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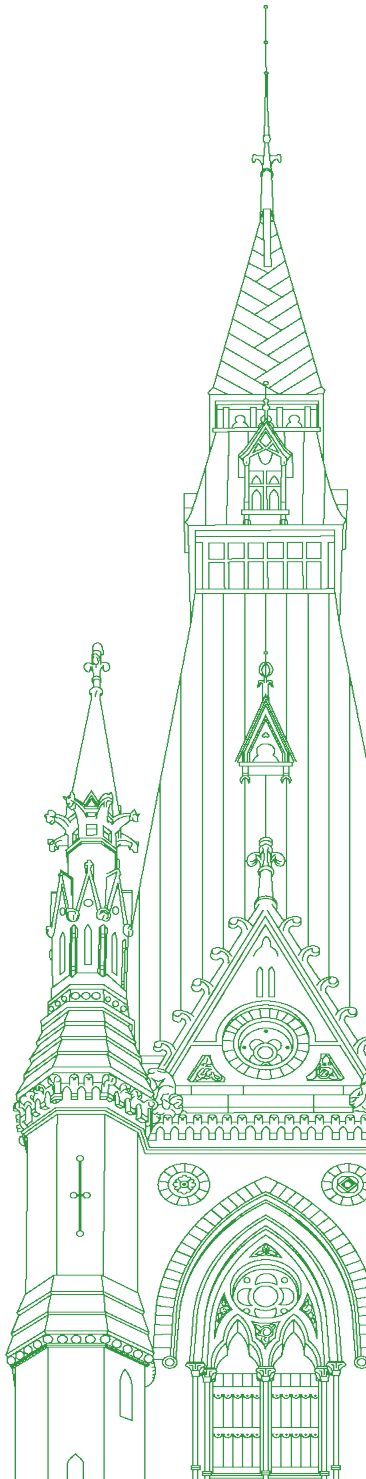

Chair: Mr. Sean Casey

Standing Committee on Health

Wednesday, February 14, 2024

● (1905)

[*English*]

The Chair (Mr. Sean Casey (Charlottetown, Lib.)): I call this meeting to order.

Welcome to meeting number 102 of the House of Commons Standing Committee on Health. Happy Valentine's Day, everyone. This is a wonderful way to spend Valentine's evening. I am feeling the love here already.

Today's meeting is taking place in a hybrid format, pursuant to the Standing Orders.

To the folks who are participating virtually, you have interpretation available to you. You have the choice on the bottom of your screen of floor, English or French. Please don't take any screenshots or photos of your screen during the meeting.

In accordance with the routine motion, I am informing the committee that all remote participants, except one, have completed the required connection tests in advance of the meeting. We will test Ms. Long, if necessary, when we get to her.

The subject matter of this meeting is Bill C-62. Pursuant to the order of reference of Tuesday, February 13, 2024, the committee is commencing its study of an act to amend An Act to amend the Criminal Code, regarding medical assistance in dying, no. 2.

I'd like to welcome our first panel of witnesses.

Appearing as individuals, we have Dr. Pierre Gagnon, psychiatrist, by video conference, and Dr. K. Sonu Gaind, professor of psychiatry at the faculty of medicine at the University of Toronto, who is here with us in person.

[*Translation*]

Dr. Georges L'Espérance, president of the Association québécoise pour le droit de mourir dans la dignité, will also be testifying by video conference.

[*English*]

Dying With Dignity Canada is also with us virtually, represented by CEO Helen Long.

Thank you all for taking the time to appear today. As it was explained, you will each have five minutes for your opening statements.

[*Translation*]

Dr. Gagnon, we will start with you.

You have five minutes to give your presentation.

Dr. Pierre Gagnon (Psychiatrist, As an Individual): Good evening, honourable members. I appreciate the opportunity to share some thoughts on this bill.

The first thing I can confirm, as a Quebec psychiatrist, is that certain documents or rumours have been circulating. It has been said that the Quebec psychiatric community is largely in favour of this expansion, which is not true, or that implementing the practice of euthanasia for patients with psychiatric disorders would not generate problems or controversy, which is not true either.

I would like to share a few points with you this evening, which can be boiled down to the following. We should start off by recognizing that suicidal ideation is one of the main and intrinsic symptoms associated with most serious psychiatric disorders. Furthermore, it is clinically impossible, even for the most gifted psychiatrists, to differentiate suicidal ideation from what would be considered a genuine request for euthanasia or medical assistance in dying by interviewing and assessing a patient.

The other thing is that all diseases are different. You can't apply the same criteria in every case. Psychiatric disorders are long-term disorders which seriously affect the will to live. The will to live and die ebbs and flows; this has been shown in a number of studies. Against all odds, patients eventually adapt and want to live. The principle of non-discrimination or equality for persons with psychiatric disorders is to provide treatment tailored to the patient's individual condition, not to provide the same treatment to all persons for all illnesses. In our opinion, the principle of equality means that we should offer treatments tailored to the individual's situation.

With psychiatric disorders, there is always a degree of uncertainty in terms of prognosis, which means that the notion of irremedialness not present. As a result, this criterion for medical assistance in dying is not met.

Similarly, having patients refuse treatment comes with the territory when we are dealing with mental disorders. There is no other field that requires practitioners to obtain court-ordered treatment as frequently as we do in order to treat patients against their will, because they lose all perspective about their condition. It is therefore inconceivable that we should let the patient decide that a doctor should end his or her life, when science proves day after day that these people can be helped, that their condition can be improved and that they can even find a way back to a fulfilling life.

In addition, the relationship between the patient and mental heathcare professionals, as well as the attitude of healthcare professionals, can play a particularly important role. The duty of psychiatrists and other healthcare professionals is always to try to instill hope, which is very valuable therapeutically.

I would also like to point out that when people argue passionately in favour of medical assistance in dying or euthanasia for people primarily suffering from mental disorders, they often give as an example rare or very serious psychiatric disorders that have resisted all treatment. In fact, studies published on cohorts of patients who had undergone euthanasia in countries such as Belgium and the Netherlands show, on the contrary, that much more common and treatable disorders were present in patients who received euthanasia.

In fact, a study published in *JAMA Psychiatry* showed that in 55% of cases, depressive disorders were the main psychiatric diagnosis. The majority of patients who had undergone euthanasia had a personality disorder or were lonely and socially isolated; 70% of those people were women, whereas suicide is more prevalent in men.

Another study of Belgian patients with mental disorders requesting euthanasia showed that there had been an idiosyncratic and excessive expansion of the concept of intolerable suffering.

● (1910)

This study revealed that psychiatrists had accepted that a significant component of intolerable suffering that made a person eligible for euthanasia could be due to social, economic and even existential factors, such as the loss of a loved one, friend or pet, financial problems or the feeling of being a burden to society.

As a result, it is the most vulnerable people, not those with severe and untreatable mental disorders, who are usually given euthanasia.

I'll leave it there. I look forward to your questions.

Thank you.

The Chair: Thank you very much, Dr. Gagnon.

[*English*]

Dr. Gaind, welcome to the committee. You have the floor for the next five minutes.

Dr. K. Sonu Gaind (Professor of Psychiatry, Faculty of Medicine, University of Toronto, As an Individual): Thank you, Mr. Chair.

My name is Sonu Gaind. I'm a psychiatrist, professor and governor at the University of Toronto, the chief of psychiatry at Sunnybrook, a past president of the Canadian and Ontario psychiatric associations and now the president of the new Society of Canadian Psychiatry. I'm not a conscientious objector and was the physician chair of my previous hospital's MAID team. My roles inform my expertise, but I'm here as an individual. I'm not representing any group.

I want to first express appreciation for the decision to pause the planned expansion of MAID for mental illness. In all honesty, this was the only responsible choice to make because there remain three critical unresolved issues.

First, MAID is for irremediable medical conditions—ones that can be predicted to not improve. Worldwide evidence shows we cannot predict irremediability in cases of mental illness—meaning that the primary safeguard underpinning MAID is already bypassed—with evidence showing such predictions are wrong over half the time. Second, scientific evidence shows we cannot distinguish suicidality caused by mental illness from motivations leading to psychiatric MAID requests. Overlapping characteristics suggest there may be no distinction to make.

Combining these inconvenient truths with the fact that those with mental illness have higher rates of social suffering, like homelessness and poverty, means that MAID assessors would be wrong most of the time when predicting irremediability. They would wrongly believe they are filtering out suicidality and would instead be providing death this March to marginalized, suicidal Canadians struggling with social distress who could have improved.

People talk of false hope. This would be assessors colluding with the patient's mental illness symptoms and providing false despair. They would be wrongly reinforcing that the situation is hopeless to the most marginalized who could have gotten better. That would be the ultimate discrimination.

How did we get here—twice being at the brink of providing MAID for mental illness and twice saying we are not ready? I think it's because those entrusted to provide evidence as experts have pushed ideology instead.

Senator Kutcher's sunset clause in 2021 never asked if we could responsibly provide MAID for mental illness, but set an agenda predetermining that we would. The CAMAP mental illness module claims to train assessors to weed out suicidality from psychiatric MAID requests, yet it does nothing of the sort and there is no evidence that we can actually do that.

The expert panel tasked with providing safeguards refused to recommend any additional legislative safeguards, despite Canada lacking a due care requirement before providing death by MAID. One-sixth of that panel resigned, yet the panel chair doubled down on pushing expansion, testifying that she is not concerned by the two-to-one gender gap of more women than men getting psychiatric MAID where it is allowed. It's remarkable.

Now, the dissenting senators, unhappy with the pause to expand, aim to convince the Senate to disregard Bill C-62's call to pause, with Senator Kutcher saying they need to "protect against the tyranny of the majority". Wow.

While citing their historical medical credentials and claiming they are addressing medical and procedural issues of the report, the dissenting senators neglect to provide any evidence to address the key medical issues of the inability to predict irremediability, the inability to filter suicidality and the risks to the marginalized when providing MAID for mental illness.

We're an outlier among peer nations in not even having a national suicide prevention strategy, and these dissenting senators are pushing easier death for mental illness. With any due respect to the dissenting senators, zealotry should not trump reality.

I'm confident that this committee, and I hope the rest of the Senate, will not follow the dissenting senators in their march against evidence.

I must point out the impact that expansionist activism has already had. After Bill C-7's expansion of MAID for any disability in 2021, MAID deaths shot up by 30% to over 13,000 Canadians in 2022, and 2023 will no doubt be higher. Of these tens of thousands of Canadians, over one-third cite that feeling like they are a burden is a suffering that leads them to MAID. Nearly one-fifth cite loneliness, and for over half it was a loss of dignity.

The debate about providing earlier, easier death has sucked all the oxygen out of the room. What are we now providing death for?

As I wrote in the Toronto Star recently, I hope this focuses us on the real issues of our fellow Canadians' suffering and propels us somewhere better than pushing death to solve life suffering. "If we're serious about addressing these issues," to quote that piece, "Canada has a chance to be a forerunner in the world by, instead of striving to be number one globally in assisted suicide, establishing the world's first portfolio for a Minister for Living with Dignity."

● (1915)

Thank you again for your thoughtful review of this issue.

I'm happy to answer any questions.

The Chair: Thank you, Dr. Gaind.

[*Translation*]

We'll now go to Dr. L'Espérance from the Association québécoise pour le droit de mourir dans la dignité.

Welcome to the committee.

The floor is yours.

Dr. Georges L'Espérance (President, Association québécoise pour le droit de mourir dans la dignité): Thank you, Mr. Chair and members of the Standing Committee on Health.

The Association québécoise pour le droit de mourir dans la dignité is grateful for the invitation.

I'm a retired neurosurgeon, an active MAID provider and president of the association.

With respect to Bill C-62, I will focus on a few main points on the new delay in accessing medical assistance in dying for people with mental illness, and then speak about advance requests for cognitive neurodegenerative diseases.

Excluding mental health disorders will only lead to legal challenges, which are cumbersome and unacceptable to affected patients. This is a political decision that goes against the interests of the few patients who could have been assessed, as is their right.

And yet expanding medical assistance in dying to those affected would make it possible to comply with the Supreme Court of Canada's decision of February 6, 2015, as noted by the Senate in 2021. Judges have never unanimously ruled out mental disorders. This exclusion forces patients, who have already been leading broken lives for decades, to go back to the courts request that their constitutional right be upheld by the government.

To give you some context, let me remind you of paragraph 252 of Superior Court of Quebec Justice Baudouin's decision, handed down on September 11, 2019, which reads as follows:

> [252] Vulnerability should not be understood or assessed on the basis of a person's belonging to a defined group, but rather on a case-by-case basis, at least for the purposes of an analysis under section 7 of the *Charter*.

This bill means an additional three years of suffering for people with mental disorders on top of the three years that have already passed since March 2021.

Further delays continue to stigmatize people with mental disorders, even though the federally mandated pan-Canadian expert panel on MAID and mental illness released its report in May 2022 and very clearly laid out its recommendations.

On the issue of advance requests for cognitive neurodegenerative diseases, the federal Minister of Health, Mark Holland, has stated that he has no plans to act on advance requests in the near future. However, in Quebec, this right has been enshrined in law since June 2023, and the Criminal Code must be amended so that patients who want to exercise their right can be assessed by providers who will not have to fear criminal prosecution. Our association urges the federal government to take concrete action on this issue.

While Ottawa dillydallies, patients are suffering. Every year, there are 14 new cases per 1,000 people aged 65 and over, and 70 new Alzheimer's cases per 1,000 people aged 90 and over. More than 15 people are impacted every hour of every day by neurocognitive disorders. By 2030, Canada could have nearly one million people living with neurocognitive disorders.

To delay the expansion of medical assistance in dying for advance requests is to dash the hopes of many citizens. Those who are struggling with the terrible loss of their personality are forced to shorten their lives while they are capable of making a decision so as not to find themselves locked in indignity.

In its February 2023 report, the Special Joint Committee on Medical Assistance in Dying already recommended that you move forward by approving advance requests.

The majority of Canadians are in favour of this measure.

Quebec developed its law on advance requests for medical assistance in dying after an in-depth consultation process that reflects the specific values and concerns of our province, which are in keeping with those of more than 80% of Canadians.

We ask you to consider any approach that would enable Quebec to follow through with its humanist legislation as of this spring, and thus meet the expectations of thousands of Quebeckers. By allowing advance requests, you have the opportunity to demonstrate your commitment to participatory democracy, Quebec institutions and respect for individual end-of-life rights, in addition to showing humanity and compassion.

It is important to note that eligibility for medical assistance in dying brings serenity and peace of mind, and enables people with disabilities to live fully in the present without the anguish of seeing long road ahead, paved with suffering and loss of dignity from a disease that inevitably leads to death.

● (1920)

Thank you.

The Chair: Thank you, Dr. L'Espérance.

[*English*]

Next, representing Dying with Dignity Canada, is Helen Long, the CEO.

Ms. Long, thank you so much for being with us. I know that you didn't have very much notice, but I also know you're very well steeped in the topic.

Welcome to the committee. You have the floor for the next five minutes.

Ms. Helen Long (Chief Executive Officer, Dying with Dignity Canada): Thank you very much for having me.

Good evening, members of the committee.

I appreciate this opportunity to testify on a matter of profound concern to the people across the country who are afflicted with severe, treatment-resistant mental disorders. I'm drawing upon a submission we made to the special joint committee in November 2023.

This is an issue that concerns us deeply at Dying with Dignity Canada because it speaks to the rights of persons who have both historically and presently been deprived of section 7 and 15 charter rights to make autonomous and lawful decisions concerning their end-of-life choices simply because their illness is psychiatric in nature and not physical.

The bill before you would extend the denial of access to MAID assessment for those whose sole underlying condition is a mental disorder for a further three years, until March 2027.

Given that Bill C-7, which brought in the right to a MAID assessment for those whose death was not imminently foreseeable, passed in 2021 with a sunset clause excluding that access for those with a mental disorder for two years, which was extended for a further year, means that persons in this category will have been denied for six years the same set of MAID entitlements as those with a physical illness.

It is outrageous to suggest that the development of a regime for MAID MDSUMC needs six years. It is especially egregious given that all of the metrics the government set for readiness in its last delay have been met. We have a nationally accredited curriculum and willing, competent assessment providers. We have practice standards against which regulators of physicians and nurse practitioners can oversee that conduct.

No new metrics are set in Bill C-62. What more is left to do? We need to look to those who are doing the work of providing MAID assessments and provisions; the regulatory bodies charged with the oversight of clinicians' conduct; the 127 physicians and nurse practitioners across this country who have confirmed in writing that the MAID system, MAID assessors and providers and psychiatrists who wish to be involved in MAID MDSUMC and who have testified that they are ready; the regulatory authorities; and, most importantly, patients with severe, treatment-refractory conditions who are ready for MAID MDSUMC.

No new metrics have been established for this delay. Adequate safeguards are in place, including the requirement for a minimum 90-day assessment period, the need to consult with an individual with expertise, a psychiatrist in these cases, and so forth.

We endorse the coming into force of MDSUMC because we have a duty to safeguard the rights of all Canadians. In this case, it's a small group of people tragically afflicted with acute, treatment-resistant mental disorders who, despite many interventions over long periods of time, have experienced unremitting suffering in their lives that cannot be relieved.

At DWDC, we hear from those who, for reasons of fear, embarrassment or stigma, are reluctant to speak publicly about their afflictions but who know only too well what deep, unrelenting suffering means. Even more regrettably, we hear from those who will not speak publicly for fear of being ostracized by their own communities. Often their voices are drowned out by those purporting to speak for them.

You're likely all familiar with the story of John Scully, who has spoken publicly for several years about his mental disorder, but I also hear from Jane and Cathy and others who are not able to speak publicly.

Canada regrettably has a long history of paternalism and arbitrary denial of rights for those with mental disorders, and we have often unfairly conflated mental illness with a lack of capacity. In Starson v. Swayze, the Supreme Court of Canada, discussing the need to redress decades of unfair presumption of incapacity in relation to the mentally ill, wrote, “For this reason it is particularly important that autonomy and self determination be given priority when assessing individuals in this group.”

Every year we hear from thousands of people across Canada who are seeking information or navigating the MAID coordination program across the country. Since Bill C-7 passed, the proportion of these individuals who identify as having a mental disorder as either a sole underlying medical condition or a comorbidity continues to rise.

We anticipate that many of these individuals will likely never be found eligible for MAID MDSUMC, but we cannot continue to deny them the right to apply. Doing so only serves to create further distress and angst. They have been left in an untenable position, unable to apply and suffering grievously.

● (1925)

The Chair: Thank you, Ms. Long.

That concludes our opening statements. We're now going to proceed with rounds of questions, beginning with the Conservatives for six minutes.

Dr. Ellis.

Mr. Stephen Ellis (Cumberland—Colchester, CPC): Thank you very much, Mr. Chair.

Thank you to the witnesses for being here on this difficult evening.

Certainly, MAID for mental illness has been talked about for an incredibly long time, but to have the calibre of witnesses we have with us in this short time this evening is incredible.

Dr. Gaind, I'm going to begin with you to try to make it more realistic for Canadians out there.

You talked about the difference between suicidality and the desire for MAID. Indeed, suicidality, if I'm not mistaken, is often one of the criteria for diagnosing depression, and you mentioned the inability to distinguish it from the desire for MAID.

For everyday Canadians, could you talk a little bit about that, sir?

Dr. K. Sonu Gaind: Thank you for the question. I think it's a very important one because, in my opinion, Canadians have been given false reassurances that the sort of suicidality you're talking about—that's a result of mental illness symptoms—can somehow be separated from other motivations leading to MAID requests for mental illness.

The evidence in the few European countries that allow and provide MAID for mental illness shows that to not be true. In fact, there are overlapping characteristics between those populations. The key issue here is that, when people with suicidality from mental illness attempt suicide, they do not typically succeed nor do they typically try again.

That 2:1 ratio of women to men that I mentioned is a stunning gender gap on which I have not heard a single expansion proponent address in any meaningful way. I would very much appreciate it if any of the other witnesses tonight are willing to address that. However, we think that this stunning gender gap of 2:1 women to men getting psychiatric MAID in the European countries reflects gender-based marginalization. For any psychiatrist, that should be a terrifying statistic because it parallels the 2:1 gender gap of women to men who attempt suicide when mentally ill. Most do not end their lives by suicide, and most do not try again.

What it points out is that, for people with suicidality from mental illness, we try to bring interventions and suicide prevention that can help, but we have no way of knowing whether we should be doing that or saying no and instead sending them through door B where we're going to facilitate their suicide.

The CAMAP guidelines, in my opinion—and I have openly said this—dangerously provide a reassurance that they're doing something that they do not do and that they cannot do. I've looked at those, and this is actually quite literally their stuff on suicide. It's 10 slides. They say that it takes about 10 minutes to go through it, and that includes a four-minute audio clip. There is nothing in there that actually helps separate the suicidality that we want to help with suicide prevention from psychiatric MAID requests except that one about impulsivity. They focus on impulsivity. The reality is that the evidence shows—and this is from the CCA report—that “in Western countries such as Canada, impulsive suicides constitute a small percentage of all suicide deaths, and they often occur when the person has consumed alcohol”.

It goes on, but the point is that many suicides here are not impulsive, so that doesn't help differentiate. The only other differentiating characteristic, when you go through their whole list of questions, is literally, “Is the person planning on doing it themselves, or have they come to you as a MAID assessor?”

Is that how we're deciding what's suicidal and what isn't?

● (1930)

Mr. Stephen Ellis: Thank you very much, Dr. Gaind.

You talked about the CAMAP guidelines or curriculum. For folks who aren't familiar with them, that's the Canadian Association of MAID Assessors and Providers. You mentioned very clearly that they don't help with determining suicidality versus seeking MAID.

Could you talk a little bit about those guidelines again? I've gone through them myself, but we talk about assessing irremediability, which, of course, I believe is an impossibility. I wonder if you've looked at that curriculum with respect to how it might teach physicians or nurses to do that.

I know I don't have much time, but I just want to plant a thought in your head. As I see it, the CAMAP curriculum is for primary care physicians or nurse practitioners. The likelihood of having psychiatrists performing these assessments, given the inability at the current time to access a psychiatrist, is almost zero.

Dr. K. Sonu Gaind: I would say that there are some psychiatrists who are willing to perform these, but in my opinion, they're willing to perform these in the absence of evidence. The fact that they're willing to do something that evidence shows they can't should not be reassuring.

I have looked at the evidence of this, and once again, there is no evidence that shows that we can predict irremediability in mental illness. It is vastly different—vastly different—from other medical conditions and neurodegenerative diseases.

Mr. Stephen Ellis: Dr. Gaind, tell us a bit about the future—not that I think you can predict it. When we look at where we've come with diagnosing and treating mental illnesses of all sorts, what do you see in the future that should give us all hope around this and...that we should not have MAID for mental illness?

Dr. K. Sonu Gaind: I think there are many promising developments in psychiatry and mental health. I'm not trying to suggest that we're always able to help everyone. I think we all recognize that it can be challenging sometimes.

We have to remember what MAID is about. MAID is about predicting who will never get better, and we can't do that. If we can't do that with mental illness, we will be providing death under false pretenses.

Mr. Stephen Ellis: Thank you, sir.

The Chair: Thank you, Dr. Gaind.

Thank you, Dr. Ellis.

Next is Dr. Hanley, please, for six minutes.

Mr. Brendan Hanley (Yukon, Lib.): Thank you very much.

I want to echo Dr. Ellis in thanking the witnesses for gathering, not just on Valentine's Day but in the evening and on short notice, and being able to provide us with this really useful testimony.

Obviously, there have been years of deliberation on this, including the recent committee meetings. I'm trying to put my questions into a framework of "what now?" What do we do after Bill C-62 in terms of next steps? How do we best prepare?

I'd like to start with Dr. L'Espérance. I want to understand more about what we can learn from the experience of Quebec and how you see the direction in Quebec, particularly for MAID eligibility for mental illness. I understand from Bill 11 that this is a permanent exclusion. Is there anything we can learn as a country from the deliberations of Quebec?

Where do you see Quebec's health system in terms of readiness for mental illness as a sole underlying medical condition? How do you reconcile that with the direction of the legislation in Quebec?

● (1935)

[*Translation*]

Dr. Georges L'Espérance: Actually, we have no experience in Quebec in terms of approving MAID in cases where a mental disorder is the sole underlying condition, because we are subject to the Criminal Code, like the rest of Canada.

The Quebec committee that studied the expansion of medical assistance in dying set aside the issue of patients whose sole condition is a mental disorder because there was not enough evidence of a society-wide consensus on the issue. However, the committee's report was prepared before the report of the expert panel commissioned by the federal government, which was tabled in May 2022. So that's a factor.

What would Quebec's position be now that the expert panel report has been tabled? I couldn't tell you. I'm not a psychiatrist, which is fortunate for patients. However, I am relying on what is presented by the experts, particularly in the report by pan-Canadian experts mandated by the federal government.

We cannot completely exclude the problem of mental health, because we would be denying certain rights, but we need very strict guidelines with a long-term view. In our discussions, we always talk about an illness that had afflicted patients for 20, 30 or 40 years and whose quality of life has deteriorated grievously as a result of a mental health disorder.

[*English*]

Mr. Brendan Hanley: Thank you very much.

Ms. Long, since the most recent report was issued by the special committee, "The Road Ahead", what are you hearing from Canadians?

Ms. Helen Long: Certainly we have tried to share the news that a possible delay was forthcoming, in a staggered bite-sized way, so that people were better able to digest that and to understand that there might be a delay. There are people who will call very distressed. We've made more crisis calls—so calls for police intervention—in the last two months than we have in the last three years, because people have been waiting. In many cases, based on our consultations with clinicians and assessors, we believe that many of these people will never be eligible for MAID, but they need to know that they can apply. They need to be able to move on and take the next steps.

We've heard from people who are significantly upset, angered and impacted by the changes and the continued delay. When the bill first passed and then it was two years and then it was another year, for these people, who have been suffering for decades and have tried every treatment—if you read the stories on our website, they've tried every treatment multiple times over years—to hear, "Okay, now it's three more years," is devastating for them. I can't impress that upon you enough.

● (1940)

Mr. Brendan Hanley: Do you believe that there is social consensus? If there isn't, do you see a role for the Supreme Court? Do you anticipate a court challenge?

Ms. Helen Long: I'm not a constitutional lawyer. I think the committee, previously, has certainly heard from those experts. I do think there will be a challenge at some point. That has been raised multiple times in the past, and I think, each time, the people who felt they might stand up as plaintiffs thought, "Well, I can get through one more year," or "I can get through these first two years." Now that we're at what will be six years and there are three years to go, I believe that is a very likely possibility.

The Chair: Thank you, Ms. Long.

[*Translation*]

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

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

First of all, I'm going to make a comment about our two psychiatrists.

It seems to me, from what they have told us this evening, that they are of the same opinion. They are testifying as individuals to tell us that they are at odds with the Canadian Psychiatric Association, the Canadian Bar Association, the Association des médecins psychiatres du Québec, the Federation of Medical Regulatory Authorities of Canada, the Canadian Association of MAiD Assessors and Providers—we have a lot of comments on that—and the Collège des médecins du Québec.

According to Dr. Gaind, the members of these organizations are ideologically motivated activists. We used to see that in the former Soviet Union, where science was pitted against ideology. When someone disagreed with the other person's opinion, they accused the other person of basing their position on ideology. It's called "scientism." That said, this is not the place for an epistemological debate.

The fact remains that I am interested in Bill C-62, but I haven't heard anything on the bill, which contains a very important provision. Do you believe that we should postpone the provision indefinitely? Do you agree with the three-year period? I would just like to know what you think.

Dr. Gagnon, you have the floor.

Dr. Pierre Gagnon: Right now, three years is very wise.

Indeed, as I explained, it is currently very difficult to see...

Mr. Luc Thériault: I'm not looking for a reason. I want to know what your position is. Is it three years or indefinitely?

Dr. Pierre Gagnon: Given the current state of science, I would say indefinitely.

Mr. Luc Thériault: Okay. That's perfect.

Dr. Pierre Gagnon: I understand why politicians are pushing for three years.

Mr. Luc Thériault: I gathered that from your speech. However, as a legislator, I wanted to ask the question.

Dr. Gaind, would you like to see a three year or an indefinite moratorium in the bill?

[*English*]

Mr. Stephen Ellis: I have a point of order, Chair.

We've had an understanding in this committee for a very long time—which, I would suggest, you have historically applied very uniformly—that the witnesses have the same amount of time to answer the question as the asker of the question took, including the preliminary remarks. I would suggest to you that we keep carefully close to the time and make it fair for the witnesses so that they actually have the appropriate amount of time to answer the question, rather than continuing to allow Mr. Thériault to badger those witnesses.

If you would, sir, please make those conditions clear to all present.

The Chair: Thank you, Dr. Ellis.

[*Translation*]

Mr. Luc Thériault: Mr. Chair, I have clearly explained what I am doing.

[*English*]

The Chair: Colleagues and witnesses, Dr. Ellis is correct. We have adopted a procedure in this committee where the witness is allowed as much time to answer the question as the questioner takes to pose it.

By rights, I should have intervened to allow Dr. Gagnon a little more time, but I will simply ask Mr. Thériault to respect the rules that we have all played by to date.

● (1945)

[*Translation*]

Go ahead, Mr. Thériault.

Mr. Luc Thériault: My question is short and to the point: would you prefer that the provision be postponed for three years or indefinitely?

[*English*]

Dr. K. Sonu Gaind: Thank you, Mr. Thériault.

Will I have time to answer the comments he made at the beginning? He characterized a number of things about my views on the CPA and others.

The Chair: No, not unless he allows you.

The question that he posed to Dr. Gaind did not include a two-minute preamble.

Mr. Stephen Ellis: He defamed him in front of the entire committee by saying he was an ideologue. That's unfair.

The Chair: Dr. Gaind, I expect that someone else may give you the time to address those things.

Dr. K. Sonu Gaind: I'll answer the question briefly.

The three years depends on what we do with it. If we go into it with a predetermined outcome, I think that is ideology. It is not looking at whether the evidence shows us whether or not we can actually provide MAID for mental illness safely.

[*Translation*]

Mr. Luc Thériault: Thank you.

Dr. L'Espérance, the committee tabled its first report in February 2023. We had to look at all the possible scenarios for expanding the eligibility criteria for medical assistance in dying, and the committee made a strong majority recommendation in favour of advance requests. It may have been a good idea for the government to wait to see what could be done for people with mental disorders, but, at the last minute, it decided not to include this recommendation in Bill C-62, whereas it included, word for word, the recommendation of the Expert Panel on Medical Assistance in Dying and Mental Illness.

Did that surprise you? How do you explain that?

Could you shed some light on how advance requests work in Quebec, so that people understand what it is all about?

Dr. Georges L'Espérance: I do not understand why there is no mention now of advance requests, when the report of the Special Joint Committee on Physician-Assisted Dying specifically made mention of it.

On the other hand, it is surprising that advance requests...

[*English*]

Mr. Todd Doherty (Cariboo—Prince George, CPC): I have a point of order.

Mr. Chair, I believe that the topic of this study we are doing tonight is the expansion of MAID for mental illness and not advance directives. I don't believe that question is germane to the conversation that we're supposed to be having tonight.

[*Translation*]

Mr. Luc Thériault: Mr. Chair, may I respond to that?

The Chair: Yes, if you wish, but I intend to rule in your favour.

Mr. Luc Thériault: My colleague can't claim that the topic isn't germane to the conversation, when there have been motions and votes in the House to try to introduce this concept in the bill.

It seems to me that it is important to be able to talk about this as we move forward.

[*English*]

The Chair: Thank you for the point of order, Mr. Doherty.

We have allowed a pretty wide latitude in terms of relevance.

I also did hear reference to advance medical directives in the course of some of the opening statements that were given. Those things, therefore, opened the door and made them fair game for questions, so Mr. Thériault's question is not out of order.

I'd like him to continue.

[*Translation*]

Mr. Luc Thériault: Mr. Chair, I would like to raise a point of order, with no deduction from my speaking time.

The Chair: I've stopped the clock. You still have two and a half minutes.

Mr. Luc Thériault: I feel that my Conservative colleagues are simply trying to undermine the exchange I can have with the witnesses.

I am appealing to their better nature. If everyone rose on a point of order every time they heard something that was not to their liking, we would not be able to hold a meeting. I am making this appeal to ensure that we have a productive meeting without interruptions. It's a matter of showing respect to the witnesses who are here with us.

The Chair: I'll do my best.

Mr. Thériault, you have another minute and a half.

Mr. Luc Thériault: Mr. Chair, I hope the Conservative point of order didn't eat into my time.

The Chair: Indeed.

● (1950)

Mr. Luc Thériault: You said two and a half minutes before I started.

The Chair: Every time a point of order has been raised, the clock has been stopped.

Mr. Luc Thériault: Yes, but when I started, you—

The Chair: You've used up four and a half minutes so far asking questions.

Mr. Luc Thériault: You said two and a half minutes. Fine.

The Chair: You have a minute and a half left.

Mr. Luc Thériault: Okay.

I'll let the witness speak, in that case.

Dr. Georges L'Espérance: You have to understand that mental health is one issue and advance requests quite another. It's true there's no medical or societal consensus on mental health. We're told the psychiatrists are split 50-50.

That being said, there's a very broad consensus across Canada on advance requests associated with neurodegenerative diseases, the best known of which is Alzheimer's. Some 82% of Canadians are in favour of advance requests. As I mentioned, cognitive neurodegenerative diseases will put an enormous weight on the shoulders of patients, first, and their families, second. This is increasingly the case, and it's increasingly prevalent as people advance in age.

Advance requests enable individuals with an established diagnosis to say, while they're still capable of making a decision, that they want to receive medical assistance in dying once they've lost that capacity, in such and such a condition. It is the essence of the law in Quebec both to enable those individuals to retain their dignity and to help them live days, months or even a year or two longer surrounded by their families and loved ones, even if they've lost some of their capacity. That's the principle of advance requests: to honour people's dignity to the end of their lives.

The Chair: Thank you, Mr. Thériault.

[*English*]

Next we have Mr. MacGregor, please, for six minutes.

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

Thank you to all of our witnesses for helping to guide us through this part of the study of Bill C-62.

I've been a member of the Special Joint Committee on Medical Assistance in Dying from the beginning, and I'm very familiar with the subject matter that's before us.

Ms. Long, I'd like to start with you, if I could.

Thank you for your opening statement and for representing Dying with Dignity. Of course, ever since our special joint committee tabled the report in the House of Commons and in the Senate with our single recommendation, we are also in receipt of a letter that was signed by the health ministers from seven out of 10 provinces and all three territories.

If you look at that letter, you can quote from the middle of it, where it says, “The current March 17, 2024, deadline does not provide sufficient time to fully and appropriately prepare all provinces and territories across Canada”. Further down, they ask the Minister of Health and the Minister of Justice to “indefinitely pause the implementation of the expanded MAID eligibility criteria to enable further collaboration between provinces, territories and the federal government”.

Ms. Long, when I look at the signatories, I see that they include ministers of health and ministers responsible for mental health and addictions. You can see that they are widely across the political spectrum. They include the NDP government in British Columbia and several Conservative governments in other provinces.

I want to know from you how Dying with Dignity responds to this letter, given that these are all cabinet ministers, they have executive-level functions within their respective governments and they are responsible for the systems of health that are actually going to be overseeing this process. If they are publicly asserting that their systems are not ready, how do you respond to that with your opening statement where you said that we are ready?

Ms. Helen Long: Thank you for the question.

I think that, when you listen to the testimony that was heard in front of the committee, there were certainly indications from the regulatory authorities, for example, that they are ready. There was an indication from individual clinicians, psychiatrists and nurse practitioners that they are ready. While every province may not feel fully ready, certainly some of the conversations we've had and the testimony that we heard, as did all the committee members, would indicate that there are people who are ready to move ahead.

In terms of system readiness from the provincial perspective, it's not clear what needs to be done, so I think the question I would have for the individuals writing that letter is this: What exactly are we looking for before the provinces determine they're ready?

Mr. Alistair MacGregor: Okay, but with respect, I don't think these ministers—yes, they're all elected officials—would have attached their names and signatures to a letter if they had not conferred with their deputy ministers and assistant deputy ministers, who are essentially the heads of the civil service, who then would have gotten feedback from their respective ministries of health.

When you're talking about the regulatory environment, if I were a cabinet minister I wouldn't attach my name to this letter unless I had a nod of approval from my deputy minister. How do you respond to that fact?

● (1955)

Ms. Helen Long: What we've heard is what we heard in testimony in terms of this issue. We're not clinicians, so we're not able to participate in all of those discussions, but it was certainly made very clear by the individuals representing the regulatory authorities in the provincial health authorities that they are ready and certainly that individual clinicians are ready.

When we look to Bill C-14 and the beginning of MAID, there was no time like this given for the provinces to be prepared in the way they are today. We are probably readier now than we've ever been to move ahead with MAID.

Mr. Alistair MacGregor: Thank you for that.

Dr. Gaind, I'd like to turn to you if I can.

We've had previous interactions at the special joint committee, and I recall that in one of our previous interactions we were talking about the track two process that's present in the Criminal Code. A lot of people have pointed to that as saying that the necessary safeguards are already present. However, I believe that in your professional capacity you've poked a few holes in that process.

Would you mind informing the committee of some of the problems you've seen in the Criminal Code with the track two process?

Dr. K. Sonu Gaind: I'm happy to, and that actually links a bit back to Monsieur Thériault's question, which is trying to set a predetermined timeline by which we will have evidence, and we don't know if we will.

The holes are this. If we are saying to people that we are predicting their mental illness won't improve, we need to have evidence that we can do that honestly, and we don't have that. Whatever there is on track two or track one doesn't address that.

As well, the separation of suicidality from psychiatric euthanasia requests also is something that the evidence does not show, so you can have people saying that they think they can do something and it doesn't mean that they can. We have physicians saying that they think you should take Ivermectin for COVID. It doesn't mean that we should set a regulatory framework to do that; it's ridiculous.

What I am speaking to is the evidence, not what any particular individual is saying.

I will also say, by the way, that in terms of my own former professional association, the Canadian Psychiatric Association, of which I am a past president, I find that the input they have provided to this file has actually been shameful.

You were asking about track two. In the consultations leading up to Bill C-7, consultations on mental illness and death, they never once mentioned suicide prevention. They never once mentioned evidence related to suicide risks of mental illness or marginalized populations. That would be like a respirologist association never mentioning smoking as a risk factor for lung health.

You go think what that means. I don't know what it means, so—

The Chair: Thank you, Dr. Gaind.

Dr. K. Sonu Gaind: The last point I'll make is that, in fact, in CAMAP guidance they have a document that goes through how you can essentially convert people from track two to track one, literally saying that examples might include stated declarations to refuse antibiotic treatment of current or future serious infections.

I don't even know how many people on track one may actually be, by other people, considered track two.

The Chair: Thank you.

Next is Mr. Cooper, please, for five minutes.

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

Dr. Gaind, proponents of this expansion, including the government-appointed chair of the expert panel, Dr. Gupta, have claimed that only a small number of individuals would be eligible for MAID for mental illness. In fact, she said that, in her many years of practising as a psychiatrist, maybe only two or three, or a handful, would be eligible.

They cite the model practice standard to demonstrate, supposedly, that this would be the case. I would be interested in your thoughts.

Dr. K. Sonu Gaind: I actually find those kinds of statements, coming from some people who were in positions to actually suggest potential legislative safeguards, quite remarkable, because while Dr. Gupta said that, she also chaired the same expert panel that literally said they were not recommending a single legislated safeguard for MAID for mental illness.

In terms of predicting irremediability of mental illness, the same expert panel—or the 10 remaining members, because one-sixth of them resigned, including the health care representatives—said they would not or could not provide guidance on the lengths, numbers or types of treatments that somebody should have access to before getting MAID for mental illness. To me, this actually speaks a bit to some of the points Ms. Long and others have raised. They paint a picture of how these are people who have been suffering for decades and decades and who have had multiple treatments. There's nothing in our legislation that requires that. It's an artificial picture.

If you want a sense of actual evidence-based numbers with respect to what this might be like, Scott Kim, a researcher at NIH, has done an evidence-based analysis and he estimates there are several thousand people a year.

The things in the model practice standard and other things that are not legislated and are not actual safeguards are basically suggestions. Suggestions are not safeguards. Reassurances without evidence are dangerous, in my opinion. This is a serious business. We are providing death to people who are not otherwise dying, and there need to be serious safeguards.

If Kenneth Law were a doctor instead of a chef, how comfortable would you be with his being your mother's MAID assessor if there were just non-binding suggestions and empty reassurances rather than legislated safeguards?

● (2000)

Mr. Michael Cooper: Thank you for that.

You said that on the issue of irremediability and determining it accurately, clinicians will get it wrong more than 50% of the time in cases where mental illness is the sole underlying condition. Would it therefore be a fair characterization to say that you would be better off flipping a coin and more likely to get an accurate result, than otherwise?

Dr. K. Sonu Gaind: In my opinion, it would actually be a more honest determination, because it would be openly showing that we're basing it on luck rather than on the false reassurance of a white lab coat.

Mr. Michael Cooper: With respect to this legislation, the government is providing a three-year pause, but you cited, as did Dr. Gagnon, two fundamental clinical issues—irremediability and distinguishing between a rational request versus one motivated by suicidal ideation.

Are you aware of any evidence you can point to that would indicate a likelihood or, for that matter, any evidence that we would be on track to be ready for what would be a significant expansion of MAID in three short years?

Dr. K. Sonu Gaind: No, I can't point to any, and none has come to light in the past three years either.

Mr. Michael Cooper: Dr. Gagnon, do you have any thoughts on the assertion that has been made by Dr. Gupta and others that this would, if implemented, be limited to a very small number of Canadians who have been suffering from mental illness for, in some cases, decades?

[*Translation*]

Dr. Pierre Gagnon: On the contrary, as I tried to explain in my opening remarks, the studies show that euthanasia requests are often associated with very common problems, such as depressive disorders, personality disorders, grief or socioeconomic problems. There's a genuine risk that a very large population would be eligible for it, especially in circumstances where safeguards and protective measures aren't sound. They are actually more sound in the Benelux countries, Belgium, the Netherlands and Luxembourg, which are expanding eligibility for euthanasia to include all kinds of psychiatric and even psychosocial conditions.

So we can expect the eligible population to be very large. It's disturbing.

The Chair: Thank you, Dr. Gagnon.

Thank you, Mr. Cooper.

[*English*]

Next is Ms. Sidhu.

Go ahead, please, for five minutes.

Ms. Sonia Sidhu (Brampton South, Lib.): Thank you, Mr. Chair.

Thank you to all the witnesses for being here. My question is for Dr. Long.

Are you aware of the available resources supported by the federal government, which are assessing this complex case, for example, the curriculum and practice standards? Have they been helpful?

● (2005)

Ms. Helen Long: Just for clarity, I'm not a doctor. I'm not a clinician. I am aware of those pieces and their development, but I cannot utilize them as I'm not a MAID assessor or provider.

Ms. Sonia Sidhu: Dr. L'Espérance, do you want to chime in on that question?

[*Translation*]

Dr. Georges L'Espérance: No, thank you.

Since I'm not a psychiatrist, I can't discuss clinical psychiatric issues. I'm simply relying on the data provided by the experts, particularly in their report and in a document published in 2019, if my memory serves me, on the situation regarding mental health and medical assistance in dying.

[*English*]

Ms. Sonia Sidhu: Are there any gaps or challenges that limit the willingness of health care professionals to undertake those complex cases?

You are talking about data. Have you seen those types of barriers?

[*Translation*]

Dr. Georges L'Espérance: As far as I know, relying once again on the data provided by the experts, I see that some data indicates that psychiatrists and physician providers of medical assistance in dying can assess the patients.

It's also very important to understand that some of the patients who request medical assistance in dying, or who are currently eligible for it as a result of physical diseases, also suffer from mental health issues. Their capacity to make decisions for themselves is therefore accurately assessed.

What's more, in my clinical practice, particularly in surgery, we also regularly work with patients who have mental health problems. You also have to assess those patients' suicidality and capacity to make decisions.

For example, if a 40-year-old patient suffering from abdominal pain tells his physician that he doesn't want surgery and would prefer to die, that patient will obviously undergo a psychiatric assessment, be treated and then be treated for the physical issue. The same is true for all physical diseases.

So physicians, generally speaking, are in the habit of assessing patients' capacity in their everyday clinical practice, where necessary, of course.

I'm absolutely convinced that very few patients with mental health issues would request medical assistance in dying for the simple reason that significant safeguards have been established in response to the expert panel's recommendations.

Medical assistance in dying may not be administered to individuals who simply appear one morning and request it. To be eligible, they must have been suffering for many decades, and attempts must have been made to administer all treatments.

Note, however, that no one is required to try all the treatments. The patient is free to reject them, as provided under the Canadian Charter of Rights and Freedoms.

Of course, if we're talking about a patient suffering solely from mental health issues who requests medical assistance in dying, they will have to have undergone a certain number of treatments. However, it's false to say that all possible treatments must be attempted because that would violate the Charter.

[*English*]

Ms. Sonia Sidhu: My next question is for Ms. Long.

Should the government take three years to further prepare the system? What are your recommendations to the federal government on making sure systems in the provinces and territories across the country are ready?

Ms. Helen Long: We don't believe the government needs three additional years to prepare. In the event that it goes ahead with this delay, it's very important that there are clear parameters outlined that must be met. There must be a clear understanding of what the expectations are in terms of the provinces and territories, and a clear commitment not to further delay.

In this case, the federal government listed the things it thought needed to be established, namely, a nationally accredited curriculum, a set of practice standards and advice to the profession, as well as revised reporting under the Health Canada reporting system. Those metrics have all been met, so if there is a delay, there has to be a better way of establishing what the next set of metrics are going to be and then ensuring we get to them in a timely manner.

● (2010)

The Chair: Thank you, Ms. Long.

[*Translation*]

Mr. Thériault, you now have the floor for two and a half minutes.

Mr. Luc Thériault: Dr. Gagnon, would you please send us the studies on the cases you've mentioned, which were numerous and concerned disorders that would have been reversible and for which patients should not have received medical assistance in dying?

You also discussed the safeguards that exist and that could have been stricter. Would you please give us a list of those safeguards? I'd like to explore that with you, since earlier you discussed an "indefinite delay". I imagine you have an idea of the safeguards that would be necessary. What would they be?

Dr. Pierre Gagnon: The safeguards in those countries include a psychiatric assessment, which we don't have. The problem that I see when I talk about indefinite delaying, is this: how are we going to resolve the fact that it's impossible to distinguish suicidal ideation from what would be considered an authentic request for euthanasia? It's going to be tough to get there.

I can say this about irremediability. Since I've been a psychiatrist since 1992, very soon, I will have been practising psychiatry for 33 years. We've seen so many cases of individuals whose situations change completely, even decades later, as a result of a significant encounter, an event that occurred in their lives or a new treatment. They still have decades of good living ahead of them, and all the psychiatrists—

Mr. Luc Thériault: What I'd like is to know what safeguards you recommend. Recommendation 10 of the expert panel's report is that a psychiatric assessment be done. What are the additional safeguards that don't appear in the experts' report and that should appear in an act?

Dr. Pierre Gagnon: I think that's why the legislators prepared this bill thinking it would not be simple, and I agree with them. I don't have the answer to that, but it won't be simple. We're talking about a delay of at least three years. I think that's wise because it will take a long time for us to identify those safeguards and properly substantiate them.

Mr. Luc Thériault: All right. That being said, I wouldn't want us to rely on a wrong impression. There's the act, about which the expert panel said that the safeguards and the track two criteria were enough. However, it shouldn't be forgotten that regulations will be made under the act and that it's the regulations that may contain the statement regarding those safeguards and how to proceed. It isn't necessary for the safeguards to appear in the Criminal Code. Those practices must then be supervised by a college of physicians that will sanction the practice. So it seems to me we can get there.

The Chair: Your speaking time is up, Mr. Thériault.

Dr. Gagnon, perhaps you'll have an opportunity to answer the question a little later, the next time Mr. Thériault has the floor.

[*English*]

We have Mr. MacGregor, please, for two and a half minutes.

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

Dr. Gaind, every problem we've had with this particular issue of mental disorder as the sole underlying medical condition you can trace all the way back to that eleventh-hour Senate amendment to Bill C-7. I was here during the 43rd Parliament. I was here in the 42nd Parliament for the first debate on MAID. I remember when the charter statement was first issued for Bill C-7, which I think reasonably explained the government's original position for excluding mental disorders as qualifying for MAID. They recognized the inherent risks and complexities that would be present for individuals. They noted that the evidence suggests that screening for decision-making capacity is particularly difficult. They noted that mental illness is generally less predictable than physical illness. However, inexplicably they accepted a very consequential Senate amendment.

It seems that we've just been constantly kicking the can down the road. The first delay was for two years. Bill C-39 delayed it by a further year. Here we now are, with Bill C-62, looking at another three years.

I'm just wondering, first of all, what your reaction was at the time when the government did that 180° turn in their decision. Also, I think you sort of answered this, but I'd like you to expand on it a bit more. Can we actually ever be ready for this, or are we just setting ourselves up for failure in 2027?

● (2015)

Dr. K. Sonu Gaind: On your last question, I'm not trying to be flippant, but I think the only honest answer is that we don't know if we would be ready in three years or not. This is why it's problematic to say that we will be ready in three years when we don't know.

The reason we don't know goes back to the first points you were making, which were reflecting the deeply flawed process that was behind this in the first place. We never asked those questions. We never actually asked those questions. From day one, with Senator Kutcher's sunset clause agenda, it was a predetermined course that we will offer this, without asking those questions that need to be answered first. To me, that's really putting the cart before the horse.

I'll also point out that on these key issues of irremediability and suicidality, I find it quite striking that it's not only the people who are expressing caution who cite those. Even the ones who have been at the forefront of saying that we should be doing this have acknowledged that.

Dr. Gupta has chaired a number of these expert panels. She also co-authored an AMPQ report in 2019 or so. I can't remember which year. In there, they literally acknowledge, the provincial association, that regarding irremediability it is possible that a person who has recourse to MAID, regardless of his condition, could have regained the desire to live at some point in the future. They acknowledge that, but then say that it should be an ethical question each and every time.

When you're getting a medical expert opinion, ethics are fine, but I think people are thinking they're getting a medical expert opinion and not the person's personal ethical judgment. On suicidality, they've acknowledged that as well on the expert panel.

The Chair: Thank you.

Mr. Doherty, go ahead, please, for five minutes.

Mr. Todd Doherty: Dr. Gaind, I'm wondering if you're familiar with this saying: I don't want to live, but I don't want to die.

What does that mean?

Dr. K. Sonu Gaind: It probably means different things, depending on the context, but it reflects a deep ambivalence. The person is not happy. “Happy” is too simplistic a word. The person is not feeling that they're able to live. It's not that they actually want to die. Usually what it reflects is that they want to live better. They want either their suffering to be dealt with or the social situation to be dealt with.

I see it as an abandonment. If we tell people in those periods of despair, “We're going to collude with the despair that your mental illness is bringing and the hopelessness and we're also going to say that you're never going to get better, and we're also going to say—in brackets—that we're not going to help with the social situations you're struggling with, but we'll provide you with an easy and quick death”, what does that say about us?

Mr. Todd Doherty: I appreciate your saying that. I said exactly that in my intervention yesterday, in my speech, on how far we have fallen as a society that we can perpetuate one's addiction, but we can't get them into recovery. We can allow somebody who is in despair to choose suicide rather than offer care and help when they need it.

Dr. Gagnon, you mentioned that we are failing Canadians. Perhaps I'm putting words in your mouth, but it's my opinion that we are failing Canadians when we do not even have a national suicide prevention strategy. Do you have a comment on that?

[*Translation*]

Dr. Pierre Gagnon: Yes, that's one of the problems. I think that's why Quebec decided, during the debates that were held a few years ago, to delay indefinitely or simply rule it out it because so much has to be done with regard to suicide prevention, as you mentioned.

Yes, the associations that work with patients with suicidal ideation are very concerned about the idea of opening up access to this kind of thing for these individuals before we have suicide prevention measures and adequate services in place. That's why Quebec was very wise in deciding not to discuss the matter for the moment. The issue may have to be addressed once again from a social standpoint, but we aren't there yet because we don't have the necessary suicide prevention services and measures, and certain issues remain unresolvable. We always come back to the irremediability of the patient's situation, for example, and to the difference between suicide and a legitimate request for euthanasia.

So that's where things stand.

● (2020)

[*English*]

Mr. Todd Doherty: We know the stats. Twelve Canadians per day die by suicide, and a further 200 attempt suicide. That's 73,000 Canadians who attempt suicide every year. Those are just the stats that we know.

How is MAID different from suicide in the context of those suffering from mental illness?

That's for Dr. Gaind and Dr. Gagnon, please.

Dr. K. Sonu Gaind: This is precisely part of the problem. We don't know how it is, or if it is. This is precisely part of the problem and, as I was saying, even some who are pushing for expansion have acknowledged that. The expert panel quite literally said, regarding chronic suicidality, “society is making an ethical choice to enable certain people to receive MAiD on a case-by-case basis regardless of whether MAiD and suicide are considered to be distinct or not.” This is a shocking statement to me. I don't remember our society making that choice ethically. The 10 people on that panel did.

Mr. Todd Doherty: Dr. Gagnon.

[*Translation*]

Dr. Pierre Gagnon: Indeed.

I work in a hospital and talk to the doctors in other disciplines who are used to medical assistance in dying. When I discuss this new development with them, they say it makes no sense and wonder how it's possible. They emphasize that the purpose of our profession is precisely to treat suicidal patients.

I talk to some of my very experienced psychiatrist colleagues who have seen some very serious cases, and they tell me that, with their patient cohort, they would never be able to distinguish a suicide from an authentic request.

A discussion took place within the Association des médecins psychiatres du Québec, in which one astute and highly experienced psychiatrist said he would never do it. He would ask a colleague to do it. He wasn't opposed to it in theory, but he said he didn't understand how he could do it in his career, despite the fact that he had extensive experience with very difficult and complex cases.

We're unfortunately unable to make that distinction at this time.

The Chair: Thank you, Dr. Gagnon.

[*English*]

Thank you, Mr. Doherty.

Next we have Mr. Powlowski, please, for five minutes.

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): Dr. Gaind, in his questioning, Mr. Thériault suggested that you and Dr. Gagnon were somehow outliers and that the majority of psychiatric organizations and psychiatrists agreed with allowing MAID for mental illness. Maybe you could comment on that.

What do we know about what psychiatrists think about MAID for mental illness?

Dr. K. Sonu Gaind: We actually know a lot now, and it is completely different from how it was represented initially in some of the earlier consultations. The reason I say that is, the CPA's position aside, we know that on the most recent national survey—it was conducted by the Ontario Psychiatric Association, but it was actually a national survey—by a 4:1 margin psychiatrists felt that MAID for mental illness should not be expanded this March. It parallels every other survey we know of for psychiatrists in Ontario, in Manitoba—wherever it's been done after the sunset clause came in—whereby a 2:1 up to a 3:1 margin of psychiatrists do not support expanding MAID for mental illness, even though they're not conscientious objectors.

Typically, 80% to 90% of them, similar to me, are not conscientious objectors overall. They recognize the exquisite vulnerability that these issues pose for our marginalized patients and the challenges that we're talking about here. That's why they oppose it.

Mr. Marcus Powlowski: Thank you.

Ms. Long talked about people with unremitting suffering. You've talked about the difficulty of determining irremediability, whether people really aren't going to get better. Also, as a practising physician, I saw someone I knew over Christmas when I was working at a walk-in clinic. As soon as he saw me, he said, “Hey, Dr. Powlowski. How are you?” I'd seen him repeatedly for either suicide attempts or suicidality over the years. In an emergency room, he would have been the exact kind of person Ms. Long would perhaps say had unremitting suffering. I was very gratified to see him, and he seemed quite happy. I asked him what had changed, and he told me a whole bunch of things.

Have you had the same experience with people who had been written off as never getting better, who actually did get better?

Maybe afterwards I can ask the same thing of Dr. Gagnon.

Dr. K. Sonu Gaind: Yes, I have. That's precisely part of the challenge here. This is why it's not an issue, as Ms. Long presents it, of autonomy. It's not an issue of capacity of the patient. It's the capacity of the assessor to honestly judge when the person won't get better—and they can't make that assessment, which is the problem.

Just yesterday, I was on a panel at the U of T faculty of law with the former head of the Ontario Bar Association, Mr. Orlando Da Silva. If you get a chance to see that streamed, I highly recommend watching his portion of it. He very poignantly describes his own experience of repeated, severe depression when he was suicidal, and also, by the way, functioning, doing cases, trial law, and completely competent. He knows he would have been able to get it, and he would have wanted it. He is very concerned about what this would do to people who would be in situations like he was.

● (2025)

Mr. Marcus Powlowski: Dr. Gagnon, can I ask you the same question?

Dr. Pierre Gagnon: Yes, I saw some of these patients, and my colleagues always talk about these patients who improve. Often, they don't understand why. Often, it's a relationship, a life event or a change in therapeutics.

I have an example. As a psychiatrist, I also follow cancer patients when they're depressed. I had a patient like that who had a severe borderline personality disorder and depression. She had been suicidal for decades and was always in the emergency room, like some patients you saw, maybe. Then suddenly she had metastatic cancer and she stopped being suicidal. She told me, “Before I had cancer, I always wanted to die when I couldn't, and now I could die and I want to live.” She had five years of very productive and fertile happiness. You see that all the time with our colleagues. It's very tough to predict.

What I also wanted to add is that we always forget that now there are new treatments. I'm the chairman of the department of psychiatry at Laval University, and my job is to recruit young physicians with new techniques and new procedures. They train all over the world and come back to our centre in Quebec City. They go into different kinds of psychotherapy, such as neuromodulation and transcranial magnetic stimulation. There are new treatments that are very promising, such as ketamine treatment or psilocybin. You have all these new treatments that could be game-changers. We sometimes forget to talk about these new treatments that could really give hope and change the course of the illness.

Thank you.

The Chair: Thank you, Dr. Gagnon.

Next is Mr. Majumdar, please, for five minutes.

Mr. Shuvaloy Majumdar (Calgary Heritage, CPC): Dr. Gaind, you mentioned earlier that when people try to commit suicide those who are unsuccessful often don't try again. They they often seek and receive treatment.

Do you think this policy would mean that people struggling with mental illness who have the possibility of recovery and overcoming this illness will end up dying and never having the chance to recover?

Dr. K. Sonu Gaind: That's precisely what I and most of my colleagues fear. You've hit the nail on the head. That is exactly what will happen, and the problem is that we will not know which of those people would have recovered. They will all go in the bucket of MAID assessors saying that this would have never gotten better. We will assume that they never would have recovered, and more than half of them would have.

I've actually heard from patients who have said that they are fearful for the future and are potentially not wanting to seek help when they get depressed again. Why? Because they're concerned that somebody is going to say to them, “Do you want MAID instead?”

We talk about the model practice standard. Remarkably, in that, it says that, for any adult who could be eligible—unless you already know, somehow, that MAID would not be in their value system or their goals of care—you need to advise them MAID could be an option. That actually means any adult with a disability, because MAID could be an option for any adult with a disability.

I don't know of any other country that has basically said something so permissive. Most say that the physician cannot be the one to bring it up, because that can be seen as suggesting it from the white lab coat.

● (2030)

Mr. Shuvaloy Majumdar: You called it the ministry of what in your opening comments...?

Dr. K. Sonu Gaind: What I personally believe we should have is a ministry of living with dignity.

Mr. Shuvaloy Majumdar: Shouldn't we be prioritizing hope and more accessible mental health resources over hurt—as my colleague MP Todd Doherty proposed with his 988 hotline—and shouldn't what this government be putting first be that main goal, which is exactly as you have named your proposed ministry?

In your professional experience, what has the data shown you? Do your patients get better with proper treatment and recovery?

Dr. K. Sonu Gaind: Yes, the vast majority do. What we know is that, as Dr. Gagnon was speaking of, there are also many treatments that our patients can't access, even for basic care. We know that less than one in three adults is able to get the basic mental health care they need, and that for things like neuromodulation and other things that can help, it's far fewer.

Mr. Shuvaloy Majumdar: We have about 90 seconds left, Dr. Gaind.

In the stories I've heard from Canadians suffering from mental illness, hope seems really far away in a world of darkness, and there's a lot of darkness in this world today. However, when given proper support networks, treatment and medication, etc., these people cherish the chance at a better life.

Do you think the government should be offering a second chance at a better life rather than a path with no return?

Dr. K. Sonu Gaind: I think we should be working on helping people live better and to address their real suffering. We can't forget that they're suffering, and it's not just from illness symptoms. It is also from other things. In fact, suicide prevention doesn't focus only on illness. It focuses on living with dignity.

Mr. Shuvaloy Majumdar: I appreciate the evidence-based advice you've provided this committee. You've published over 21 papers on this. It's a far superior background than being some sort of suicide lobbyist.

Thank you for being here.

The Chair: You have another minute if you want it. Okay.

Thank you.

Mr. Maloney, please, you have five minutes.

Mr. James Maloney (Etobicoke—Lakeshore, Lib.): Thanks, Chair. I appreciate the opportunity.

Dr. Gaind, I was on the special committee. You and I have met before.

In fact, I was on the special committee's most recent incarnation and the one before that. I was also on the justice committee that dealt with Bill C-7, so I have some knowledge of this. However, I don't profess to be anywhere close to any of you in terms of my ability to comprehend some of the challenges we're dealing with, which is where I'm going to go with my question.

We're here dealing with a piece of legislation on a fairly specific point. We're not here discussing the morality of medical assistance in dying. We're not here debating whether it is constitutional or is not. We're not here dealing with advance requests. We're dealing with whether or not this bill should proceed in its current form and why.

I'm not a doctor. There isn't a consensus on this. I've been on the committees, as I said. Look, we have three doctors on this committee, and I'm reasonably comfortable in saying that I don't think we have a consensus at this table, and that's excluding you, Dr. Gaind.

Here's my question. We have four witnesses here, two of whom, if I'm correct, have said that we should not delay. Two have said we should.

I want to start with you, Ms. Long. Here's my dilemma. We're tasked as legislators with deciding whether the system is ready or not. I've had the opportunity to hear from numerous witnesses, review numerous briefs and review all kinds of articles and information on all of this, and there's no consensus.

You're here saying there should be no delay because we need to safeguard people's rights—and I'll get to that in a minute too—but put yourself in my shoes. I've heard from all of these people and read all of this information and there's no consensus. It's not even close to being a consensus. I'm not a judge and I'm not on a jury. I don't get to decide who's right and who's wrong. What I have to do is decide whether the system is ready.

If you're in my shoes and you're faced with that situation—you have a whole bunch of people saying the system is not ready and they're highly trained professionals—am I not doing the responsible thing by saying we should delay it and discuss it further?

Ms. Helen Long: Thank you for the question.

I think if we go back and look at what the government outlined as what was required to demonstrate readiness, that has been done, and the testimony did say that. I think people need the ability to make their own choices once they've engaged in reflection and once they've had treatment. We talk about people not having to have treatment, people not needing to see a psychiatrist. The MAID assessors and providers that I know are people who are careful and thoughtful in their work. No one is looking to help people die by MAID instead of helping them to live.

I think there have been a lot of stories in the media that would lead people to believe that there have been cases of wrongdoing. There are no cases of wrongdoing. There have been no criminal charges laid in the past. These are careful assessments done on a case-by-case basis. Not being a psychiatrist, I can't speak to many of the points that have been raised. I think Dr. Gupta and others—

● (2035)

Mr. James Maloney: Thank you, Ms. Long. I think I've given you adequate time to respond pursuant to the rules of this committee.

You're not answering my question. You're putting forward your opinion again.

Put yourself in my shoes. You have a large group of medical professionals—not like you, not like me—who are saying that the system is not ready. What would you do in my shoes? Am I not acting responsibly?

It's a fairly straightforward question, ma'am.

Ms. Helen Long: I think you're acting responsibly, considering everything you've heard, but we need to listen to those who are doing the work and those who testified.

I don't believe the testimony that I—

Mr. James Maloney: We are. That's precisely my point. There's a large number of them who disagree with what you're saying. They say that the system is not ready, so I'm doing precisely that.

My last point, while I have a few seconds, is this. In terms of safeguarding people's rights, does that not include people who might make a decision at a stage when it could be premature and who might potentially recover?

There are rights on both sides of the equation. It's not a one-sided issue. That's one of the challenges I have with this discussion. People pick one side or the other, but it's not black and white. When it comes to people protecting the rights of individuals, you have to look at both sides of the discussion. Is that not fair?

The Chair: Ms. Long, that's Mr. Maloney's last question. Please take 30 to 40 seconds to answer. I won't let him interrupt you again.

Ms. Helen Long: We need to listen to the clinicians who are doing the work and who believe they can assess these very specific and unique circumstances.

All individuals need to be considered on their own case-by-case assessment and their own merits. We need to listen to the testimonies. Yes, there were testimonies on both sides, but if you listen to the totality of the testimonies, there were certainly at least as many, if not more, people who testified that they were prepared to move ahead.

The Chair: Thank you, Ms. Long.

[*Translation*]

Mr. Thériault, you have the floor for two and a half minutes.

Mr. Luc Thériault: Dr. Gagnon, the Canadian Association of MAiD Assessors and Providers, or CAMAP, and the expert panel on MAiD and mental illness say that individuals in suicidal crisis aren't eligible for medical assistance in dying.

Earlier you discussed suicide attempts and suicide prevention. These experts say that suicidality is a reversible state. So the question doesn't arise. There's no way a person in a suicidal state can be eligible for medical assistance and die.

Why are you confusing the issue? If an assessor sees a connection between a request and structural vulnerabilities, there's no way he or she should agree to a request for medical assistance in dying.

You say there are no safeguards, but there are. These people have established their own safeguards. They conduct assessments and tell their peers there's no way a patient can be eligible in that kind of situation. I imagine you agree with that.

Dr. Pierre Gagnon: It's true that suicidal crises may occur. That's obvious. However, earlier I cited the example of the patient who was chronically suicidal. His state has improved. He was suicidal for 20 years, but now is not. Suicidality can be acute, but it can also be chronic. There are subtle differences.

That's why we say it's extremely difficult to differentiate a suicidal patient from one who makes a genuine request for medical assistance in dying. We can't do it. There may be the obvious cases, but there are many cases between the two extremes. It's those cases that are becoming extremely difficult.

Mr. Luc Thériault: However, the extremely difficult cases must stay within the safeguards that the expert panel has put in place. Those safeguards are real. They exist. We could discuss them at another time because we can't do it in two minutes.

However, no one can say that there are no safeguards. Earlier I asked you what additional safeguards were necessary. You didn't answer me. I would have liked to hear an answer to that question today.

What specific safeguards should we add to improve this bill?

● (2040)

Dr. Pierre Gagnon: It's complicated. Some theoretical and practical issues are extremely complex and remain unresolved. How do you differentiate suicide from euthanasia? How do you determine the irremediability of a state? You have to examine those questions. This has been put off for some years now, and we still aren't able to resolve these issues.

That's why we say it will take a long time for us to come up with answers and solutions so we can say we need such and such safeguard.

Mr. Luc Thériault: In the meantime, patients suffer.

The Chair: Your time is up.

[*English*]

We will now go to Mr. MacGregor, please, for two and a half minutes.

Mr. Alistair MacGregor: Thank you, Mr. Chair.

Dr. Gaind, I want to step back from this and approach it from a Charter of Rights and Freedoms angle.

I know that you and I are not constitutional experts, but you know what's invoked when we we look at section 7, which is the security of the person, the right to life and so on. Basically the layperson's interpretation is that everyone has the right to make decisions about what happens to their own body. Of course, section 15 provides that everyone has equality under the law. In section 1, some rights of the charter can be justifiably infringed upon by a free and democratic society.

My struggle through every aspect of my work on the special joint committee has always been trying to find a balance between an individual's rights to make decisions about their own body and the need for society to sometimes step in and protect our most vulnerable. That's been a real struggle for me—I won't lie.

I'm just wondering from your perspective and from other physicians' perspectives, when it comes to this particular issue of mental disorders as a sole underlying medical condition, how do you approach and find that balance?

Dr. K. Sonu Gaind: As you point out, I'm not a lawyer, so this is just my understanding of it and obviously not my expertise and stepping outside of that.

I do recall that, even in the original Carter decision and the section 7 argument, I thought part of that was the issue of foreshortened life, meaning that, if somebody is in a state where they can foresee that they will get to a point where they cannot act to end their own life and they choose to end their life earlier than that period of intolerable suffering, that's foreshortening their life. It was one of the rationales, in my understanding, that MAID needed to be an option.

That entire argument doesn't apply to mental illness because, while mental illness causes tremendous suffering and sometimes can affect capacity—although most of the time people remain fully legally competent—it very rarely takes away the person's agency to act to end their life or do other things. Right there you see some differences between some of the arguments that were made on that case in Carter. People sort of forget about that.

It is a significant issue because, as I alluded earlier, of the difference between doing something for someone or someone doing it themselves. When we talk about the right to my own choice, the way I think about that simplistically is that it's the right for me to do things for myself. When I expect something to be provided to me, that incorporates other things. If we're expecting the state to provide an easier, facilitated death, I think it's incumbent on us to think about how that plays out for everyone—not just on one person but everyone, including vulnerable populations.

We know that our laws can affect different people differently. As the poet Anatole France said, the law, in its majestic equality, forbids the rich as well as the poor to beg in the streets, to steal bread and to sleep under bridges.

The Chair: Thank you, Dr. Gaind.

The final round for the Conservatives will be Mr. Doherty, please, for five minutes.

Mr. Todd Doherty: Thank you, Mr. Chair.

Thank you to our guests for being here.

Dr. Gagnon and Dr. Gaind, you said some things that are resonating with me. Last night, in my intervention on Bill C-62, I shared for the first time something that I had not shared previously. While I have spent every minute of being elected for the last eight and a half years fighting for mental health supports for our frontline personnel, whether it's those who are struggling with PTSD or OSI, and I've been fighting tooth and nail for the country to adopt a national, three-digit suicide hotline, there was a time in my life when I struggled. The thoughts of death consumed my whole being. I attempted suicide twice. I'm living proof today that life is worth fighting for.

When I speak about fighting for those who don't have a voice and about my concerns about what Ms. Long is saying, I don't believe there are enough safeguards we can put in place to ensure that somebody who, like I was, is in a dark spot and finds a permanent solution for a temporary problem....

I appreciate your comments and all of your testimonies. I can respect all of the testimonies. My worry is that there will be many people, if we expand this to those who are struggling with mental illness, who say that they want to die, but they don't want to be dead. It's such a final act.

I also have a loved one who has recently chosen MAID. While we hear about the safeguards that are in place—a cooling off period and what have you—I also know that if that loved one of ours wanted it right away, they could get that.

My worry is for those who are struggling with mental illness and want to die because of whatever situation they're in. If only we can provide hope for the helpless and care instead of despair, I think we can really make a difference.

I thank you for your testimony.

● (2045)

Dr. K. Sonu Gaind: I'll just say thank you for sharing that. It cannot be easy and it takes deep courage too.

I also think it conveys a profound message of hope, so thank you for sharing that.

The Chair: Mr. Cooper, you have a minute and a half.

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

Dr. Gaind, one thing that Dr. Gupta and others have repeatedly said on the issue of suicidality is that this is something that psychiatrists and medical professionals deal with all the time, so there's nothing to be concerned with in cases of persons suffering from a sole underlying mental health disorder requesting MAID.

Could you comment on that?

Dr. K. Sonu Gaind: With respect to Dr. Gupta and others, including Senator Kutcher, they will tell a room full of psychiatrists who don't share this view that this is one of their core competencies.

We are trained to assess and address suicidality. Professor Gagnon was not confused when he said that we can't separate that suicidality from MAID requests for mental illness because we don't know how to do that. Those are different things. Anyone who's providing that kind of reassurance.... Frankly, I would say they are selling a bit of snake oil.

The Chair: Thank you, Dr. Gaind.

A final round of questions will come from Mr. Naqvi for the next five minutes.

Mr. Yasir Naqvi (Ottawa Centre, Lib.): Thank you very much, Chair.

This is obviously a very sensitive, emotional and, for many, personal issue that we're discussing here today.

I don't profess to have the depth of knowledge on this particular issue, especially as it relates to MAID that applies to people with mental disorders, that many members of this committee do, given the extensive amount of work that has been done. My engagement on issues on MAID goes back to 2016 and 2017 when the Carter decision was being implemented. I served as the attorney general for the Province of Ontario and worked along with the minister of health at that time to apply the federal law in the provincial space.

What I do know from that work is that there needed to be a fair amount of work that had to be done in terms of the health care system being ready to apply MAID in a manner that, from a legal perspective, protected people's rights, but from a health care perspective, ensured there was appropriate training, curriculum and safeguards in place so there was no abuse of any kind.

That's where I'm coming from. For me, BillC-62 is about whether or not the system is ready to apply the laws being passed by Parliament. It is the view of the government, based on what we have heard from experts, based on what we have heard from the requests we have received from the provinces and territories, that the system is not ready and we need more time, hence, the extension for three years.

I will go to Dr. L'Espérance first and then to Ms. Long.

In your view, is the system ready to administer MAID for people with mental disorders as early as March 17 of this year, or is it appropriate and prudent to have an extension of time before we are sure that the health care system across the country, and not just in certain parts of the provinces but across the country, is sufficiently ready to administer MAID to people with mental disorders?

I will start with Dr. L'Espérance first.

● (2050)

[*Translation*]

Dr. Georges L'Espérance: Thank you for your question.

I'll answer it simply by saying that it isn't the system that administers medical assistance in dying; it's the clinicians.

All the clinicians who belong to the Canadian Association of MAiD Assessors and Providers, or CAMAP, have worked very hard in the past two years to establish safeguards. To do that, in the past year, they've followed the recommendations of the experts' report, among other things. We agree this isn't a simple issue. However, three years have now elapsed, and I don't think we'll be any further ahead if we delay another three years.

The issue is based on a clinical decision element, with all the necessary safeguards, as recommended in the expert's report. However, I repeat that this isn't a simple issue. In my view, delaying for another three years will result in absolutely no change in the situation. We will only be indefinitely postponing the decision, as we mentioned earlier.

[*English*]

Mr. Yasir Naqvi: Thank you.

Ms. Long.

Ms. Helen Long: I don't really have much to add. I think Dr. L'Espérance dealt with that quite well.

Certainly, in all the conversations we're having with MAID assessors and providers, with psychiatrists, with regulatory health authorities, with members of the provincial health teams, there is readiness. I think if there is a province that for whatever reason does not feel they can proceed, they don't have to do so. I think those that are ready should be able to proceed as soon as they are ready, and that would be March 17 for some.

Mr. Yasir Naqvi: Ms. Long, I will go to you first.

I want to pick up on what Mr. MacGregor was talking about when he was citing the letter that has been signed by most provinces and all territories explicitly making the point that the health care system in their respective jurisdictions—and they are responsible at the end of the day—is not ready and requesting that the federal government, or this Parliament, give an extension.

Does that not indicate to us—and again, as Mr. Maloney was saying, put yourself in our position in terms of options available to us—to extend at least for three years so that the provinces and territories are ready to provide that particular health care provision for people who may need it?

● (2055)

Ms. Helen Long: Again, I think those who administer MAID are ready. The individuals I speak to who work within the health care system indicate, for the most part, that they are ready. I don't know what it is that the ministers would be looking for in order to continue to prepare. I think it would be very helpful to understand what they feel is missing in the system.

The Chair: Thank you, Ms. Long.

That concludes three complete rounds of questions. We're at five minutes before nine. We're expecting the ministers at nine, so we're going to suspend now as we switch over to the other panel.

Please allow me, on behalf of the committee, to say to all of you that this has been an absolutely fascinating panel. We very much appreciate your expertise and how quickly you responded to the invitation from the committee. We gave you as much time as we had in terms of lead time, which is a lot less than we usually have, but you responded. You've been very patient and professional throughout the evening with your answers, and we are absolutely grateful to you for that.

With that, we're going to suspend and await the arrival of the two ministers.

Thank you very much to our witnesses. You're welcome to stay, but you're free to leave.

We're suspended.

● (2055)

_____(Pause)_____

● (2100)

The Chair: I call the meeting back to order.

Before we begin, I would like to welcome the Honourable Mark Holland, Minister of Health, and the Honourable Arif Virani, Minister of Justice.

We also welcome the officials accompanying them tonight. From the Department of Health, we have Jocelyne Voisin, assistant deputy minister, strategic policy branch; and Katarina Pintar, director, health care programs and policy directorate. From the Department of Justice, we have Robert Brookfield, director general and senior general counsel, criminal law policy section; and Jeanette Ettel, senior counsel, human rights law section.

Before I invite you to bring your opening remarks, I will just say that I know this is your first time before this committee, Minister Virani. We've adopted in this committee a convention that, I would say, has worked fairly well for us, so I just want to make you aware of it. It's quite simply that you will be afforded as much time to answer the question as the person who poses it takes to ask it. It is the prerogative of the questioner to allow you to go on for longer, but if they ask a four-second question and you speak for 10 seconds, they'll probably interrupt you and I won't stop them.

With that, we're going to begin with opening statements, beginning with Minister Holland. I know it has been a long night for both of you after a couple of hours in the Senate. We appreciate your being here.

You have the floor, Minister Holland. Please go ahead.

● (2105)

Hon. Mark Holland (Minister of Health): Thank you very much, Mr. Chairman. It's good to be back in front of the health committee.

We did just have a very productive session, the last couple of hours, with the Senate, getting an opportunity to talk about what is a very delicate and sensitive issue, one that requires a lot of calm, patient deliberation.

I appreciate the members of this committee for their input and work. I certainly appreciate the work of the joint committee as we attempt to navigate this very difficult issue.

I think I'll start by making a very clear and important distinction between mental health and mental illness. Mental health, not only in Canada but across the world, is in a state of crisis. Coming out of the pandemic and dealing with the rise of very devastating wars, global economic uncertainty and the existential crisis of climate change, these are difficult times to be a human being.

However, the challenges we're facing in mental health are completely separate and apart from the issues that we're talking about in Bill C-62 with respect to mental illness. That distinction is an important one, because a conflation is both dangerous and, I would represent, irresponsible.

When we talk about mental health, there are the historic investments we're making in mental health across this country, co-operating with governments of every stripe. I had an opportunity just yesterday to be in the Northwest Territories and announced our bilateral agreement on both aging with dignity and working together. Just the day before that, I was in British Columbia announcing our aging with dignity agreement there. Of course, I've already announced the working together agreements with B.C., Alberta, Nova Scotia, P.E.I. and many more to come, with specific and detailed plans of how we're going to take on the challenges we're facing in mental health.

When we're talking about mental illness, we have to recognize that there are some people who are trapped in an irremediable situation, where their state of illness is not able to be remedied through medical intervention, so we have to ask the question, as a society and indeed as Parliament, of at what point we allow a person, of their own recognizance, if they have an irremediable condition, to be able to make the choice to access MAID.

If somebody has suffered for 10 years, 20 years, 30 years or 40 years, where they've tried absolutely everything, where they've gone to medical practitioner after clinician after expert and have never been given the opportunity to escape that mental health illness—not a momentary mental health crisis—what do we do as a society? That's what we've been trying to navigate.

The decision we have in front of us now is to ask for more time to prepare the system. I've had opportunities to talk with health ministers. We had a very constructive conversation in Charlottetown when I was together with all the health ministers, Mr. Chairman, in your home province, discussing how we navigate that and how we get the system ready.

Frankly, we need more time.

We need more time for indigenous engagement. We need more time to work with the provinces and territories to make sure they have appropriate safeguards. Talking with CAMH, we want to make sure that, if there's a possibility that clinical guidelines are required to create uniformity across the country, we have an opportunity to explore that. We need more time to work with the disability community and with the community of folks with lived experience, so a three-year pause is appropriate so that we can deal with mental illness, which is separate and apart.

I would welcome the conversation on mental health, but hopefully tonight people will not be conflating those two because they are two separate conversations.

We do need time and I'm appreciative of the opportunity to be before committee tonight to have that conversation and to take the questions of the committee.

Thank you very much.

The Chair: Thank you, Minister Holland.

Minister Virani, welcome to the health committee. You have the floor for the next five minutes.

Hon. Arif Virani (Minister of Justice): Thank you very much, Mr. Chair. I'm pleased to be here to speak to Bill C-62, which proposes to delay for three years, until March 17, 2027, the expansion of the eligibility of MAID to persons whose sole underlying medical condition is mental illness. As members will be aware, this bill also requires that a joint parliamentary study be undertaken on the topic, by a mixed committee of Senators and MPs, approximately one year before the new date of expansion.

I will start by expressing my sympathy for anyone experiencing intolerable suffering. I acknowledge that mental illness can cause the same level of suffering as physical illnesses, and that having a mental disorder does not mean that an individual does not have decision-making capacity. Everyone deserves dignity and respect.

As this health committee is aware, the Supreme Court of Canada's decision in the Carter case led to the legalization of medical assistance in dying in Canada. In that decision, the Supreme Court declared the Criminal Code's absolute prohibition at the time on physician-assisted death to be unconstitutional, noting that it should be available to competent adults who clearly consent to the termination of life and who have a grievous and irremediable medical condition. That led to Canada's first MAID law in 2016. Many members were here with me in 2016 when we enacted that law, which restricted eligibility for MAID to persons whose natural death was “reasonably foreseeable”.

● (2110)

[*Translation*]

A few years later, in the Truchon decision, a trial court in Quebec ruled that the reasonably foreseeable natural death requirement was unconstitutional.

The federal government didn't appeal the decision. Instead it made the general political decision to introduce Bill C-7 to expand eligibility for medical assistance in dying to persons whose death wasn't reasonably foreseeable. When it was introduced, the bill permanently excluded from eligibility for MAID persons whose only underlying health issue was a mental illness.

During consideration of the bill, the Senate introduced an amendment to make that exclusion temporary. The House of Commons supported the amendment, and the bill, as adopted, would automatically have nullified the mental health exclusion two years later.

[*English*]

I want to be clear about something, which is that the government's decision to go forward with those expansions at the time was a matter of social policy. I appreciate, though, that there are those who believe that the charter required us to act in this regard on mental illness, and I want to address this point directly.

MAID is a complex and deeply sensitive topic, and there are important charter-protected interests that arise in this area. On the one hand there is the autonomy and dignity of individuals in making end-of-life decisions. On the other hand, there is the protection of those who are vulnerable and who might be at risk in a permissive regime. In its decision in Carter, the Supreme Court recognized the complexity of legislating in this area and suggested that Parliament's choices on how to balance these competing interests would be given a high degree of deference.

MAID is particularly complex in the context of mental illness. As noted in the various MAID-related charter statements, these inherent complexities are the basis for the mental illness exclusion. Some of the complexities include that the course a mental illness may take is more difficult to predict than that of a physical illness and that many people with a poor prognosis will improve, at least in terms of their suffering, which may alter or impact their wish to die. Moreover, distinguishing routine suicidality and a valid request for MAID becomes particularly challenging when suicidality may be a symptom of the mental illness that led the person to request MAID in the first place.

The MAID mental illness exclusion is not based on harmful assumptions nor stereotypes about mental illness. We recognize, as Minister Holland just said, that the suffering mental illness can cause is on par with the suffering that physical illness can cause. This exclusion is not a denial of this fact. We also accept, as I said at the outset and as I repeat here again, that the decision-making capacity of those who are mentally ill is well established.

As we have said, we do believe the exclusion should be lifted when the health care system is ready to manage the inherent risks and complexities of assessing requests for MAID that are based on mental illness alone. Our provincial and territorial partners agree that more time is needed. Medical experts agree that more time is needed. The lack of consensus on this issue proves that more time is needed.

This bill reflects the caution required to ensure the safety of Canadians and to get this right. As the interests at stake are significant and the consequences, Mr. Chair, are permanent, we must get this right.

Thank you very much.

● (2115)

The Chair: Thank you, Minister.

We will now begin with rounds of questions, starting with the Conservatives for six minutes.

Dr. Ellis, go ahead.

Mr. Stephen Ellis: Thank you very much, Chair.

Thank you to both ministers for being here.

Minister Holland, in your mind, will having MAID for solely mental illness be a foregone conclusion at some point? Is that the destination we're going to get to?

Hon. Mark Holland: It's my belief that folks who have an irreversible, irremediable mental illness for which they've sought all kinds of treatment and have been unable to get any relief, in many cases for decades, eventually, when the system is ready, should have access to MAID.

Mr. Stephen Ellis: Thank you for that.

How do you propose to get systems ready given the two outstanding issues of suicidality and irremediability?

Hon. Mark Holland: Suicidality is an issue that's completely separate and apart. If somebody who is having suicidal thoughts goes in and sees a clinical professional and seeks assistance, that's somebody who is able to be helped.

Somebody who has a mental illness is somebody who, despite going and getting help for, potentially, decades, is unable to lift themselves out of that circumstance and is in an irremediable state, a state of decline, so there's an important distinction to be made.

Mr. Stephen Ellis: Thanks for that, Minister.

You talked about suicidality being an incidental thing, but, realistically, it's part of the diagnosis of many mental illnesses. Do you not think that is true?

Hon. Mark Holland: As somebody who has suffered greatly and who has spoken publicly about my own mental health challenges, I do not believe that suicidality is at all incidental. What I'm trying to do is to make a distinction between the folks we're talking about in Bill C-62 and folks who are having a mental health crisis.

Mr. Stephen Ellis: Minister, that was not the question I asked you.

What I asked you specifically was whether suicidal ideation was an important part of a diagnosis of many mental illnesses. That's correct—is it not?

Hon. Mark Holland: This is—

Mr. Stephen Ellis: It's a simple question.

Hon. Mark Holland: Yes. If you are mentally ill, then that could absolutely be present.

Mr. Stephen Ellis: Thank you very much.

How do you then expect, Minister, to get systems ready when suicidal ideation is a part of the illness that you're talking about? That doesn't make any sense.

Hon. Mark Holland: What we're talking about is not somebody who has a mental health crisis and who has suicidal ideation in a moment. We're talking about somebody who, potentially, for decades...and this is why we need to take time, so that we can make sure we are talking about the same cases.

I'm sure, if I would pose it to you—

Mr. Stephen Ellis: Respectfully, Minister, when you read the diagnosis—

Hon. Mark Holland: Let me just pose it to you so we're talking about the same thing.

Mr. Stephen Ellis: No, I'm sorry. I'm asking the questions, not you. Thank you.

The Chair: Go ahead, Dr. Ellis.

Mr. Stephen Ellis: When you look at the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition, which talks about mental illness, suicidal ideation is an essential part of the diagnosis of, for instance, depression.

Hon. Mark Holland: You are somebody with a history within the medical profession. If you have somebody who has tried absolutely everything and has been suffering with a mental illness for decades, at what point...one decade, two decades, three decades? How long should it be before that person has autonomy over their own decision?

Would you not recognize the difference in somebody who has been suffering for many decades and who is trying to get service versus somebody who is in a mental health crisis?

Mr. Stephen Ellis: Minister, I'm not talking about irremediability. I'm talking about suicidality, which you said was something that came on suddenly. I forget your exact words, but clearly that's not the case.

The second part of it is irremediability. What we know clearly about irremediability with respect to mental illness is that it's impossible to prove. There are many cases—yours, perhaps, being one of them—of people who have gotten better from a mental illness. Here we are today talking about irremediability, and we know that those two things, suicidality and irremediability, are in no way related to systems.

Hon. Mark Holland: Irremediable means that you aren't able to remedy it. It means that it doesn't get better. You don't get out of it. It means that somebody is trapped in an illness that doesn't allow them....

Frankly, it gets back to the point about physical suffering and mental suffering and how when there's an illness, it is a very different thing from a mental health crisis. A mental health crisis is something you can get out of. A mental illness that is irremediable can't be remediated.

Mr. Stephen Ellis: Minister, those are your words. They're not mine.

Is diabetes irremediable?

Hon. Mark Holland: Well, I mean—

Mr. Stephen Ellis: It's a simple question.

Hon. Mark Holland: No, diabetes is manageable as a disease. It is—

Mr. Stephen Ellis: Mental illness is not manageable. Is that what you're saying?

Hon. Mark Holland: You've talked to doctors. I've talked to doctors. There are certain mental illnesses that people have not been able to escape, just as there are—

Mr. Stephen Ellis: Is cancer—

● (2120)

Ms. Sonia Sidhu: Mr. Chair, I have a point of order.

I just want to say that in the last panel we said that rules should be followed, and there should be no interruptions, please.

Hon. Mark Holland: That's fine, Mr. Chair. I'll just make this point very briefly.

Cancer is irremediable.

Mr. Stephen Ellis: Minister, I'm the one asking the questions.

Hon. Mark Holland: It ends in death, and it is irremediable.

The Chair: Mr. Holland, please. Minister—

Mr. Stephen Ellis: Here we go. This is exactly—

Hon. Mark Holland: I don't understand the point of trying to make an equivalency between multiple different illnesses.

Mr. Stephen Ellis: —what happened last time, Sean.

The Chair: Okay.

Go ahead, Dr. Ellis. You have another minute and 20 seconds.

Mr. Stephen Ellis: Thank you, Mr. Chair.

If I might remind you, Minister, I'm the one asking the questions. If I have a question for you, as part of this committee, you need to answer it.

The second part that we need to get to, clearly, is that this particular program that you have has a lack of safeguards. Substance-use disorders, mental illness, post-traumatic stress disorder—for which your government has offered MAID to veterans—are mental illnesses, as is autism.

How are you going to square your circle with respect to irremediability with regard to those illnesses?

Hon. Mark Holland: First of all, I guess we just have different purposes and discourse. I ask questions to seek clarity and to get on the same page. We're trying to deal with a very difficult issue.

When you're asking me the question about irremediability, I'm trying to say that, if somebody has an irremediable condition—and we're not talking here about some other disease but about mental illness and somebody who's trapped in it—I would ask you the question.... You say that you don't want me to ask questions. The purpose of my question isn't a political point. It's one of clarity.

If somebody is in a situation for 20 years, 30 years or 40 years, at what point, when they themselves are the ones asking—

Mr. Stephen Ellis: Thank you.

Hon. Mark Holland: —for relief and are saying that they have an irremediable condition—

Mr. Stephen Ellis: With regard to irremediability, though, you continue to say that you need to get systems ready. Irremediability is something that you can't prove. You can't make a system to prove irremediability. It's an impossibility. That's a clinical judgment by a clinician in front of that patient. It doesn't matter what you change the system to. You're never going to get to the point of irremediability.

We've heard from multiple experts that they are the ones making that decision around irremediability, not a system.

Hon. Mark Holland: What I'm saying is that—and this is why I posed the question; I think it's important for clarity—if you have somebody who is trapped in mental illness, who is saying that they want to end their life and have been saying that for five years, 10 years, 15 years or 20 years, who has attempted all therapy, everything at their disposal, at what point do you feel that this person has autonomy over that decision? If the answer is “never”, then that's an ideological position, and there's not a lot further to go.

However, if the point is that somebody at a certain point of suffering has an opportunity to have autonomy over their own life, then that's an important debate and one that is not rooted in ideology.

The Chair: Thank you, Minister.

We're going to move to Dr. Hanley, please, for six minutes.

Mr. Brendan Hanley: Thank you very much.

Thanks to both of you, Ministers, for appearing, and thank you to your officials as well. I also appreciate the opening comments from both of you.

I want to just briefly continue on the train of irremediability and suicidality.

In your understanding, Minister, is determining suicidal ideation and distinguishing suicidality not already a part of MAID assessment, even as currently applied to someone with a physical condition and mental illness?

Hon. Mark Holland: Yes, 100%. One of the things in our conversations with provinces and territories is that we want to make sure that the moment somebody expresses suicidal ideation, they have access to care and are channelled to a pathway of treatment. The circumstance, even for somebody who was attempting...who said that mental illness was the sole underlying cause and wanted to proceed with access to MAID.... Even if this regime was permitted, the person would need to demonstrate that they had tried everything and there would have to be two clinicians who would have to validate that the person had tried everything and that the person, in fact, had an irremediable condition.

Mr. Brendan Hanley: I'm sorry for interrupting you, but I have so many questions.

In your understanding also—because you've had many conversations with practitioners—are there physical illnesses where irremediability requires judgment on the part of the physician?

Hon. Mark Holland: Yes, in many instances there are physical conditions where you are told by a clinician that your condition is terminal and irremediable.

Mr. Brendan Hanley: Then it's not necessarily a black and white decision or something in a textbook. It's a judgment that is required—

Hon. Mark Holland: That's correct.

Mr. Brendan Hanley: —as may well be required for mental illness.

Given that this is such a difficult issue, as we've all acknowledged, are you punting a difficult issue down the road?

Hon. Mark Holland: No. If we were punting it, then we would have voted for MP Fast's bill, which set no date or would have set this off for an indeterminate length of time. What we've said.... I could run through it, but I want to be respectful of the time that you asked the question. I can run through specifically some of the things that I think need to happen.

We need time for our work with the provinces and territories to get to the position where there is system readiness, and that isn't present today.

● (2125)

Mr. Brendan Hanley: Thank you.

In the one-year extension that was applied a year ago, there were four criteria applied—a national reporting system, MAID practice standards to regulators in all provinces and territories, finalizing an accredited national MAID training program and considering the final report by the joint committee of the House and Senate. Of these four criteria, which have not yet been met, in your view?

Hon. Mark Holland: I think excellent progress was made. There was the development of the MAID practice standards. There was the development and delivery of a national accredited MAID curriculum. There were 1,100 clinicians registered. I could go on, but I think one concern is that only 2% of psychiatrists have been trained at this moment in time. Of the 1,100 clinicians who received training, only 40 of them have completed that training. In talking with CAMH, there's discussion about wanting to have clinical guidelines. Those would take time to develop.

Lastly, perhaps I could very briefly mention the engagement with indigenous leadership. As I've gone and had these trilateral meetings, they're asking for more time—and specifically 2025. This is also true of the community of folks with lived experience in the disability community.

Mr. Brendan Hanley: Thanks.

There's the letter from seven provinces and three territories. We all know about that letter. How influential was that letter in respect of the committee recommendations? How did each of those weigh into your decisions?

Hon. Mark Holland: I'll be frank. When I became health minister and I had initial conversations, because of the points that you've just raised and the enormous progress made in a year, I really felt that the system might be ready. In Charlottetown, what I heard every health minister say was that they weren't ready. They needed more time. That caused me to have a pause at that moment in time. It led me to a lot of other conversations where I'm reflecting on some of the things that happened here. I would say that the joint committee in its testimony and work was also very important in coming to that determination.

It was certainly a part of the equation, the position of the provinces and territories.

Mr. Brendan Hanley: Let's say that letter came from maybe one province or from two provinces and one territory. How would that have changed? In other words, if some provinces are stating that they in fact are ready, how can we justify holding back when they say they're ready to go and they have all the systems in place?

Hon. Mark Holland: Maybe I'll paint the picture in an inverted fashion and say that it was no province and no territory. All 13 said they were not ready. I had very thoughtful conversations with many different health ministers who completely agreed on the equivalency between mental and physical suffering. However, they were requesting more time to get their systems ready. That was an earnest expression, I believe, on their part.

Hon. Arif Virani: Perhaps I can point out to Dr. Hanley that, in Quebec, they actually legislated the fact that, for mental illness alone, this should not be provided. They took a more active step than the letter.

Mr. Brendan Hanley: Thank you.

The Chair: Thank you, Dr. Hanley.

[*Translation*]

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

Mr. Luc Thériault: The structure of the bill reiterates the recommendation that the members of the special joint committee voted on, except as regards the matter of the three-year delay. Everyone but the Conservative Party members felt people weren't ready. We thought that, a year later, it would be wiser to work on that timeframe.

I think we were lax in that regard. How was it that, at the moment when the committee tabled its report and a decision had to be made a few weeks before the deadline, the provinces submitted a letter to us that we hadn't heard about in the previous year? You allowed the panel to submit a recommendation to us that became a bill, and you talked about the constitutional right of the people who were suffering, but what did you do about Sandra Demontigny? What did you do about the main recommendation that this committee accepted by majority vote one year ago, and who said we had to focus on advance requests? How is it that we don't have a bill that contains that component when you had a year to prepare it? The final component on the mental disorders issue could have appeared at the end. Why are you abandoning people like Sandra Demontigny when there's a consensus across the country?

● (2130)

Hon. Mark Holland: That's a good question, and I do appreciate it.

People definitely suffer a great deal. I detest that, and it really disturbs me.

At the same time, we clearly have to ensure that the system in general is prepared for a change regarding medical assistance in dying. If the system isn't prepared, the consequences will be very serious.

We've made a lot of progress in the past year. It's remarkable, as I explained to Mr. Hanley, but it isn't enough.

The advance requests issue is extremely complex. For example, if a person is in poor shape, and one member of that person's family believes it's time to administer medical assistance in dying, while another family member thinks it isn't, it's the physicians who will have to make a decision. The individual won't be capable of making a decision. So there's a lot of complexity, and we're going to speak with the others—

Mr. Luc Thériault: No, I'm going to stop you there. Stop that; this is disinformation. Stop it.

Read the Quebec statute. You aren't being rigorous. I'm going to calm down, but your answer makes no sense.

This isn't about one member of the family or another. Under the Quebec statute, the assessment is conducted by a third party. A third party will be appointed, and that third party won't have the authority to tell the attending team to administer medical assistance in dying. The third party will be the guarantor of the person's wishes based on criteria that will have been established, and that third person will tell the attending team that he or she thinks the person meets those criteria and will request that assessment.

What are you talking about? We made that recommendation to you one year ago, and you're giving me a truly crazy answer this evening. I'm going to calm down, but I understand why we don't have a bill by now if that's how you understand advance requests in Quebec. The National Assembly of Quebec is unanimous on this point, and the approval rate across the country is 85%. People are waiting for this because people are suffering.

What are you waiting for? Are you at least going to commit, this evening, to helping us come up with a bill before the end of this parliament?

Get informed.

Hon. Mark Holland: I understand the reasons why people want access to a system that permits advance requests. It's logical. However, my point is that this is completely different from the present situation and from what the bill proposes.

Today people can say in advance what they want to happen in a given future situation. However, if, at that time, they're incapable of expressing what they want, someone else will have to do it. That's a major change because someone else will have to make a choice instead of that person.

I'm entirely prepared to discuss this. We're going to speak with all the provinces and territories—

Mr. Luc Thériault: No, but, listen—

Hon. Mark Holland: It's a complicated situation.

Mr. Luc Thériault: Neurodegenerative diseases are physically degenerative diseases where irremediability and developmental stages toward the end, toward decline, are objectively determined. From there, you can't think they're any more complicated than mental disorders over which people are, in a way, torn over remediability. So—

[*English*]

Mr. James Maloney: On a point of order, Mr. Chair, with the earlier panel—

[*Translation*]

Mr. Luc Thériault: Why is there a point of order? Let me speak.

[*English*]

Mr. James Maloney: —Mr. Doherty made an objection, which I agreed with at the time. We're not here talking about advanced requests. We're here talking about Bill C-62. It's a piece of legislation with a very specific outcome.

As much as I appreciate Mr. Thériault's passion, it's not on topic.

● (2135)

The Chair: Thanks for the intervention, but we've allowed it all evening. I'm not inclined to change it now. It appears the ministers are ready to speak to it.

[*Translation*]

Mr. Thériault, please ask your question, then we'll give the minister 30 seconds to reply because your turn to speak is nearly over.

Mr. Luc Thériault: All right. Will there be a bill? Will you look into this so we can have this component that would cover people who are suffering? Are you going to read the Quebec act for inspiration so we can solve this problem once and for all? According to an Ipsos survey, the national approval rate is 85%. That's a real poll.

The Chair: You have 30 seconds left.

Hon. Arif Virani: We're entirely up to date on the bill that was passed in Quebec.

Mr. Thériault, I can tell you that we've been proceeding cautiously from the very start, in 2016, but always at the national level, for the entire country. The same was true when we responded to the Truchon decision. The same is true when we handle advance request cases. We're going to do it in consideration of Quebec's study and leadership, but we will conduct a study that applies all across Canada.

Mr. Luc Thériault: Caution isn't welcome when it makes people suffer.

The Chair: Your time is up, Mr. Thériault. I even allowed you a little extra time.

[*English*]

Mr. MacGregor, go ahead, please. You have six minutes.

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

Thank you, Ministers.

Minister Holland, I'd like to start with you on the subject of the letter that was signed by seven out of 10 provinces and all three territories.

In our first panel, some witnesses were talking about readiness in the system. I am assuming that these ministers would not have signed this letter unless they had confirmed with their deputy ministers or assistant deputy ministers that in fact their system was ready.

You've had in-depth conversations with these members. You've probably had conversations with their deputy ministers. What conditions would have to be in place for you to attach your name to such a letter? You would probably want to consult with your deputy minister to get that kind of assuredness from the health care system that you're overseeing.

Hon. Mark Holland: Do you mean the letter saying that it would be indefinite, as opposed to three years?

Mr. Alistair MacGregor: What conditions would have to be in place for you to sign such a letter? Would you want to check with your deputy minister first?

Hon. Mark Holland: I always would check with my deputy minister.

Mr. Alistair MacGregor: Okay, that's a good point to put into place.

Also, these ministers were very careful to ask for an indefinite pause. What caused you to choose the three-year delay instead of listening to the ministers who have that oversight of the health care systems?

Hon. Mark Holland: There were detailed conversations with the health ministers. Part of that was about how long it was going to take their systems to get ready.

One concern with some of the ministers, really, was a question of readiness. They acknowledged the equivalency between mental suffering and physical suffering, but a few of them were simply ideologically opposed to the idea of ever proceeding in such a way.

I think that if we were to put it off indefinitely, then we'd see no progress in the system in terms of the adoption of the curriculum or even the belief that we were moving towards that. That would leave people who are in unimaginable suffering.... We're talking about a very small number of people, but these are people who have tried everything and are stuck in unimaginable mental hell. After decades, in many cases, of asking, they are saying, “I want access to MAID”. That is a consideration here.

Mr. Alistair MacGregor: Thank you.

I am going to take issue with two of your earlier comments.

I do think, actually, that this issue has been punted down the road. It was punted down the road by two years with the Senate amendment. It was further punted down the road by one year of Bill C-39. Now we're looking at a three-year punt.

I also take issue.... I've been on the special joint committee since its inception. I agree with the recommendation that we put forward, but we did not have anywhere near enough of a time frame to study this issue in depth. We had three meetings of three hours each.

How can you say that this is not punting it down the road? How can you say that the special joint committee had adequate time when in fact we did not?

Hon. Mark Holland: This, of course, was the second time the joint committee had been sitting. The joint committee, in its previous iteration, had spent an extraordinary amount of time on the subject. It was round two, if you will, for the special joint committee. We're very appreciative of their work. They did extensive work in the first round and that wasn't very long ago.

The second point was that there seemed to be a uniformity of opinion within that joint committee that more time was needed. I don't know how much time you need to study.... Once you reach a conclusion that says you need additional time, to keep studying to say you need more time doesn't make a huge amount of sense to me.

In terms of punting down the road, you can use whatever nomenclature you want. The point here is that we have to make sure the system is ready. Given the opportunity, I can talk about all the things that were done over that one-year period and why we thought they would be sufficient, but the underlying reality is that it was insufficient and we needed more time. I wish I had clairvoyance and could have known that, but I lacked it.

● (2140)

Mr. Alistair MacGregor: Thank you.

I'd like to turn to Minister Virani, if I could.

You were mentioning, to paraphrase the Supreme Court, that they were going to give a high degree of deference to Parliament when legislating in this area because of how sensitive it was. When Bill C-7 was first introduced, I thought there was a very reasonable charter statement issued that explained the government's initial reasons for excluding this. Then at the eleventh hour, a very consequential Senate amendment was accepted. I think that really is the root of all the problems we're finding ourselves in today.

Do you, as a minister, now have regret about that decision?

I truly believe that this decision was putting the cart before the horse—and I'm speaking as a member of the special joint committee. We have been playing a game of catch-up ever since. The law was changed in advance of the important consultation and in advance of those committee hearings. As a result, we have had to constantly shift the timeline.

Again, why didn't the government exercise that high degree of deference, as you put it, that the Supreme Court gave you the room to exercise in the first place?

Hon. Arif Virani: I think there are two issues there, Mr. MacGregor. One is what deference is accorded by the Supreme Court, and then the other is your criticism of our response circa 2019-21 vis-à-vis mental illness.

Do I regret that decision? Not at all, because I think what the Senate prompted was an active discussion about mental illness and the evolution of this law and its potential expansion. The development of the MAID curriculum, the model standard and things like the oversight mechanisms that are under development are all by-products of that function. I think that's proper vis-à-vis showing equivalence between mental suffering and physical suffering and not perpetuating negative stereotypes such as that mental suffering does not deserve the same level of treatment or to be addressed, and also not perpetuating pejorative assumptions about the decision-making capacity of people who are mentally ill.

On the deference piece, Mr. MacGregor, what I would say to you is that the court has said that there's a certain amount of deference owed as part of the dialogue between the courts and Parliament. There's extra deference shown in the matter of complex social policy, and then they highlighted in the Carter decision that, when it comes to MAID, that deference is directly applicable.

What they're saying there is that they're going to allow a margin of manoeuvrability for Parliament to try to get this right when we're balancing delicate interests. I'll say to you what I said at the outset. When you have issues around the unpredictability of the course of one's mental illness and when you have the possibility of suicidal ideation being a symptom of someone's condition, while I firmly believe you can distinguish between suicidal ideation and a well considered, well-thought-out request for MAID, you have to make sure that difference and that distinction can be made. You also have to ensure that all of the health care practitioners, MAID providers and assessors have the ability to do so.

When only 40 people have had that education, I think that's not enough.

The Chair: Thank you, Minister.

We have Mr. Cooper, please, for five minutes.

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

Minister Holland, you have repeatedly claimed this evening that the only persons who would be captured by this expansion of MAID for mental illness are persons who have been suffering with an irremediable, irreversible mental health condition for a prolonged period—decades—and have sought all treatment options. That is false, and you know it to be false.

Minister, on what basis can you peddle such a false claim?

Hon. Mark Holland: I would hope that anybody who is in a mental health crisis would come forward and would seek mental health services, and of course under the regime that we're contemplating here today, that would mean that somebody would get help. They would not have access to the regime. What I'm saying, sir, is that for the people I'm speaking to, these are very real cases with individuals who are trapped—

Mr. Michael Cooper: Minister, it's my time and my question.

The Chair: Go ahead, Mr. Cooper.

Mr. Michael Cooper: There are no legislative safeguards, none whatsoever in the case of MAID for mental illness. All that would be required is for someone to sign off—two clinicians, not even a psychiatrist, not even a medical doctor necessarily—and they would then have the green light and would be eligible with the 90 days.

What are you talking about when you talk about safeguards, because there aren't any?

● (2145)

Hon. Mark Holland: That's just not true, and Minister Virani can speak to it as well.

First of all, let's reverse this. The accusation and the way you're coming at me is as if somehow I don't care about people and their mental health.

Mr. Michael Cooper: You made a very specific claim repeatedly—

Hon. Mark Holland: You're being extremely aggressive with me and not allowing me an opportunity to express.... I understand you have a political point to make. It's a question of whether or not you want to hear my answer.

The Chair: Mr. Cooper, you're holding him a little too tight to the timeline.

Take another 10 or 12 seconds on this question, and we'll move to the next one.

Go ahead.

Hon. Arif Virani: The safeguards are that you “must be informed of available and appropriate means to relieve [your] suffering, including counselling services, mental health and disability support services, community services, palliative care—

Mr. Michael Cooper: Minister, it's my time. I'm reclaiming my time.

Hon. Arif Virani: Also, the person and practitioners must discuss those means and agree that the person is seriously—

Mr. Michael Cooper: I'm reclaiming my time.

The Chair: Go ahead, Mr. Cooper.

Mr. Michael Cooper: I'll go back to Minister Holland.

If what is being referenced is the so-called model practice standard, that has no teeth. That is very different from a Criminal Code safeguard. With respect to that so-called model practice standard, there's nothing there that provides guidance on the lengths, numbers and types of treatments. There's nothing about all treatment options being exhausted by the patient.

In the face of that, how can you possibly claim that this will impact only a small number of people who've suffered over a prolonged period of time? That's simply false, and you know it, Minister.

Hon. Mark Holland: You can say that, but it doesn't make it true. Secondly, you won't allow us to enumerate the ways in which there are safeguards. You say there aren't safeguards, and then you aggressively talk over me as we try to talk about what those are.

I would simply posit to you that the eligibility criteria is extraordinarily strict and that the model practice standards being incorporated by the provincial regulators will be similarly strict. As for the Criminal Code, if somebody violates those, it is a criminal violation. It is not a light matter and—

Mr. Michael Cooper: Minister, it is my time.

Hon. Mark Holland: —my interest in this, as has been expressed—

Mr. Michael Cooper: It is my time, and I would cite—

Hon. Mark Holland: You're certainly making it clear what your time is about, sir.

Mr. Michael Cooper: Here's a fact. There was a survey released by the Ontario Psychiatric Association that provides that 78% of Ontario's psychiatrists—this was released two weeks ago—are of the view that the current so-called safeguards are insufficient and will result in the inappropriate application of MAID for persons who are struggling with mental illness—in other words, wrongful deaths.

Why would Canadians believe you and trust you over 78% of Ontario's psychiatrists?

Hon. Mark Holland: First of all, my interest, like yours, is to protect life and to make sure that people who are suffering get every opportunity to get the help that they need.

Second, the situation that exists right now is asking for additional time because we do believe safeguards are present. I have talked about some of those, but we think we have to go that much further to make sure that those safeguards are there. The people who are trapped.... By the way, we're talking about people on their volition in an irremediable mental illness circumstance—

Mr. Michael Cooper: Minister, there are no legislative safeguards.

Hon. Mark Holland: You can say that. It's your theatre, and you continue to play—

Mr. Michael Cooper: You haven't cited one. You haven't cited any, and you haven't responded to the fact that 78% of Ontario's psychiatrists believe that whatever so-called safeguards that will be in place are completely insufficient.

We're talking about wrongful deaths when there's an inappropriate application of MAID. That's what we're talking about.

Hon. Mark Holland: We're talking here and see in this legislation—

Mr. Michael Cooper: What we're talking about, minister, is what you've demonstrated: that you're ideological and you're reckless.

Hon. Mark Holland: First of all, I'm just going to say that I reject that—

Mr. Michael Cooper: You're playing with people's lives, and that's absolutely disgraceful.

Hon. Mark Holland: No. What is disgraceful is mis-characterizing my position or mis-characterizing the position of any member of Parliament, sir. Saying that any member of Parliament doesn't care about human life is a disgraceful thing that I will not tolerate.

For you to step into this committee and make an accusation of any member of Parliament that they do not care about the life of another human being is absolutely beyond reproach, sir. I have spent my entire life, as you have, fighting for the good in this world. To accuse a good person of not caring about human life...shame on you.

Hon. Arif Virani: Mr. Chair, I will just point out that the safeguards that I mentioned are in the Criminal Code of Canada. That is a legislated safeguard. We also have protections, save for exceptional circumstances, against compelled treatment in this country. That is protected under the charter.

Thank you.

The Chair: Next up we have Mr. Naqvi, please, for five minutes.

● (2150)

Mr. Yasir Naqvi: Thank you very much, Chair.

I want to go back to the safeguards, because I think that's a very important conversation to have.

Starting with you, Mr. Virani, why don't you outline the legislative safeguards that are in place?

Perhaps, Minister Holland, you can then talk about the safeguards that are being put in place for the medical community in order to administer MAID properly.

Hon. Arif Virani: Let me start with the legislated safeguards that are in the legislation called the Criminal Code of Canada. We're talking about track two, which is where death is not reasonably foreseeable.

You must make the request in writing. Two independent doctors or nurse practitioners must provide an assessment. The person must be informed that they can withdraw their request at any time and in any manner. The person must be informed, to Mr. Cooper's point, of available and appropriate means to relieve their suffering, including counselling services, mental health and disability support services, community services and palliative care, and must be offered consultations with professionals who provide those services. The person and the practitioners must have discussed reasonable and available means to relieve the person's suffering and agree that the person has seriously considered those means. This assessment must take at least 90 days. You can pause it. What I have heard anecdotally is that, in the context that mental illness is the sole underlying condition, it would likely take much longer than 90 days. Last, you must provide final consent immediately before MAID is provided.

All of those safeguards are legislated. These are not practice guidelines or practice standards, etc. Those are in the Criminal Code of Canada under the MAID provisions.

I'll turn it over to Minister Holland.

Mr. Yasir Naqvi: Just very quickly to cap that part off, "legislated" means, being in the Criminal Code, we have the full force of the law as it relates to the Criminal Code of Canada behind those safeguards.

Hon. Arif Virani: That is correct.

Mr. Yasir Naqvi: Thank you.

Go ahead, Minister Holland.

Hon. Mark Holland: Thank you so much.

As I get an opportunity to talk with clinicians, doctors and nurses across the country, all of them are trying to get this right and are deeply concerned about their patients. That's why I get so upset, because I think that, as parliamentarians, casting aspersions on people's motives and trying to insinuate that somehow anybody is not caring about human life is just deeply irresponsible.

In my experience, those who developed the national accredited MAID curriculum, those who developed the practice standards and those who are in the system are trying deeply to work with people who are in extraordinary pain. When a doctor has a patient who has been coming to them for decades in unspeakable pain and that doctor says, "I can't do anything for this patient; we've tried everything," and that patient is asking for a way out, it is extraordinarily painful to hear that.

You could have an ideological position that you don't want to deal with that, but I think that understanding and navigating this and trying to work with the provinces and territories so they have appropriate safeguards, and looking at CAMH suggestions around clinical guidelines, are entirely appropriate, because we have to make sure that those safeguards are as strong as possible and that we are only dealing with those remote and most unusual of cases.

Mr. Yasir Naqvi: It is a very difficult place for us, as parliamentarians, of course, to make sure that those who are responsible to administer the system feel confident that they have all the systems in place. I believe, personally, that it is prudent for us to grant this extension so there is no doubt that the system is available across the country with the equity that we want to be sure of.

I give a fair bit of credence to the letter that is before us, which you received from seven provinces and three territories. The part that got my attention is, "It is critical that all jurisdictions, health authorities, regulations and MAID practitioners have sufficient time to implement these safeguards and to address capacity concerns that are expected to result from the expansion of MAID eligibility. The current March 17, 2024 deadline does not provide sufficient time to fully and appropriately prepare all provinces and territories across Canada".

How much was that an influence in your decision to bring forward this particular piece of legislation?

Hon. Mark Holland: Certainly it was a significant contributing factor, as I indicated earlier. I have a very good working relationship and talk nearly every day with my provincial and territorial counterparts, so when they say that their system needs more time, I take that very seriously. They put that in a letter to us. It had been clear that they wanted to look at additional safeguards, potentially saying that they want a psychiatrist to be present and involved in every instance and asking again about the issue of clinical guidelines.

I think that listening to the provinces, who are responsible for the administration of those programs, is critically important, and certainly it played a significant role in the decision to also listen to the joint committee's work.

● (2155)

Mr. Yasir Naqvi: Thank you very much.

The Chair: Next, we have Monsieur Thériault.

[*Translation*]

Mr. Thériault, you have the floor for two and a half minutes.

Mr. Luc Thériault: Yes, there are legal and clinical safeguards that must be considered.

Shouldn't recommendation 10 of the expert panel report be referred to in the act or the regulations that will be made under the act? I think it's important to do that. I know that what we'll eventually adopt will be completely different from what we now have because we haven't come up with the final bill. However, it seems to me that, if we want to have a discussion and do good work in the short term, we should mention recommendation 10.

The other recommendation that I consider important regarding mental disorders is recommendation 16, which concerns prospective oversight, not retrospective oversight. Quebec has established a committee to monitor medical assistance in dying acts and to report retrospectively on those acts.

Consequently, there should be a prospective provision regarding mental disorders and thus an additional step that would have to be taken before acting. If the request is admissible and the patient has gone through all the steps, a committee would review the process to determine whether it's satisfactory and complies with all the safeguards, both clinical and legal. I think it's important to do this properly in the case of mental disorders, given the fact that the experts are divided on the matter. We will have to proceed this way if we want to establish a system in a calm manner.

The question I would ask is as follows.

It's all well and good to postpone passage of this bill, but, from the moment it's passed, once it has been passed by the Senate, what intermediate steps will have to be taken? What will you have to do right away once this bill is passed? That's the problem that we've had since we started this study on medical assistance in dying. We delayed action, again and again, and wound up with deadlines that were too short and requests for extension.

What will you do immediately after royal assent so that we can continue our work?

Hon. Mark Holland: It's not just a matter of what happens immediately after the bill is passed in the Senate. This concerns a situation that we're studying now; we're working every day with every province and territory to improve our system's capacities.

We're still discussing issues such as advance requests and the other aspects of medical assistance in dying. We definitely have to continue training to ensure we have a system that's ready for these changes.

This isn't a subject that's easy to address. It's a subject that's emotionally charged, as we can see today.

The Chair: Mr. Thériault, it took more than two minutes for you to ask your first question. You don't have any more time.

Minister, if you have a few thoughts to share, go ahead briefly.

Hon. Mark Holland: No, that's not a problem. I'm prepared to answer other questions.

The Chair: Unfortunately, Mr. Thériault's speaking time is already up.

[*English*]

The Chair: Mr. MacGregor, please, you have two and a half minutes.

Mr. Alistair MacGregor: Thank you, Chair.

I want to ask one question of each of you in the two and a half minutes, so please respect the time I have.

I will address you first, Minister Virani.

I've heard the constitutional arguments thrown on both sides of the equation. As Minister of Justice and Attorney General of Canada, is there is an interest from your department in referring this issue to the Supreme Court of Canada?

Hon. Arif Virani: The matters of complex social policy are for Parliament to determine and for courts to evaluate after the fact. There is no interest in pursuing a reference right now, and an abstract reference question can even be denied to be answered by the court.

Mr. Alistair MacGregor: Thank you for answering that.

Minister Holland, I understand the differentiation between mental health and mental illness, but when I go around my riding of Cowichan—Malahat—Langford in particular sections and particular communities, it's quite obvious that many people are suffering from a mental illness. You can see it right on the streets.

I take the point of the legislative safeguards that exist in the Criminal Code, but there still is a very real concern that, because of an individual's circumstances, such as the fact that they may come from a disadvantaged population and may not have had the same access to services throughout their life, they may still be able to satisfy the legislative safeguards in the Criminal Code but they may have been sent down that path because of the life circumstances they find themselves in.

As the Minister of Health, given the great needs we have and are very evident across our country, how do you resolve that as a minister and with it being such a very sensitive issue?

● (2200)

Hon. Mark Holland: Thank you so much for the question. I acknowledge that to be true. Often there is a direct correlation between those who have suffered the most and those who are in the worst state of mental health. Sometimes when somebody has a mental illness—which, again, is different—it can certainly be greatly exacerbated by trauma or by those very difficult circumstances of which you speak.

One of the reasons I think we need time is that we need to make sure we get that line exactly right. To the point you're making, we don't want to wind up in a circumstance where somebody has a mental illness and they push, and there was something we could have done.

We have to exhaust everything, and it can really only be at the end of the road, after we have tried everything. If we have been unable to find a solution, then I think we're left with the question of what we as a society can do if somebody has tried absolutely everything and is at the end of their rope in terms of pain and they wish, of their own volition, to end that. It's a complicated and difficult question. That's why I think we have to take time.

However, I acknowledge the circumstances you're taking about. That's one reason I said at the outset that I think those conversations with many of those disadvantaged communities are so essential, to make sure they are fully comfortable that the controls are in place and that we're proceeding in the appropriate way.

The Chair: Thank you, Minister.

Thank you, Mr. MacGregor.

We are at almost exactly one hour. I propose one question each for the Conservatives and the Liberals. Please keep the questions and answers short. It has been a long day for everyone.

I'll turn it over to the Conservatives for one question.

Mr. Todd Doherty: Minister, I want to start with this. I believe your outburst earlier was inappropriate. I believe that it was very charged. I believe you owe not only the committee members here but also those who were sitting beside you an apology. If you could have see the look of shock on their faces when you had your outburst—

The Chair: Please get to the question, Mr. Doherty.

Mr. Todd Doherty: The question I have for you is whether substance use disorder is a mental illness. Are you going to answer?

Hon. Mark Holland: To the first point, I did become emotional, and I apologize for that. I think it's so terrible. I have never done this. To cast aspersions and particularly to accuse another member of advocating for death and not caring about human life, I think at a certain point we have to draw lines in our discourse. At a certain point we have to say there are boundaries and places that we shouldn't go—

Mr. Todd Doherty: Sir, are you going to answer my question?

Hon. Mark Holland: —and there are things that are inappropriate. I would suggest that Mr. Cooper's making the suggestion that I or any other member of Parliament doesn't care about human life is irresponsible and is something that at some point, yes, will elicit an intemperate response.

The Chair: Okay.

Mr. Doherty also asked a question about whether something was—

Mr. Todd Doherty: Is substance use disorder a mental illness?

Hon. Mark Holland: I think we have a crisis absolutely with substance use in this country. Substance abuse in many instances has at its root a mental health concern.

Mr. Todd Doherty: Is it a mental illness, though?

The Chair: Thank you both.

The last question is for the Liberals.

Mr. Maloney, go ahead.

Mr. James Maloney: Thank you, Chair.

Thank you to both ministers.

My question is going to be for Minister Holland. This is an emotionally charged debate. I don't think anybody needs to apologize for demonstrating passion when they are discussing this.

I have been involved in this process since very early on, along with Mr. MacGregor, Mr. Cooper and others. We're dealing with a very specific issue and that is whether to postpone the implementation of MAID solely for the purpose of mental illness. We're not here to debate constitutionality. We're not here to debate advance requests. We can debate the morality. These discussions are going to take place in another context.

My question is this, and I put this to a witness earlier. I feel the only responsible thing that I as a legislator can do—and I think people around this table would agree with me—regardless of what side of the discussion I fall on, if I'm faced with a lack of consensus by professionals, is to postpone it to allow for further discussion.

There are two parts to my question. That's the first part. Do you agree with me? The second part is on the timeline. You have introduced a piece of legislation that postpones it for three years as opposed to indefinitely. Minister, you addressed this briefly earlier, but is the reason for doing that not to advance an agenda but to keep it on the agenda since, otherwise, it could just fall into never-never land?

Thank you.

● (2205)

Hon. Mark Holland: I think that's an entirely appropriate way to characterize it. I think the concern with putting it off indefinitely is that we leave those people—there are not many, but they're there—who are in intractable, horrifying conditions trapped in mental torture with no prospect of our moving toward any possible solution, so it creates an imperative to act and an imperative to keep moving.

In two years' time, Parliament will get the opportunity once again to conduct a parliamentary review and evaluate the state of readiness at that time.

The Chair: Thanks—

[*Translation*]

Mr. Luc Thériault: On a point of order, Mr. Chair.

The bill before us has been the subject of several Bloc Québécois motions to introduce the issue of advance requests. I can't accept the contention that we shouldn't discuss it because it doesn't concern what we're doing this evening.

The Chair: That wasn't a point of order, but rather an expression of your point of view.

[*English*]

First of all—I know you're aware of this—the motion that resulted in this meeting taking place indicated we could have a minister, and we had two ministers show up. Thank you.

I know it's been a long day for you. It's been a tough day for everyone. It's clear how important and how difficult this issue is, but it's also clear that you care deeply about it. We very much appreciate your being here and working through all of this.

Is it the will of the committee to adjourn the meeting?

Some hon. members: Agreed.

The Chair: We're adjourned.