvantage that they may result in a violation of section 15.

Therefore, the current law reflects an attempt to respond to materially different risk profiles in a way that manages the distinct nature of mental illness in the MAID context.

Thank you, and I would appreciate any questions.

The Joint Chair (Marcus Powlowski): Thank you.

Professor Gilbert, you have five minutes.

Professor Daphne Gilbert (Full Professor, University of Ottawa, Faculty of Law, As an Individual): Members of the committee, thank you for inviting me to join you this evening. I'm realizing that tonight, I'm the odd person out in this gathering.

My name is Daphne Gilbert. I am a full professor at the University of Ottawa, faculty of law. I have taught constitutional and criminal law for over 25 years and have researched MAID since the Carter decision. I am also vice-chair of Dying with Dignity Canada, though I appear here in my individual capacity as a law professor.

I will focus my remarks solely on MAID where mental illness is the sole underlying condition, MI-SUMC, as I understand this committee's mandate to be limited to that issue and not to all of track 2 MAID.

The exclusion of individuals who would otherwise qualify for MAID but for the fact that their grievous and irremediable condition is a mental illness is discriminatory and violates section 15 of the charter, the equality guarantee. It has been six years since the government accepted that it had to permit people with MI-SUMC to request MAID, yet it continues to delay implementation.

I will quote the Supreme Court of Canada in Attorney General v. G, a 2020 decision:

> People with mental illnesses face persistent stigma and prejudicial treatment in Canadian society, which has imposed profound and widespread social, political, and legal disadvantage on them.

This exclusion adds medical disadvantage to that list.

Consider the classic image of an iceberg. The small visible tip above water represents the very limited number of individuals who would ultimately qualify for MAID MI-SUMC. Clinicians agree that only a small number of people will ever meet the stringent eligibility criteria and rigorous safeguards. This matters because one justification for continued exclusion is a speculative claim that large numbers of people will become eligible if the ban is lifted. There's no evidence to support that claim.

The much larger mass of ice beneath the surface represents the thousands of individuals harmed by the language and rationale of exclusion. They are harmed by the suggestion that because of mental illness, they lack decision-making capacity, must be protected from themselves and that their suffering is somehow less real or less serious than physical illness.

In 2026, we are reinforcing historical stigma and paternalistic assumptions, attitudes we claim to reject. Public campaigns, like Bell's Let's Talk days, encourage honest conversations about mental health, but the law continues to infantilize those with mental illness. Our commitment to equality is measured not by empty messaging but by equal legal treatment.

As affirmed in 2026 by the Supreme Court of Canada, the section 15 analysis has two steps.

First, does the law create a distinction based on an enumerated or analogous ground? Here, it clearly does. The exclusion differentiates on the basis of disability by treating those with mental illness differently from those with physical conditions.

Second, does the law impose a burden in a way that reinforces, perpetuates or exacerbates disadvantage? Again, the answer is yes. The law denies access to MAID and, in doing so, reinforces stigma and harmful stereotypes: that individuals with mental illness are incapable and in need of protection from themselves. These messages affect not only the small number who might qualify, but also the broader community, who hear them echoed in legal and policy settings like these committee sessions.

This breach of section 15 cannot be justified under section 1. The stated objectives—protecting vulnerable individuals and ensuring system readiness—do not support a blanket exclusion. Following repeated extensions, there is no clear benchmark for readiness. A constitutional violation cannot rest on an undefined and shifting standard. In contrast, those working within the MAID system have indicated that they are ready. Nor is the exclusion minimally impairing. A blanket prohibition denies any possibility of individualized assessment. At minimum, there must be a mechanism to allow individuals to be assessed, as discussed in the G case.

● (2105)

Finally, the exclusion produces no salutary effects. Rather than protecting vulnerable individuals, it deepens stigma and marginalization.

I remind this committee that decision-making capacity is at the heart of all MAID requests. To suggest that an entire category of competent adults should be denied a legal medical service is profoundly discriminatory.

I look forward to your questions.

The Joint Chair (Marcus Powlowski): You're under time.

Professor Sheehy and Professor Grant, you have five minutes between you. I assume you know who's going to start.

Professor Elizabeth Sheehy (Professor Emerita of Law, University of Ottawa, As an Individual): Yes, that's me. Thank you.

Thank you for inviting us to speak to the committee tonight. I will deliver our remarks and Professor Grant will answer questions.

Professor Grant and I are legal scholars with a combined 75 years of collective experience working on violence against women. We've published multiple papers on track 2 MAID. If MAID is extended to those whose sole disabling condition is mental illness, it will disproportionately end the lives of mentally ill women, just as track 2 already disproportionately ends the lives of disabled women. As scholars who have devoted their lives to ending violence against women, we urge you not to take this discriminatory path.

The UN Committee on the Rights of Persons with Disabilities highlighted the ableist assumptions underlying track 2 and urged its repeal, including the planned extension to mental illness. The committee expressed its concern about the disproportionate number of women accessing track 2 and the role of gender-based violence in the marginalization of disabled women.

It's important to understand that when one allows doctors to provide MAID to people to end difficult lives as opposed to hastening difficult deaths, one inevitably targets the most marginalized Canadians. Health Canada data backs this up. Approximately 59% of all track 2 deaths in 2022 and 2023 were women, as were 57% in 2024. Track 2 recipients are younger, more likely to live alone and more likely to report loneliness, perceived burdensomeness and a lack of dignity in their lives as reasons for seeking MAID. Ontario data suggests they are more likely to live in the most marginalized neighbourhoods and less likely to have family members as next of kin. Professor Grant has demonstrated the discriminatory impact of track 2 on women, which will only worsen if MAID is extended to mental illness.

When we examine the jurisdictions that allow psychiatric euthanasia, we see it's overwhelmingly women who are dying. In one study, researchers found that of 100 patients who applied for psychiatric euthanasia in Belgium based on at least one psychiatric disorder, 77% were women. Those women were on average just 47 years old. Dr. Marie Nicolini and her colleagues found that between 69% and 77% of those receiving psychiatric euthanasia in countries where it is allowed are women.

Research helps explain why this pattern occurs. Dr. Nicolini explains that the gender breakdown for psychiatric euthanasia is virtually identical to the gender breakdown for attempted suicide. Almost twice as many women attempt suicide, but more men complete it, because men choose more violent means to end their lives. Most women who attempt suicide do not go on to die from suicide. Psychiatric euthanasia risks turning the disproportionate numbers of women who attempt suicide into completed suicide by offering a way to die that is portrayed as peaceful and painless.

Male violence contributes to women's mental illness through such conditions as depression and PTSD, but this violence is also disproportionately targeted at women with mental illness. Stats Canada data indicate that 25.9% of women with mental illness report sexual violence, at least double the rate experienced by other women. People with mental health disabilities also face three times the risk of intimate partner violence.

Alarmingly, male violence also contributes to suicidality. A recent study published in The Lancet demonstrated that women who have experienced intimate partner violence were four times more likely than other women to have attempted suicide. Those who had experienced sexual abuse within a relationship were seven times more likely to have attempted suicide. Data from the Netherlands and Belgium show that 36% of those who died from psychiatric MAID had a history of trauma—for example, from physical and sexual abuse. We know that it is women who are disproportionately subjected to physical and sexual violence, yet Canada collects no data on the role of trauma in MAID requests.

● (2110)

The Joint Chair (Marcus Powlowski): You have 30 seconds to finish.

Prof. Elizabeth Sheehy: Canada's resources should be focused on providing better supports for women with mental illness to escape male violence and to live dignified lives, not on developing secretive curricula for training people to facilitate their suicides.

We urge this committee to take the UN recommendations seriously and have the courage to put an end to the prospect of MAID on the sole basis of mental illness. Canada will never be ready to facilitate the suicides of women with mental illness.

Just as a reminder, please direct your questions to Professor Grant. She will respond on behalf of both of us.

Thank you.

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

First up is Mr. Cooper for four minutes and 50 seconds.

Michael Cooper: Thank you, Mr. Chair.

Professor Froc, the only time that the Supreme Court, in Carter, touched on MAID for psychiatric disorders was in the context of finding that slippery slope concerns and data from other jurisdictions were not relevant because they "would not fall within the parameters suggested in these reasons"—this is at paragraph 111—that they are "the product of a very different medico-legal culture" and that "These cases offer little insight into how a Canadian regime might operate."

Do I have that right?

Dr. Kerri Froc: That's right. Carter was responding to a very particular set of facts before it. Those facts and the evidence included the evidence from other countries. It was specifically asked and talked about MAID in relation to mental illness at one paragraph. It said that it was not dealing with that case, and it was not dealing with that on the facts before it. Those are really the limitations of Carter.

Carter also didn't deal with section 15, which I'm pleased to talk about, too, because I don't think equality rights mean extending the criminal exemption as well.

● (2115)

Michael Cooper: Just to be clear, nowhere in Carter did the court specifically recognize a charter right with respect to MAID in the context of mental illness being the sole underlying condition.

Dr. Kerri Froc: No. Carter was dealing with a blanket prohibition that existed at the time. It was asked to evaluate that blanket prohibition in relation to section 7. As I mentioned, it was dealing with state action there, because the court accepted, on the facts, that people possibly were terminating their lives prematurely because they may become physically incapacitated. We're not dealing with that here with mental illness.

Michael Cooper: Professor Downie and others have cited the 2016 E.F. decision, but in E.F., the court—in that case the Alberta Court of Appeal—made no pronouncement on the constitutionality of a legislative response that might exclude MAID for mental illness. Is that correct?

Dr. Kerri Froc: As I understand E.F., it was based on asking for an exemption, which was permitted under the Carter decision. As I understand E.F., it was in relation to having a psychiatric overlay to a physical condition. In that respect, it's not a precedent for anything. It was simply asking for an exemption.

Michael Cooper: That's right, and the court said expressly in paragraph 24, "These are not individual constitutional challenges." They were dealing with whether or not the applicant qualified for the constitutional exemption at the time before the passage of Bill C-14.

You touched upon Truchon. Just to be clear, in that case the question before Madam Justice Baudouin was not concerning a condition of a sole underlying mental health disorder. Is that right?

Dr. Kerri Froc: That's right. The thing about Truchon is that in the evidence before that case, it was dealing with people who had grave, irremediable physical conditions but just couldn't meet the standard that their death was reasonably foreseeable. Obviously, that doesn't apply in the case where the sole underlying condition is mental illness.

Michael Cooper: At paragraphs 386 and 387 of that decision, Madam Justice Baudouin said:

> Neither Mr. Truchon nor Ms. Gladu has a psychiatric illness that could be related to their request for medical assistance in dying.
>
> Therefore, the relevance of any evidence adduced by the Attorney General of Canada on the subject of people who might avail themselves of medical assistance in dying based solely on a psychiatric illness is doubtful, to say the least.

In other words, it wasn't relevant to the issue before Madam Justice Baudouin, which she was to determine.

Dr. Kerri Froc: That's right.

Michael Cooper: Therefore, to date, no Canadian court has specifically recognized a charter right to MAID where mental illness is a sole underlying condition. Is that right?

The Joint Chair (Marcus Powlowski): Give a very brief answer.

Dr. Kerri Froc: That's right.

Michael Cooper: Why should we presuppose—

The Joint Chair (Marcus Powlowski): I'm sorry, but your time is up.

Dr. Jaczek.

Hon. Helena Jaczek: Professor Gilbert, your work has examined MAID through a charter lens and an access-to-care lens. This evening, we've heard certain concerns that track 2, to date, has been, in some way, particularly offered to those with a disability, where social support or other interventions could mean that track 2 is, perhaps, inappropriate.

Could you tell us what the stats actually show—what the data is? I believe there are annual reports. Could you detail for us who is accessing MAID through track 2?

● (2120)

Prof. Daphne Gilbert: I recommend to the committee that you consider inviting Dr. James Downar and Dr. Kieran Quinn, who published an empirical study in the fall of 2025 that looked at all the data around track 2 MAID.

With respect to the question on marginalization, by every metric, MAID recipients are less marginalized than the appropriate comparator. MAID recipients are overrepresented in the highest income quartile relative to the general population of natural deaths. We understand that most MAID recipients are white and educated, and they have means.

As far as statistics on gender go, it is true that there are slightly more women than men availing themselves of track 2 MAID. That tracks with the epidemiology of populations with chronic conditions. Women are more likely to develop these conditions and less likely to die from them. It's not a purely gender-driven issue.

Hon. Helena Jaczek: Thank you for the clarification.

Professor Sheehy made some comments in relation to international experience.

What would you recommend in terms of potential safeguards, should medical assistance in dying be available where the sole underlying condition is a mental illness? What do you see as some of those requirements?

Prof. Daphne Gilbert: I think the existing safeguards are more than adequate to deal with adding mental illness as a sole underlying condition.

I have found it very troubling today to hear MAID providers described as murderers. If there are egregious provisions happening, there should be criminal charges laid. There should be reports to the police. There has never been a criminal prosecution of a MAID provider. Similarly, they could be reported to the appropriate college. Again, we don't know of any disciplinary proceedings that have successfully resulted in any sanction for a MAID provider.

I think the existing safeguards are very strong. There are multiple criteria that have to be fulfilled, and these can accommodate MI-SUMC.

Hon. Helena Jaczek: Thank you.

The Joint Chair (Marcus Powlowski): Thank you.

[*Translation*]

Mr. Thériault, you have the floor for four minutes and 50 seconds.

Luc Thériault: Thank you.

Ms. Gilbert, Quebec enacted the Act Respecting End-of-Life Care even before the Supreme Court issued the Carter ruling. Because of that decision, Quebec had to amend its original law, which had only allowed medical assistance in dying in circumstances where people were terminally ill, at the end of life.

However, it was through the Truchon and Gladu cases, as well as Judge Baudouin’s ruling, that Quebec later realized its law excluded a certain number of people and could be discriminatory. Quebec’s law has recently been amended.

In addition to its end-of-life care law, Quebec has established a commission tasked with compiling records and reviewing them as necessary. Every instance of medical assistance in dying is subject to review, if necessary.

I don’t know, and this seems to be the case in other parts of Canada, but it might be a solution for people who are concerned about how care is provided.

Professor Downie, who appeared before the committee, told us that a blanket ban targeting individuals whose only underlying health condition was a mental disorder ran counter to the Carter ruling, because it did not allow for individualized assessments.

I imagine you agree with that, don’t you?

[*English*]

Prof. Daphne Gilbert: I agree.

[*Translation*]

Luc Thériault: The professor also noted that a temporary exclusion from access to medical assistance in dying for MAID MD-SUMC constitutes a violation of sections 7 and 15 of the Canadian Charter of Rights and Freedoms and cannot be justified under section 1.

She refers, among other things, to Justice Sheehan’s decision in the Truchon case.

I will quote an excerpt:

> […] the rights that are guaranteed must prevail over a legislative intent that could not be carried out within a reasonable time frame.

What she pointed out is that we are in a time frame that might seem unreasonable by constantly postponing the effective date of the law regarding medical assistance in dying.

What do you think?

Are we complying with section 1 of the charter by constantly postponing the decision?

● (2125)

[*English*]

Prof. Daphne Gilbert: My recollection of Professor Downie's testimony is that she pointed out to the committee that this has been by far and away the longest extension of a suspended remedy in charter history. It's been six years. That is an incredibly long period of time to suspend charter rights.

I know the committee is going to hear from CAMAP and FMRAC on the medical regulatory authorities' oversight on MAID, but it exists and it is robust across the country.

The G decision from 2020, which talked about individualized assessments under section 15, is a really important reminder that blanket prohibitions don't withstand charter challenges.

[*Translation*]

Luc Thériault: In the event that committee members do not agree on the interpretation of the Carter ruling—two witnesses have already offered differing interpretations—do you believe it would be important to seek an opinion from the Supreme Court so that it may advise us on how we should interpret this decision?

[*English*]

Prof. Daphne Gilbert: I have no doubt that this issue will make its way to the Supreme Court of Canada. There is a charter challenge right now in Ontario to the continued exclusion of MI-SUMC. I suspect that we will get the voice of the Supreme Court weighing in on this at some point. It will be an important voice, but it can't alleviate this committee's or this government's obligation to be respectful of charter rights and do what is right for Canadians.

The Joint Chair (Marcus Powlowski): Thank you.

Senator Dalphond, you have three minutes.

[*Translation*]

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

[*English*]

Thank you to the witnesses.

My questions will be directed to Ms. Gilbert.

You are part of Dying With Dignity. You are one of the advisers on legal issues. In August 2024, you were quoted in a press release that announced the launch of a constitutional challenge before the Ontario Superior Court of Justice.

Here we are, a year and a half later. Where are we now in this file? Are we going to proceed soon?

Prof. Daphne Gilbert: I would love it if someone from the government would let me know.

We are expecting the government's response materials at the end of April. We have filed our claim and we have filed all of our expert opinions. We're just waiting for the Department of Justice to catch up.

Hon. Pierre Dalphond: I see.

Is there court management for that file?

Prof. Daphne Gilbert: There is, and we hope that in the next week, we'll have those materials.

Hon. Pierre Dalphond: Is there a date scheduled for the hearing?

Prof. Daphne Gilbert: No. It's my understanding that Ontario is incredibly backed up in its court dates. We're not anticipating a date until sometime in 2028.

Hon. Pierre Dalphond: I understand that the preferable route would be to go straight to the Supreme Court on a reference case.

Prof. Daphne Gilbert: That would be an option. I'm not sure it's necessary, because I think the government—

Hon. Pierre Dalphond: You're going there.

Prof. Daphne Gilbert: Eventually...but I also think the government can make a decision to lift the exclusion in March. That would be the right thing to do, instead of forcing people to go to court.

Hon. Pierre Dalphond: Thank you.

The Joint Chair (Marcus Powlowski): Thank you.

Senator Martin, you have two minutes and 50 seconds.

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

This question is for Dr. Froc.

We've heard deep expert disagreement about irremediability and suicidality in regard to mental illnesses. If the core criteria themselves are not reliably assessable, is Parliament entitled to keep the exclusion in place under the charter?

● (2130)

Dr. Kerri Froc: Yes. Essentially, what section 15 says is that sometimes differential treatment is required for equality.

Now, we have various unresolved issues with respect to mental illness, as you've pointed out, and equality doesn't mean that you have to ignore those. If you, as a committee and a Parliament, decide that mental illness as the sole underlying condition presents special problems of prognosis, irremediability and suicidality, then drawing a distinction on that basis is not necessarily going to be found to be discriminatory by a court.

In fact, as you've heard, there's a competing equality consideration that you've heard from disability rights organizations that say removing criminal protection from this group rests on an ableist principle that their lives are not worth living and that death is a better option for them. I commend Dr. Isabel Grant's section 15 article about that very thing.

What I want to emphasize, however, and what my colleague and friend, Dr. Gilbert, neglected to talk about, is that the very first thing you have to prove under a section 15 analysis is that there's a benefit under law. You don't even get to the equality test, the two-part equality test, unless you can show that, and the variation through the provinces.... We have Alberta now passing its own legislation. Quebec has its own legislation.

Provinces are the ones that provide MAID. Even accepting that MAID provision is a benefit, this is not under the federal law. The federal law is only granting an exemption to criminalization. Therefore, section 15 may not even apply here.

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

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

Next, we have Senator Loffreda for two minutes and 50 seconds.

Hon. Tony Loffreda: Thank you, Mr. Chair.

Thank you to all our panellists for being here. My question is for Professor Gilbert.

Your work is focused extensively on equality rights and removing discriminatory barriers in access to MAID.

How do you reconcile the expansion of access based on equality rights with the obligation of the state or the government to protect individuals who may be vulnerable due to mental illness, particularly where capacity, irremediability and external pressures are difficult to assess?

Where should Parliament draw the line between expanding rights and ensuring sufficient safeguards?

Prof. Daphne Gilbert: I would defer to clinicians with respect to how they go about making their assessments in terms of the medical process for that, but the legal safeguards are very strong. It's not only that you have the condition. It's not only that you have the mental illness. It has to be a serious mental illness. It has to have enduring physical or psychological suffering that is intolerable to them. The word “enduring” says to me a length of time, a lengthy period of time. You have to be in an advanced state of irreversible decline in capability.

These are all qualifiers to the definition of what a grievous and irremediable condition is. It's not just that you have the mental illness or a disability. It's that you have all of these other qualifiers that make it a much more serious condition, which I then trust our clinicians to be able to assess.

Hon. Tony Loffreda: Thank you.

Thank you, Mr. Chair.

The Joint Chair (Marcus Powlowski): Thank you.

Next, we have Senator Wallin for two minutes and 50 seconds.

Hon. Pamela Wallin: Thank you.

Professor Gilbert, you are indeed one out of nine or 10 witnesses tonight on the other side of the issue. The testimony has been quite imbalanced on that score. I'd like to hear from you as to what you actually think the limits now are on the federal government. You've talked about six-year delays: that the government could simply move to lift this restriction and they would be in compliance with the law.

The second part of my question is about the provinces and where they stand, because we are told that they have the power to make the rules and the access much more restrictive, but they can't make it wider; they can't make something illegal legal.

Could you answer on where the feds are and where the provinces are?

Thank you.

● (2135)

Prof. Daphne Gilbert: I do think that the task for the government is simple, and that is to lift the exclusion. As I said, the government has already accepted that it eventually has to include MI-SUMC. A six-year delay was unnecessary, but that's what we have and we shouldn't add to it in any way.

As far as the provinces are concerned, the provinces are also required to be charter-compliant. In terms of whatever restrictions provinces put into place with respect to MAID, they will have to make sure that they come, very clearly, within the health authority that the provinces have and that they're not a colourable attempt to regulate in criminal law. There will be charter challenges, I'm sure, in the provinces, which is why it would be preferable, in my opinion, if the federal government had a strong message around where it stands on MI-SUMC.

Hon. Pamela Wallin: Does that require a change to the Criminal Code or a continued exemption from it?

Prof. Daphne Gilbert: All it would require is to lift the sunset clause to lift the exemption, and then mental illness would be part of track 2, with all of the safeguards inherent in track 2.

Hon. Pamela Wallin: Do you think we are going to have to go through this process through the courts in 10 provinces and three territories?

Prof. Daphne Gilbert: We certainly have it already happening in Ontario, and I would imagine it will follow suit across the country if we don't lift the exclusion.

Hon. Pamela Wallin: Thank you.

The Joint Chair (Marcus Powlowski): Thank you.

We go to Professor Wells for two minutes and 50 seconds.

Hon. Kristopher Wells: Thank you.

My questions are for Dr. Gilbert.

We've heard many references, including here today, to the UN special rapporteur, the three UN experts and the UN Committee on the Rights of Persons with Disabilities and the conclusions they have drawn with respect to MAID in Canada.

Do you believe it would be reasonable for us as committee members to base any conclusions about MAID MI-SUMC on these documents?

Prof. Daphne Gilbert: There is nothing on the record in that report, or in the committee reports from the UN, that show they consulted with anyone outside of those who are opposed to MAID MI-SUMC. They didn't talk to any experts or people with lived experience who were not opposed. They had a private briefing session with organizations that only brought the anti-track 2 perspective.

I think it's hard to base profound decisions like what you're facing on a report that is based on very one-sided submissions. It would be better to consider the research that is objective and based on looking at both sides of the issue.

Hon. Kristopher Wells: It sounds like that's a reminder to our committee to ensure that we are balanced in perspectives over the course of our hearings and that we do not favour any one side over the other. Thank you for that.

Is it true that the plaintiffs in Truchon and Gladu were persons with disabilities and, for example, were not on what came to be known as track 1?

Prof. Daphne Gilbert: Yes.

Hon. Kristopher Wells: Is it true that decisionally capable people with disabilities have the legal authority to refuse life-sustaining treatment?

Prof. Daphne Gilbert: Yes. If they have capacity, they can make decisions about their treatment.

Hon. Kristopher Wells: Is it true that decisionally capable people with disabilities living in circumstances of what some describe as internalized ableism or socio-economic vulnerability or marginalization have the legal authority to refuse life-sustaining treatment?

Prof. Daphne Gilbert: As long as all of their options are carefully reviewed with them, as required by the legislation, then yes.

Hon. Kristopher Wells: Is it true that decisionally capable people with serious mental illness have the legal authority to refuse life-sustaining treatment, even when the consequence of that refusal will be death?

Prof. Daphne Gilbert: Yes, capable people can choose death.

Hon. Kristopher Wells: Is it true that decisionally capable people with serious mental illness living in circumstances of socio-economic vulnerability and marginalization have the legal authority to refuse life-sustaining treatment?

Prof. Daphne Gilbert: Yes. Again, as long as their options are carefully reviewed with them, as the legislation requires, then yes.

Hon. Kristopher Wells: Thank you.

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

We will go to the last round.

Ms. Jansen, you have two minutes and 50 seconds.

Tamara Jansen: A woman's assisted suicide request is rooted in violence, trauma or abandonment, and Canada responds by making her eligible for MAID on the basis of mental illness.

Is that really about autonomy, or is that a profound failure of protection, Dr. Grant?

Professor Isabel Grant (University Killam Professor, Peter A. Allard School of Law, University of British Columbia, As an Individual): Obviously, I think that's a profound failure of the system in a number of ways, not just in terms of protection but in terms of the fact that we have woefully failed to provide the resources that women need to escape violence.

Much of my research has focused on how women with mental illness are particularly targeted for violence and for sexual violence. The idea that death to the victim would be an appropriate response to violence against women is utterly untenable.

If I could just mention it, Professor Sheehy and I participated in the UN hearings. It was open to any organization that wanted to make a submission. I do take issue with the assertion that they were having secret meetings. Those meetings were open to any organization that wanted to make a submission.

● (2140)

Tamara Jansen: Canada doesn't even systematically track trauma, abuse or violence in MAID requests, so how can Parliament consider expanding MAID for mental illness when it's still blind to some of the very factors that are driving women towards death through MAID?

Prof. Isabel Grant: I think the work of Dr. Nicolini and the work of Dr. Kim have really demonstrated the degree to which trauma and history of violence contribute to a desire to die, either through suicide or through psychiatric euthanasia. I just don't see a safeguard that's going to prevent that in a world where women are facing violence.

Tamara Jansen: Thank you.

I'll cede my time to Mr. Lawton.

Andrew Lawton: Thank you.

Professor Gilbert, you've spoken, advocated and written that health care facilities that are publicly funded should not have the right to not offer MAID on the basis of a religious objection. We have had testimony from numerous psychiatrists and medical practitioners who do not feel, for medical reasons and knowledge of psychiatry, that MAID for mental illness should happen at all, irrespective of safeguards.

Do you believe that health care facilities should be allowed, if this expansion proceeds legally, to not offer this to people with mental illness, solely based on that?

The Joint Chair (Marcus Powlowski): Answer very briefly.

Prof. Daphne Gilbert: I believe that individual practitioners have the right to have a conscientious objection but that institutions do not.

Andrew Lawton: Then you'd force institutions to euthanize people with mental illness, even if they don't believe it's medically legitimate?

Prof. Daphne Gilbert: I would say that institutions don't have charter rights.

The Joint Chair (Marcus Powlowski): Thank you.

Kristina, you have two minutes and 50 seconds.

Kristina Tesser Derksen: Thanks, Mr. Chair.

I want to take us back to the charter, particularly with respect to compliance, and this is for Professor Gilbert.

I'm going to rely a little bit on Morgentaler because I think there are some lines to be drawn here. In that case, Justice Wilson stated that she believed “that the framers of the Constitution” were contemplating “the freedom of the individual...to make his own choices for good or ill”. I believe those were her words. This was implying the right to make decisions about one's end of life, including through MAID, as a fundamentally personally autonomous choice.

You mentioned that you believe MAID provisions would be saved by section 1 of the charter. Is it safe for me to presume that this is based in part on the contention that although consenting to medical treatment is different from consenting to MAID, the same basic conditions apply in both situations—that is, a capacity assessment must be completed by a medical practitioner?

Prof. Daphne Gilbert: First of all, Justice Wilson in Morgentaler spoke really passionately about the fact that people should have the right to make fundamental life choices, which would include the most fundamental: when you want to die or how you want to die, if you are eligible for MAID.

As far as capacity assessments are concerned, of course people can only receive MAID if they are capable of understanding and consenting to MAID. There are additional safeguards around that in the legislation, such as that they have to be informed of all of their alternatives and that they have to have considered what else could be done for them. The practitioner has to be satisfied that they have actually seriously considered those things. That's all in the legislation.

Kristina Tesser Derksen: That's perfect. Thank you.

I'll just lead off of that.

We heard concerns from a previous witness tonight about the importance of requisite capacity in providing consent for medical decisions, particularly in accessing MAID. She represented folks with intellectual disabilities. It could be argued that consent is actually impossible in that context because those Canadians lack the intellectual capacity to understand the consequences of those decisions.

Can you comment on your understanding of the legal nexus, in the MAID context, between an intellectual disability and the ability to consent?

Prof. Daphne Gilbert: Again, I'm not a clinician, so I really can't comment on how capacity assessments are done. That is totally in the purview of medical professionals. I think that people with intellectual disabilities can sometimes have capacity. It would all depend upon the assessment of the provider.

● (2145)

Kristina Tesser Derksen: Thank you.

I'll yield the rest of my time.

The Joint Chair (Marcus Powlowski): Thank you.

[*Translation*]

Mr. Thériault, you have the floor for one minute and 50 seconds.

Luc Thériault: Thank you, Mr. Chair.

Ms. Gilbert, how do you explain that the history of medical assistance in dying in Canada always stems from a Supreme Court ruling before parliamentarians can finally legislate?

How can this be explained, and how do you explain it to yourself?

[*English*]

Prof. Daphne Gilbert: I appreciate that it's very hard to be in your position. It's very hard to be in the position of having to legislate around really complicated social issues. I'm not surprised that so many of these issues—like abortion, like MAID—ended up at the Supreme Court of Canada. I think it's very hard for you to weigh all of the conflicting constituents that you have and their different opinions. Really, it is the court's ultimate role to pronounce on charter rights.

I think, though, that the government, when it knows what the charter right is and knows what the entitlements are, should act to do that.

[*Translation*]

Luc Thériault: Isn't it up to legislators to make laws and to make them with the well-being of the people they represent in mind?

In that sense, isn't it abnormal that, following the Carter ruling, we are still placing the burden on citizens—on people who are suffering—to assert their rights, and that Parliament then has very little time to discuss these issues?

Our committee will be six years old in 2027.

Is it not abnormal to place the burden on citizens?

[*English*]

The Joint Chair (Marcus Powlowski): Reply quickly, please.

Prof. Daphne Gilbert: I think it is very unfair.

The Joint Chair (Marcus Powlowski): Thank you.

Senator Dalphond, you have one minute and 50 seconds.

Hon. Pierre Dalphond: Thank you.

I'm coming back to this pending litigation. Was intervenor status granted to some organizations, so far?

Prof. Daphne Gilbert: No, we have not reached the state yet where we are welcoming intervenors.

I want to say one thing about that litigation in terms of the burden that we put on people. We had two plaintiffs with lived experience of severe and profound mental illness, over decades. One of those plaintiffs dropped out because the litigation was taking too long and the burden on them was too onerous. That's a very real consequence of litigation. Had we not continued the extension, then that burden would have been put on those people.

Hon. Pierre Dalphond: I certainly shared these comments in my dissent in the last report. I made it clear that we should refer the matter to the Supreme Court right away, just to end the suffering and to make a clear path for the people to know if they have access to it or not.

I thank all the witnesses for their presence tonight.

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

Finally, we have Senator Martin for one minute and 50 seconds.

The Joint Chair (Hon. Yonah Martin): That's very little time. I guess this is the last question.

I will direct it to you, Dr. Grant.

We heard that expanding MAID would “disproportionately end the lives of...women”. You can comment on that or anything else you heard, if you wish to have the final say.

Prof. Isabel Grant: Thank you.

We have to be really suspect of any federal law that is disproportionately going to result in dead women. Unless we're going to say that we're totally different from the experience in Europe or that somehow MAID for mental illness is fundamentally different from what we've already seen with track 2, we are going to end up with dead women—dead women with mental illnesses, who have a history of being marginalized and whose autonomy has been denied precisely by the medical profession.

I want to point out that there's other litigation going on in Ontario that also has individual plaintiffs who have had an enormous burden imposed on them by the existence of MAID. Both of those plaintiffs have mental illness. Both of those plaintiffs were offered MAID when what they were seeking was support to live. Both of those plaintiffs have a long history of marginalization by the medical profession.

The idea that offering death is somehow going to promote the autonomy of women with mental illness is frankly just so appalling that I don't know how to respond to it. Women with mental illness deserve access to a dignified life.

Thank you.

● (2150)

The Joint Chair (Marcus Powlowski): Thank you.

I'd like to thank the witnesses for appearing.

I'd like to briefly make mention of this. Several people referred to the Wilson judgment in Morgentaler as being relevant. I think it's a very good judgment, and I urge anybody who's interested in this to read that judgment.

Let me point out that next week, on Monday and Tuesday, we have meetings on both of those days.

If there's nothing else, I adjourn the meeting.

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