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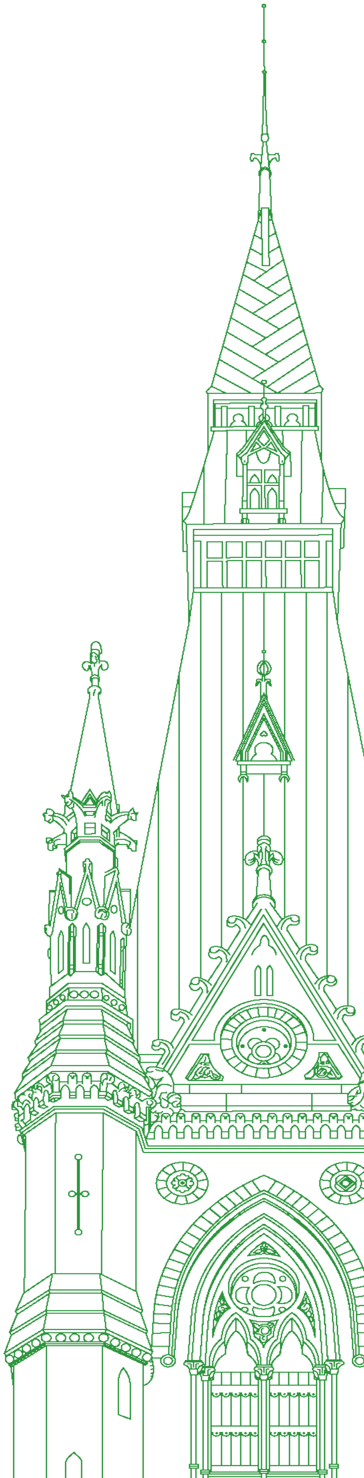

Chair: Ms. Iqra Khalid

Standing Committee on Justice and Human Rights

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● (1105)

[*English*]

The Chair (Ms. Iqra Khalid (Mississauga—Erin Mills, Lib.)): I call this meeting order.

Welcome to the fifth meeting of the House of Commons Standing Committee on Justice and Human Rights as we continue to study Bill C-7.

Today's meeting is taking place in a hybrid format. I understand that there are a number of members who are in the committee room at this time.

The proceedings will be made available via the House of Commons website. Just so you are aware, the webcast will only show the person who is speaking, instead of the entirety of the committee room.

To ensure an orderly meeting, I would like to outline a few rules.

Members and witnesses, you may speak in the official language of your choice. Interpretation services are available for this meeting. You have the choice at the bottom of your screen. You can select either the floor language, or English or French for your translation or interpretation.

For members participating in person, proceed as you usually would when the whole committee is meeting in person in the committee room. Keep masking and health protocol rules as a priority as you attend in person.

Before speaking, witnesses and members, please wait until I recognize you by name. For those participating virtually, please click on the microphone icon to unmute yourself. For those in the room, the microphone will be controlled as normal by the proceedings and verification officer.

As a reminder, all comments by members and witnesses should be addressed through the chair.

When speaking, please speak slowly and clearly. When you are not speaking, your mike should be on mute.

With respect to keeping the dialogue respectful and engaging, it's okay to disagree, but it's not okay to be disrespectful to one another.

With regard to the speaking list, the committee clerk and I will do the best that we can to maintain a consolidated order of speaking for all the members, whether they're participating virtually or in person.

I'd now like to welcome our witnesses, which are four organizations that are represented by various esteemed guests.

We have the Canadian Association of MAiD Assessors and Providers, represented by Dr. Stefanie Green, president.

We have the Canadian Medical Association, represented by Dr. Ann Collins, president, and Dr. Cécile Bensimon, director of ethics and professional affairs.

We also have with us the Commission on End-of-Life Care, represented by Dr. Michel Bureau, Dr. David Lussier, Pierre Deschamps and Stéphanie Goulet.

We also have Ménard, Martin Avocats, represented by Jean-Pierre Ménard himself.

Each of these four organizations will have five minutes to make its opening statement, followed by rounds of questions.

I'll invite the Canadian Association of MAiD Assessors and Providers to please begin. You have five minutes.

Dr. Stefanie Green (President, Canadian Association of MAiD Assessors and Providers): Thank you for the opportunity to be here today.

My name is Stefanie Green. I'm a physician with 25 years of clinical experience. In June 2016, I began working almost exclusively in medical assistance in dying. I'm currently an assessor of eligibility as well as a provider of MAID in B.C.

While I wear a number of MAID-related titles, I am primarily here today in my capacity as the president of the Canadian Association of MAiD Assessors and Providers, a national medical association that represents and supports the variety of professionals who have arguably grown into the foremost experts on assisted dying in this country.

I wish to impress upon this committee that as an organization, we do not work to advocate assisted dying. We are in fact the community of professionals who do the work to the highest of medical standards and always within the law of the country, whatever that law may be. We have the collective lived experience of how the practice of assisted dying has unfolded across this country, where the obstacles and successes have been found and how the system might be improved to the benefit of all involved. It is in this context that I now address you and hope to answer your questions.

In the limited time I have, I want to be sure to first emphasize what I think Bill C-7 has gotten right, and then speak to what I think needs clarification and suggest two simple but important practical changes.

I first want to support the proposed removal of the 10-day reflection period for those whose death is reasonably foreseeable. In four and a half years, there has been no evidence that this reflection period has safeguarded anyone from anything, but there is evidence to suggest that it has mandated substantial suffering, which I do not believe was the intention of the law. In my written brief, I have provided some of this convincing data, and in my comments now I simply bid good riddance to what has proven to be an essentially false safeguard.

Second, I want to strongly support the proposed amendment to allow the waiving of final consent in the specific situation outlined in Bill C-7. A 2019 survey of MAID providers suggested that 85% of providers have personally experienced the situation of walking into a room to facilitate an assisted death only to find the patient no longer able to provide final consent due to an unexpected loss of capacity. I can tell you from first-hand experience how horrible that situation is. Loved ones standardly beg for the clinician to proceed. It is an agonizing situation for all, and I am unable to appreciate who exactly is being protected in such a situation by not proceeding with the previously planned MAID death. I am absolutely clear on who is harmed. The proposed amendment is essential, overdue and will be welcomed by patients, their families and the professionals involved in this work.

I do find the proposed requirement of setting a specific date somewhat problematic from a practical point of view. In my written brief, I have suggested that a 90-day time frame be used instead of a specific date being set, and I have suggested some very simple altered wording for your consideration.

Third, I applaud the government for specifically using the term “expert” when seeking expertise in complex illnesses and patients whose deaths are not reasonably foreseeable. This is a recognition that one does not need to be a particular medical subspecialist to have expertise in illness. Very often, family physicians and nurse practitioners are, by the nature of their practices, experts in a wide array of illnesses. This is especially true of practitioners in rural communities. In fact, many types of health professionals can and do develop expertise in specific illnesses, and it is wise to recognize this wide range of possible expertise.

That said, there are two remaining issues that must be highlighted.

First, I need to point to what I believe is a small but tremendously important error in Bill C-7, one that suggests a misunderstanding of health care realities and carries significant ramification. I believe this error can be easily and consensually remedied.

The current wording of proposed section 3.1 suggests that a clinician with “expertise” in the illness must be one of the assessors of eligibility for MAID in patients whose death is not reasonably foreseeable. Requiring the input of an expert on the illness in such a situation is not an unreasonable requirement, but mandating that the expert complete an assessment of eligibility for MAID itself is wholly unrealistic. As consultants consistently write in their reports to me, they will comment on their area of expertise but respectfully decline to opine on a patient’s overall eligibility for MAID, as that is neither their area of expertise nor their interest.

In my written submission, I have suggested simple wording that maintains the requirement for expert input but allows—in fact, requires—that two experienced MAID assessors do the work of assessing the patient's eligibility for MAID. To do otherwise, as is currently written, would essentially obstruct access to MAID for those whose death is not reasonably foreseeable.

Finally, the term “reasonably foreseeable” has historically created confusion. Now that a consistent, clinical consensus has developed and we have a court-backed working interpretation, it would be helpful if the government were to reinforce that the determination of what constitutes a reasonably foreseeable death is indeed a clinical decision and that its meaning has not changed with the implementation of Bill C-7.

I'm happy to answer any questions on these or other issues, and I thank you for your serious consideration of my comments.

● (1110)

The Chair: Thank you very much for that, Dr. Green, and also for keeping your remarks within five minutes. I really appreciate it. I think it's a great sign.

Next, we have the Canadian Medical Association, with Dr. Ann Collins and Dr. Cécile Bensimon.

Your time starts now. Please go ahead.

Dr. Ann Collins (President, Canadian Medical Association): Thank you, Madam Chair. It's my honour to appear before you today.

I am Dr. Ann Collins. Over the past three decades in practising medicine, I have taught family medicine, run a family practice, served with the Canadian Armed Forces and worked in nursing home care. Today, in my capacity as president of the Canadian Medical Association, I represent our 80,000 physician members.

In studying Bill C-7, it is incumbent upon us now to consider the effects on patients that the passing of this bill will have, as well as the effects on the medical professionals who provide medical assistance in dying, MAID.

When the original MAID legislation was developed as Bill C-14, the CMA was a leading stakeholder. We have continued that commitment with Bill C-7. Having examined Bill C-7, we know that in a myriad of ways, the results of our extensive consultations with our members align with the findings of the government's round tables.

Fundamentally, the CMA supports the government's prudent and measured approach to responding to the Truchon-Gladu decision. This thoughtful and staged process undertaken by the government is consistent with the CMA's position for a balanced approach to MAID.

Nicole Gladu, whose name is now inextricably tied to the decision, spoke as pointedly as perhaps anyone could when she affirmed that it is up to people like her “to decide if we prefer the quality of life to the quantity of life”. Not everyone may agree with this sentiment, but few can argue that it is a powerful reminder of the real stakeholders when it comes to considerations of this bill. This applies just as critically to those who are currently MAID providers and those who will become providers. They are our members, but we can't lose sight of the fact that we must all support both patients and providers.

Through our consultations, we learned that many physicians felt that clarity was lacking. Recent federal efforts to provide greater clarity for physicians are exceedingly welcome. The CMA is pleased to see new, non-legislative measures lending more consistency to the delivering of MAID across the country. The quality and availability of care, including palliative care, mental health care, care for those suffering from chronic illness and care for persons with disabilities to ensure that patients have access to other appropriate health care services is crucial.

The CMA holds firm on our convictions on MAID from Bill C-14 to Bill C-7. We believe, first, that the choice of those Canadians who are eligible should be respected. Second, we must protect the rights of vulnerable Canadians. This demands strict attention to safeguards. Finally, an environment must exist that insists that practitioners abide by their moral commitments.

These three tenets remain equally valid. Our consultations with members demonstrate strong support for allowing advance requests by eligible patients who may lose capacity before MAID can be provided. The CMA believes in the importance of safeguards to protect the rights of vulnerable Canadians and those who are eligible to seek MAID. The CMA also supports expanding data collection to provide a more thorough account of MAID in Canada; however, this effort must not create an undue administrative burden on physicians.

The CMA views as problematic the language in the bill that explicitly excludes mental illness from being considered an illness, disease or disability, and it has the potential to be stigmatizing to those living with a mental illness. We trust that Parliament will carefully consider the specific language used in the bill.

Finally, the CMA endorses the government's staged approach to carefully examine more complex issues. However, we must move forward to ensure practitioners are given the tools that will be required to safely administer MAID on a wider spectrum, such as support for developing clinical practice guidelines that aid physicians in exercising sound clinical judgment. Such guidance would also serve to reinforce consistency in the application of the legal criteria.

In conclusion, Madam Chair, allow me to thank the committee for the invitation to participate in today's proceedings and to share the perspective of Canada's physicians. The pursuit of a painless and dignified end of life is a noble one. The assurance that the providers of this privilege are supported is an ethical imperative.

● (1115)

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

We'll next move to the Commission on End-of-Life Care. Please go ahead.

[*Translation*]

Dr. Michel Bureau (Chair, Commission on End-of-Life Care): Madam Chair, committee members, as chair of Quebec's commission on end-of-life care, I would like to thank you for this invitation. Joining me are two of the commission's members, Pierre Deschamps and Dr. David Lussier, as well as the general secretary, Stéphanie Goulet.

Since December 10, 2015, the commission has reviewed the declarations in nearly 6,000 medical assistance in dying, or MAID, cases, drawing a number of lessons. The commission will comment on the data as they relate to five features of Bill C-7, but will not speak to MAID in relation to mental illness or individuals who do not have the capacity to consent, given the commission's lack of relevant data.

We will speak to five points.

First, the commission supports the removal of the requirement for a reasonably foreseeable natural death. If passed, Bill C-7 will make MAID available to many people who are suffering with serious and incurable illnesses, diseases or disabilities and who would have to continue suffering for years, if not decades. The commission does not believe the requirement's removal will lead to a significant spike in the number of MAID requests or the emergence of a death on demand culture.

Second, the commission approves of the elimination of the 10-day waiting period before MAID can be administered. The data and accounts collected by the commission show that the 10 days between the request and follow-through is a time of great suffering for the individuals concerned and their loved ones. In Quebec, more than half of people—53%—receive MAID less than 10 days after requesting it, not only because they fear becoming incapable of providing consent, but—

● (1120)

[*English*]

The Chair: Sorry, Monsieur Bureau; I can hear that the interpreters are rushing quite quickly to try to catch up to you. If you could slow down just a little bit so that everybody can understand the content of what you're saying, I'd appreciate it.

Thank you. Please continue.

[*Translation*]

Dr. Michel Bureau: Thank you for your comment.

The fact is that half of people receive MAID within less than 10 days because they are in great pain or fear losing the capacity to consent.

Third, the commission supports the waiver of final consent. Nearly a quarter of the forms submitted to the commission, so 26%, show that the patient refused pain medication because they feared losing the capacity to consent. As a result, they experienced unnecessary suffering.

Fourth, the commission supports the establishment of two separate assessment safeguards for the administration of MAID, depending on whether the person's natural death is reasonably foreseeable or not. The commission believes that the current assessment and safeguard measures are appropriate when a request is made by a person whose natural death is reasonably foreseeable. The commission supports the provision in Bill C-7 to establish a more extensive assessment and safeguard process specifically for people who request MAID when their natural death is not reasonably foreseeable.

Fifth, the commission recommends a safeguard mechanism in the form of an assessment and review committee, in other words, an oversight committee, for all cases in which MAID is administered. The Quebec National Assembly chose to establish a similar mechanism, entrusting the responsibility to the commission. It followed in the footsteps of Belgium and the Netherlands.

Having spent the past five years reviewing 6,000 MAID cases involving individuals whose natural death was foreseeable, we have come to three conclusions. We would like to share them in the hope that they may inform any decision to expand MAID eligibility to individuals whose natural death is not reasonably foreseeable.

First, MAID providers must report the administration of MAID beforehand, they must describe the complete clinical presentation that supports MAID, and they must be aware that the clinical presentation will be subject to expert review.

Second, the post-hoc analysis of every case in which MAID is administered provides an opportunity to give physicians and institutions regular and immediate feedback when explanations or supporting information is needed. In addition to reassuring the public, this step helps to prevent potential abuse.

Third, the real-time assessment of cases in which MAID is administered helps to detect borderline cases and allows for a swift response, where necessary.

Ladies and gentlemen, thank you for listening.

We will be providing a short brief outlining our position.

● (1125)

The Chair: Thank you, Dr. Bureau, for your statement and your commitment to the community.

[*English*]

We will now go on to Mr. Jean-Pierre Ménard for five minutes, please.

[*Translation*]

Mr. Jean-Pierre Ménard (Lawyer, Ménard, Martin, Avocats): Good morning. It's a pleasure to appear before the committee today.

I had the singular opportunity to represent Mr. Truchon and Ms. Gladu in their challenge of the federal legislation. Mr. Truchon, who left us in April, would be especially pleased to see the outcome.

I will not go over every aspect of the amended provisions. I will simply speak to a few broader elements.

To begin with, I fully support all the provisions that make MAID more accessible to those who need it. Specifically, I'm thinking of the removal of both the requirement for a reasonably foreseeable natural death and the 10-day waiting period, and the simplification of the overall process, including the waiver of final consent.

Two aspects of the bill are nevertheless very concerning.

With respect to the notion of a reasonably foreseeable natural death, the Superior Court of Québec struck it down as a criterion to access MAID, but went even further. The criterion was hard to apply and had little meaning for physicians. The government is, on one hand, removing the criterion, but on the other, reintroducing it by creating a second process for those whose natural death is not reasonably foreseeable.

This opens the door to the creation of two classes of people: those in the second class will be treated differently than those in the first, whose natural death is reasonably foreseeable. Those in the second class will be subject to a series of additional measures, including a 90-day waiting period. I have no idea why the government established such a time frame. It is totally unnecessary.

In her decision, Justice Baudouin made it clear that assessments should be carried out on a case-by-case basis and that it is the physician's responsibility to assess the request on its merits. She stated that people whose natural death is not reasonably foreseeable should not be placed in a separate category, as though they are vulnerable and matter less than the others. This is an override provision. I discuss that at length in my brief.

I would point out that the corresponding 90-day waiting period is totally unnecessary. People who want to receive MAID and who meet the requirements should have access to it immediately, without submitting to procedures other than those set out in the legislation, plain and simple.

What is more, under the bill, mental illness would not be considered an illness. This is the wrong way to go. Again, Justice Baudouin was very clear in her decision, recommending case-by-case assessments based on the person's capacity, not a sweeping judgment that puts everyone in the same category—which would open the door to all kinds of discrimination. This would unnecessarily stigmatize mental illness. It would also lead to other forms of abuse. It seems to me that the provision would very likely be the basis of a court challenge.

It requires careful examination. What happens in cases where a person's natural death is not deemed to be reasonably foreseeable and where a person has a mental illness? As I understand it, the bill will create subclasses of people, something that will not easily stand up to a constitutional challenge.

● (1130)

Still, the bill is an improvement worth protecting, so this snarl should be avoided.

Thank you.

The Chair: Thank you, Mr. Ménard.

[*English*]

We're now going to go into our first round of questions. We will start with Mr. Moore for six minutes.

Please go ahead. The floor is yours.

Hon. Rob Moore (Fundy Royal, CPC): Thank you, Madam Chair.

Thank you to all our witnesses for being here today.

There are a multitude of opinions on this issue, but there are people of goodwill on all sides who want the best for Canadians.

Dr. Collins, it's good to see you again. I want to direct my first question to the Canadian Medical Association.

I feel the true measure of a society is how we care for the most vulnerable. As we have undertaken this study, I know I have been contacted, as have all members of this committee, about concerns for people who are at a low point in their lives, people who have just heard about a major illness and people who are the most vulnerable in our society.

One of the concerns that has been raised is that even though Bill C-14 was passed just a short time ago and we still haven't had our parliamentary review of Bill C-14, the government did not appeal the Quebec Superior Court decision last year. This bill, this response, pulls out a number of the safeguards that Parliament in its wisdom put in place a few short years ago.

You mentioned in the brief you circulated to us the importance of ensuring vulnerable Canadians are adequately protected. We know of cases that have been publicized of people who clearly have been coerced to consider MAID, who didn't raise MAID but were approached to consider it. I find that concerning.

Could you give some thoughts from the Canadian Medical Association's perspective on how we can ensure vulnerable Canadians are adequately protected?

Dr. Ann Collins: The Canadian Medical Association feels it is important for all of us and for parliamentarians to consider the concerns and to respect the needs of vulnerable populations. We feel that safeguards should ensure that there's no undue influence on any patient, either those seeking MAID or those not.

We have a responsibility, we believe, as physicians and as society, to make sure that all vulnerable Canadians have access to proper care and the support they need. That includes support for good mental health care, for the care that people with disabilities require and for people who live with chronic conditions.

Hon. Rob Moore: Thank you for that.

The Canadian Medical Association has said it's important that there be an environment where physicians can adhere to their moral commitments and that it must be maintained. Recently the committee circulated a letter with almost 800 signatures from physicians who are concerned about their conscience rights in providing MAID under Bill C-7 to someone who is not dying, whose death is not reasonably foreseeable.

Can you provide thoughts from the Canadian Medical Association's perspective on the importance of protecting conscience rights for medical professionals—doctors, nurses, etc.?

● (1135)

Dr. Ann Collins: Fundamentally, the CMA supports maintaining the balance between three equally legitimate considerations: respecting decisional autonomy for those eligible Canadians who are seeking access, protecting vulnerable persons through careful attention to safeguards and creating an environment in which practitioners are able to adhere to their moral commitments.

The CMA equally supports conscientious objection and conscientious participation. Although in surveys we have not seen consensus among our physician members, this is one area in which there is a continued high level of support for CMA's position.

Hon. Rob Moore: Thank you.

I think protecting vulnerable people and protecting the conscience rights of physicians are things that, around this table, we should all agree on. I know that I have only a couple of seconds, but Bill C-14 required a parliamentary view. What role would you like the Canadian Medical Association to take in the process of that review, which was supposed to have already taken place?

The Chair: Go ahead very briefly, Dr. Collins.

Dr. Ann Collins: Thank you, Madam Chair.

I will just say briefly that the Canadian Medical Association looks forward to working together and providing what input and support we can for a parliamentary review on these very complex issues.

The Chair: Thank you very much.

Hon. Rob Moore: Thank you.

The Chair: Thank you, Mr. Moore.

We're now going to go to Mr. Maloney for six minutes.

Go ahead, sir. Your time starts now.

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

Let me add my thanks to all the witnesses for coming to help us discuss a very complicated but very important piece of legislation.

Dr. Collins, I hate to pick on you again, but you said in your opening remarks that the CMA finds “problematic” the language in the bill that explicitly excludes mental illness from being considered and that it has the potential of stigmatizing those living with a mental illness.

No one here will disagree that stigmatizing those with mental illness is a significant concern, but in this context of MAID, there are some dire consequences. Are you saying that you agree or disagree with the prohibition of mental illness as a sole ground for requesting MAID?

Dr. Ann Collins: Our comment is around the language that is used in the bill. It is a problem in that it does potentially stigmatize those living with mental illness. We recognize that this is another complex issue that will continue to be dealt with as we move through these legislative processes. It is a complex issue that the Canadian Medical Association looks forward to working on with you in seeking clarity with regard to eligibility.

Mr. James Maloney: Okay. We all agree it's a complex issue, but that means it requires an answer, which hopefully isn't complex.

Are you suggesting there should be some cases in which mental illness shouldn't be a barrier to MAID, or...? I'm just not clear on what you're saying.

Dr. Ann Collins: This is one of the areas in which there is no consensus when we survey our physician members. It is an area that I believe reflects what is heard at other tables. It is an area that requires further clarity and further review.

● (1140)

Mr. James Maloney: Thank you.

That leads to my next question. That lack of consensus, I think, is the reason this is in the bill.

[*Translation*]

Mr. Jean-Pierre Ménard: Mr. Maloney, I'd like to add something, if I may.

In her decision, Justice Baudouin clearly states that each case should be assessed individually to determine whether the person meets the requirements to receive MAID, regardless of their illness. That means preference should be given to individual assessments, rather than a blanket solution that covers as many people as possible.

Justice Baudouin recommended a perfectly acceptable solution. We must not create another situation whose consequences would send us backwards.

[*English*]

Mr. James Maloney: Thank you, sir. That leads to my next question. As it stands, mental illness is prohibited, but it's not prohibited if it's in conjunction with another illness.

In my view, that may potentially lead to a problem. If you have a medical illness that does put you in a situation of being eligible for MAID, but there's a mental illness component to it, you're still forced into that situation of having to assess the mental illness, which is the concern that gave rise to it being prohibited as the sole basis for requesting MAID.

I'm struggling with how you reconcile those two things, particularly in a scenario in which you require a second expert opinion. If the expert opinion is on the non-mental illness issue, do you then require a third opinion regarding the mental illness issue?

Dr. Stefanie Green: I'm hoping that question is for me.

Mr. James Maloney: It's for all of you.

Dr. Stefanie Green: Perfect. I'm going to take the first opportunity to answer it. Thank you for the question.

Madam Chair, I would like to point out what I'm sure is clear among most of our members, which is that mental health as a sole underlying condition is not explicitly prohibited under Bill C-14. In fact, there have been cases in this country of people with mental health illness as the only underlying condition going ahead, qualifying for and proceeding with MAID.

That's not commonly achievable with naturally foreseeable death and we don't see it very often. It is obviously much more common for us to have already seen patients with both mental health illnesses and physical illnesses applying for and being found eligible for MAID and proceeding.

Of course, there are many people.... In that situation, it's up to the assessors and the providers to do the best job possible to ensure that capacity is still present. Mental capacity is always presumed to be present, unless it isn't. It's not uncommon in that situation for physicians and clinicians—who assess capacity in our patients all the time, every day in our offices, for all medical treatments and surgical interventions—to be able to distinguish between the two.

The Chair: Thank you, Dr. Green.

Mr. James Maloney: Thank you.

The Chair: That brings you to exactly six minutes, Mr. Maloney.

[*Translation*]

Mr. Thériault, you have six minutes. Go ahead.

[*English*]

Mr. Thériault, I believe you're on mute, sir.

[*Translation*]

Mr. Luc Thériault (Montcalm, BQ): Sorry, Madam Chair. I was having issues with my sound.

Mr. Ménard, if I understand correctly, you believe that, much like Bill C-14, Bill C-7 could blatantly throw the door open to legal challenges because it represents an unreasonable infringement on charter rights. Do I have that right?

Mr. Jean-Pierre Ménard: Yes, because it creates classes of people on the basis of a vague criterion. The criterion for access to MAID is specific to each person. When assessing the individual's medical condition, the physician determines whether or not that person meets the requirements. Having the diagnosis of the condition is one factor, but not the main one or the most relevant. The question that has to be answered is whether the individual fully understands what they are committing to when they seek MAID.

Creating a second class of people whose natural death is not reasonably foreseeable suggests that these people are not like the others—that they are more vulnerable and require more protection—which is not true.

● (1145)

Mr. Luc Thériault: If a reasonably foreseeable natural death is not the right factor, what would you suggest?

It is no longer a criterion, in fact, but I feel as though it was brought back simply to distinguish this debate from previous ones.

Mr. Jean-Pierre Ménard: Basically, as soon as the person meets the requirements to access MAID, that should be enough and MAID should be provided. I don't understand the rationale for imposing additional requirements on people who otherwise meet all the criteria for access. That is a paternalistic approach with no basis in law. There is no reason not to provide MAID to anyone who meets the requirements.

Mr. Luc Thériault: We agree on the fact that Parliament must be able to establish the requirements for free and informed consent.

Mr. Jean-Pierre Ménard: Yes.

Mr. Luc Thériault: From that basis, we can agree that there are no issues when it comes to patients who are terminally ill. Quebec has five years of experience in the area. The introduction of medical aid in dying requests is part of a continuum of end-of-life care. Normally, it would fall under palliative care, but that's not quite the case. I have another question on the topic for Mr. Bureau.

When a patient is not terminally ill, they may or may not be at the end stage of the illness.

When a patient has a mental illness, how do you determine that they are capable of giving free and informed consent and that a symptom of their illness is not behind it?

Mr. Jean-Pierre Ménard: It is up to the physician to determine that. The physician carries out an assessment in every case.

Let me be clear. In the majority of cases where mental illness is the dominant factor, the health professional is likely to proceed much more cautiously and MAID will be slightly harder to access. Nevertheless, there is no reason to deny these people access to this care outright. While it may prove necessary to take more precautions, prohibiting access out of hand is unacceptable.

Mr. Luc Thériault: I'll now turn to Mr. Bureau.

Quebec did the right thing by not making the request for medical assistance in dying, known as euthanasia, and palliative care mutually exclusive.

Proponents of palliative care are worried that, in the process of opening up or allowing access to medical assistance in dying, fewer and fewer resources will be allocated to palliative care. There's a real issue with access to palliative care.

After five years, is your commission aware that some care units in hospitals don't admit into palliative care, meaning full support until death, patients who have applied for medical assistance in dying? Is this normal?

Dr. Michel Bureau: As you said earlier, medical assistance in dying is part of a process that usually begins with palliative care in institutions.

Admittedly, early on, private or semi-private institutions decided to refer patients who were seeking medical assistance in dying to other places. If you're talking about hospices, almost all of them refused to admit these patients, at first. Now, half of the 35 hospices provide medical assistance in dying. The trend is changing.

Granted, there was some opposition at first between palliative care and medical assistance in dying. After five years, that's all in the past. The Commission on End-of-Life Care is finding this to be the case.

Mr. Luc Thériault: We could have a discussion on this topic, because the situation still prevailed this winter. We'll talk about it again.

● (1150)

The Chair: Thank you, Mr. Thériault.

[*English*]

We have to move on now to Mr. Garrison for six minutes.

Mr. Garrison, please go ahead. The floor is yours.

Mr. Randall Garrison (Esquimalt—Saanich—Sooke, NDP): Thank you, Madam Chair.

I want to thank all of the witnesses for appearing today. I think a particular strength of this panel is its experience with what actually happens in the provision of medical assistance in dying. My concern is that too often we've had discussions that are theoretical and sometimes aren't grounded in reality.

I want to thank Dr. Green, who on behalf of the Association of MAiD Assessors and Providers shared time with me earlier to help me understand what actually happens.

Two things that have been raised today that cause me concern are the allegation that some people have been coerced into requesting medical assistance in dying, as well as the question that has been raised about some people having possibly transient desires to seek medical assistance in dying.

I'd like to ask Dr. Green to comment on actual experience with those two issues.

Dr. Stefanie Green: I think the issue of coercion has been raised many times by many people. There are a lot of different ways to answer that question, but ultimately what you're asking my colleagues and me is whether we know how to do our job.

I know that seems very personalized, but the truth is that physicians, clinicians, nurse practitioners and health care workers make decisions about capacity and levels of coercion every single day in our office, every single time we see a patient, every single time we offer them a medication or a surgical treatment or any treatment at all. We need to make sure the patient is aware of the information so that they understand their situation, their treatment options and the pros and cons of those treatment options. If they seek our guidance, we can do so, but ultimately the decision has to be the patient's, which is not always the same as how I might guide them or how the family might guide them. The patient's autonomy is essential.

We are very, very well skilled at making those determinations. Certainly with all of my colleagues, the standard of care is to meet with the patient at least once, if not more times, privately to ensure that there's no one coercing the patient in any subtle or external way. Coercion is something we're very much aware of, so thank you for that.

On the concept of “transient suicidality”, it's a term I'd never heard before this committee sat. I find it interesting. Certainly my experience—and it's very well versed, coming from British Columbia—is that the patients I see have spent many, many weeks, months and often years thinking about this issue. This is not a snap decision for anybody. The idea that they're having a transient thought that will allow them to proceed to MAID is I think insulting to the patient, to their process, to their decision-making ability, as well as to the ability of assessors and providers.

We certainly recognize what we call adjustment disorders. If somebody's had a ski accident and becomes paralyzed, nobody is going to offer them MAID within that week. That's absurd. We're very well aware of these issues.

Mr. Randall Garrison: Thank you for that, Dr. Green.

Two things I think are important in this bill from the point of view of my constituents are the elimination of the 10-day reflection period and the waiver of final consent. Could you tell us a little a bit more? I know there will be stuff in your submission, but I think these are two reasons that this legislation is urgent. I'd like you to talk about your experience with those two.

Dr. Stefanie Green: I think the issue of the 10-day reflection period, as I alluded to, has proven itself to be more problematic than helpful. I come from a region of the country that has the has percentage of assisted dying in the province, in the country and in fact in the world. That dataset has clearly shown that a significant portion is expedited within 10 days, because patients are coming too late for care for a multitude of reasons, but what's most interesting to me as we look at all the provisions over the last four and a half years is that the single day that has the highest number of provisions is day 11. It's striking. From the data I sent you, clearly people have been waiting for the 10 days to be done. On the stroke of midnight, they're going ahead on the eleventh day. It shows that they've simply been waiting. This is not a 10-day period for these people. It's been weeks, months or years. They're just waiting for that reflection period to be over. I think that's striking.

Your second comment was about the amendment to allow people to proceed if their death is reasonably foreseeable and they've lost capacity. I think Audrey Parker made a sensation in the national media about why this was important. Certainly, my experience is that the public vastly supports this idea. The patients and the families I've dealt with feel very, very strongly that this is a horrible situation to find themselves in. I personally found myself in that situation. It was probably the hardest moment of my four and a half years.

Let's say a patient has gone through the rigorous process, the rigorous procedures, the rigorous safeguards and done everything right. They finally found a care provider, finally filled out the forms and finally were found eligible. Then I turn up, at a specified day and hour, and find them unable to give consent. It's just horrible for the family, who then feels they've let their loved one down. We cannot proceed, of course.

Therefore, I think this amendment is timely and needed, and will be extremely welcomed by many.

• (1155)

Mr. Randall Garrison: I have heard anecdotally and had personal experience of people choosing to go earlier than they might have had to go because of their fear of loss of capacity. From your experience, is this something we find in the practice of medical assistance in dying?

Dr. Stefanie Green: This is a real concern among patients and their families. Even after years of experience, even after I can tell patients that there's no reason to believe they should stop their pain medications, that there's no reason to believe they're going to lose capacity.... I can reassure them as much as I want; people and their families are still terrified of this possibility, and they will often receive subpar care, during those 10 days while they're waiting, for fear of loss of capacity. The number one fear of people, after they have been told they're eligible, is the fear that they might still lose the choice.

Mr. Randall Garrison: Just quickly—I have about 30 seconds left—on the question of conscience for physicians, can you talk about the possible impacts that failures to refer them have on people accessing the service for medical assistance in dying?

Dr. Stefanie Green: Madam Chair, I think it's important to point out that Bill C-14 and Bill C-7 are very clear about protecting, respecting and supporting conscience rights, and certainly our organization is very strongly in support of that, but when people do not follow professional guidelines to do effective referrals, we're finding obstruction of access to care. What's happening is that patients and families are coming to us very late on, and that's where we get into the problem with the 10-day waiting and the loss of capacity. They come to us in a much more urgent situation.

Many of our patients are socially isolated. They may have been hospitalized for weeks. They may not have social friends or even the technical abilities to find access to care, and they are absolutely reliant on their caregivers to provide that information and provide a way for them to access better information and access to care. Without that possibility, they are simply locked out of this.

The Chair: Thank you very much.

Mr. Randall Garrison: Thank you, Dr. Green.

The Chair: Thank you, Dr. Green. Thank you, Mr. Garrison.

With three minutes left of this hour, I think it's time for us to thank our witnesses.

To all of the witnesses, if you have any additional clarification or any additional information you would like to provide the committee as a result of the lines of questioning from members, please submit it to the clerk. We look forward to reviewing the evidence you are providing. Thank you for taking the time to appear before us and to give your remarks.

We'll now suspend for a few minutes as we switch the two panels.

Thank you, everyone, once again.

• (1155)

_____________________(Pause)_____________________

• (1200)

The Chair: I welcome everybody back.

I'd like to welcome our witnesses.

We have, appearing as an individual, Dr. Serge Gauthier, who's a neurologist and professor in the departments of neurology, psychiatry and medicine at McGill University; we have Dr. Mona Gupta, who is a psychiatrist and associate professor; we have Dr. Leonie Herx, who is a palliative medicine consultant; and we also have Dr. Tarek Rajji, from the Centre for Addiction and Mental Health.

Thank you for appearing with us today.

Each of you will have five minutes to give your opening statements. We'll start with you, Dr. Gauthier.

[*Translation*]

Dr. Serge Gauthier (Neurologist and Professor, Departments of Neurology, Psychiatry, and Medicine, McGill University, As an Individual): Thank you, Madam Chair.

Thank you for the invitation to appear before the committee. I hope that my experience in conducting clinical research on Alzheimer's disease for the past 35 years will be useful for your deliberations.

I'll make a brief opening statement and then answer your questions.

I can confirm that, in recent years, a number of people in the early stages of Alzheimer's disease have spontaneously expressed their desire to die peacefully, surrounded by their family, at a time of their choosing. For example, I'll read you an excerpt from a document written two years ago by one of my patients, an 84-year-old woman. This document is part of her confidential medical record:

> Should medical assistance in dying be added to the advance medical directives, I am asking, with a clear mind, that medical assistance in dying be added to my list of desired care if, having become irrevocably incompetent, I no longer recognize my husband and daughter-in-law. This would be the ultimate indignity for me.

I'm trying to point out that people think many years in advance about the stage of Alzheimer's disease where they no longer wish to keep on living. This also applies to Parkinson's disease.

The stages of Alzheimer's disease follow a fairly predictable pattern and are irreversible. For example, nighttime urinary incontinence, in the absence of an infection or other disease, is known to occur at stage 6, level a, out of 7 stages. People living with the disease and family members who wish to become informed know about these stages. This information is usually provided when people request it. These stages occur over a period of six to eight years, until natural death. A fairly common feature of all these illnesses is that patients develop aspiration pneumonia, often repeatedly, until natural death. The end-stage dementia usually affects people who have been in bed for a year without being able to communicate with anyone.

I have a proposal for the committee. The current text of Bill C-7 refers to dates chosen by the person seeking medical assistance in dying. However, for neurodegenerative diseases, such as Parkinson's or Alzheimer's, the reference points should instead be stages, which people can choose in advance and which families and clinicians will later recognize.

My question is the following. Can the concept of disease stages be added to the bill, rather than a reference to specific dates?

Thank you for your attention.

● (1205)

[*English*]

The Chair: Thank you very much for that, Dr. Gauthier. You spared us a whole minute, and we really appreciate that.

Now we'll move to Dr. Mona Gupta. You have five minutes, Doctor. Please go ahead.

Dr. Mona Gupta (Psychiatrist and Associate Professor, Centre de recherche du CHUM, As an Individual): Thank you, Madam Chair and members of the committee, for the opportunity to meet with you today. I'm going to restrict my remarks to the question of MAID for persons whose mental disorder is their sole underlying medical condition, as this is my area of expertise. Throughout, to be more succinct, I will shorten this to MAID for mental disorders.

I'm a psychiatrist and an associate professor at Université de Montréal. In my clinical practice I work in consultation with liaison psychiatry, which involves the psychiatric care of the medically ill. I'm a researcher in the ethics and philosophy of psychiatry, and I've been working on assisted dying for the last several years. I did serve on the Council of Canadian Academies' working group on MAID for mental disorders as the sole underlying medical condition.

As a psychiatrist in Quebec, I'm a member of the Association des médicins psychiatres du Québec, the AMPQ, which represents the province's 1,200 psychiatrists. Currently I am chair of its advisory committee on MAID for mental disorders. This committee includes five psychiatrists with divergent views about the topic, a patient partner, and a family member. The committee has worked over the last nine months to produce an advisory document laying out an approach to thinking about the difficult clinical questions that can arise in the context of a person's requesting MAID for a mental disorder. We've just finished it. I've sent the French version—

The Chair: Dr. Gupta, I'm sorry; you're speaking very fast, and interpretation is having a little bit of difficulty pacing themselves. Please just slow down your pace a little bit. Thank you.

Dr. Mona Gupta: Yes, absolutely. I will try.

I have sent the French version of the report to the clerk and I will be able to send you the English version at the beginning of next week.

Our committee's work illustrates that professionals working with patients and families are able to come together and agree on standards and safeguards for MAID for mental disorders. Of course, there will be people who disagree. Indeed, in a survey of our own members, while 54% of respondents replied that MAID for mental disorders is permissible in certain circumstances, 36% disagreed. There will also be those who object on conscience grounds, but this is the case already.

In the course of doing this work, we explored the issues of assessing capacity, incurability, irreversibility, suffering and suicidality. Today I'm going to speak specifically about capacity and incurability-irreversibility, as these are identified in the charter statement as the reasons mental illnesses can be excluded as a basis for MAID access.

First, I will say a quick word about language.

Bill C-7 uses the expression “mental illness” while standard psychiatric language uses “mental disorder”. It's unclear if mental illness is a synonym for mental disorder or if it refers to a subgroup of conditions. If it's a subgroup, we don't know which conditions are included and which are excluded.

In either case, in thinking about the exclusion clause for mental illness, we are confronted by the fact that neither the Canadian nor the Quebec laws permitting MAID ever excluded persons with mental illness or disorder, nor do they make reference to diagnosis at all.

The eligibility criteria are based on the clinical circumstances of the requester. Furthermore, those who have conditions with both psychiatric and physical aspects and those who have comorbid mental and physical conditions have never been excluded, nor will they be by Bill C-7, even if the psychiatric condition motivates the request, so any rationale to exclude people whose mental disorder is their sole underlying medical condition needs to apply to this and only this group of people.

The government's stated rationale is that screening for decision-making capacity is particularly difficult and subject to a high degree of error, and that mental illness is generally less predictable than physical illness in terms of the course the illness will take over time.

I want to point out two things about the worry about assessing capacity.

If assessing capacity is difficult for people with mental illnesses, then the same difficulty ought to apply in cases of mental and physical comorbidity. There is nothing about the existence of a second, physical condition that would remove this difficulty. If anything, it makes the situation more complex. In fact, at present we do assess capacity to consent to MAID in people with mental disorders and comorbid physical conditions. Presumably, if the method works in one circumstance, we would need a specific reason that shows it does not work in the other.

The second worry is that we might make mistakes in our assessment of capacity. This is not the right way to frame the problem. Capacity is not something you get right or wrong; determining whether somebody is capable is a judgment, and in matters of judgment it's to be expected that assessors may not always agree. However, because capacity is not presumed for MAID and has to be established, if assessors cannot agree, they cannot proceed.

Regarding predictions of incurability and irreversibility, it is tempting to say that because of the finality of MAID, we should not act unless we are 100% certain. However, outside the context in which a person's natural death is reasonably foreseeable, prognostication becomes more difficult in many situations. This is not limited to situations of mental disorder. The proper clinical question is how much certainty is required in order to find someone eligible.

Reflecting on cases of people with comorbid physical and psychiatric conditions who have accessed MAID in this country reveals that the concerns raised about assessing capacity and prognosis are already part of current practice. I have explained this with some real case examples in a short document that I have sent to the clerk.

In conclusion, I don't think there's a way that withstands logical scrutiny of distinguishing all cases of mental illness as a sole underlying medical condition from other clinical problems for which MAID is permitted.

As a result, what the exclusion clause will do is show that it is acceptable to treat people with mental illnesses differently from others. The AMPQ does not accept this position. We believe our patients must be entitled to exercise the same rights as all other persons.

Thank you.

● (1210)

The Chair: Thank you very much for that, Dr. Gupta.

I will now move on to Dr. Leonie Herx—

[*Translation*]

Mr. Luc Thériault: I have a point of order, Madam Chair.

The Chair: The floor is yours, Mr. Thériault.

Mr. Luc Thériault: While I was raising my point of order, the interpretation continued. On that note, I'd like you to ask the witnesses to slow down. Otherwise, the interpreters' job is extremely difficult and the interpretation is unintelligible.

It's unfortunate that we have only five minutes to hear everything that witnesses of this quality have to say. However, given that briefs were submitted, discussions should be encouraged.

Sorry for taking up time.

[*English*]

The Chair: You're absolutely right, Monsieur Thériault. Thank you for your important intervention. I've been trying to make sure that we're getting as much as possible, but we'll continue to try harder.

Dr. Leonie Herx, please commence your five minutes. For the benefit of interpretation, can you please speak at as moderate a pace as possible?

Thank you.

● (1215)

Dr. Leonie Herx (Palliative Medicine Consultant, As an Individual): Thank you, Madame Chair, and thank you to the committee for having me today.

Good afternoon. My name is Dr. Leonie Herx. I'm a palliative medicine specialist, associate professor and head of palliative care at Queen's University. I'm the immediate past president of the Canadian Society of Palliative Care Physicians and I've been on their board of directors for the past eight years. I'm also an adviser to the Vulnerable Persons Standard, an internationally recognized evidence-based framework that outlines the safeguards necessary to protect vulnerable persons who may be subject to coercion and abuse in a system for medically administered death.

I come before you today to share concerns that are not mine alone, concerns that are shared by many physicians across Canada, as evidenced by the 959, and counting, physicians from all medical specialties who have signed our MAID to MAD petition that was submitted to this committee. In the Carter v. Canada ruling, the Supreme Court stated that a carefully designed and monitored system of safeguards would limit risk to vulnerable persons. In our recent publication in the World Medical Journal in April 2020, my palliative medicine colleagues and I documented concerns and reviewed evidence of errors and harm occurring under the current Bill C-14 MAID regime. A copy of our paper has been submitted to you as well.

Bill C-7 proposes to further reduce these safeguards and put more Canadians at risk of wrongful death. Year after year, there have been documented cases of non-compliance and misapplication of the law and policy with respect to MAID in Canada. The chief coroner of Ontario, the end-of-life care commission in Quebec and, very recently, the correctional investigator of Canada have all reported on these issues.

We also see instances of vulnerable patients being told by their health care team that they should consider a medically administered death because the cost of their care is too great. Roger Foley, from London, Ontario, required 24-hour care that was not able to be provided in his home. While living at the hospital, an administrator suggested that he get MAID, not out of compassion for his circumstances but out of concern for the cost of his care on the system. This conversation was recorded and, of course, has been widely shared.

MAID has also been suggested when the health care team perceives an individual as not having value. While receiving emergency treatment in hospital, Candice Lewis, a 25-year-old woman with a developmental disability and chronic medical problems, had a doctor approach her mother and suggest that she consider MAID for her daughter. Her mother said they were not interested in MAID, and the doctor told her she was being selfish. The doctor then tried to convince Candice herself that she should get MAID. Because Candice felt scared, she asked to go home. The family complied and took her home, feeling that it was unsafe to stay in the hospital.

The UN special rapporteur on the rights of persons with disabilities issued a concern after a recent trip to Canada in 2019. She stated that she was “extremely concerned about the implementation of the legislation on medical assistance in dying from a disability perspective” and that there was a lack of protocol “to demonstrate that persons with disabilities have been provided with viable alternatives when eligible for assisted dying.”

We have seen countless patients whose hope and resilience were restored when their basic care needs were met. We know that many people request medically administered death out of fear of being a burden to others. This demoralization and sense of being a burden is amplified when real options to support living do not exist.

If we are trying to make a medically administered death regime safer for Canadians, then we should look to the Victoria, Australia, legislation, which employs stringent safeguards to address important issues such as the risks of coercion. I've included sections of the legislation in my written brief for your reference. In the Victoria legislation, doctors must not bring up assisted death to a patient unless they ask about it. This is especially important for persons who already feel they are a burden and less valued in society as a result of systemic discrimination.

Bill C-7 is written in such a way that a patient could choose to die before they have actually received therapies that we know in medicine have a high likelihood for recovery or relief of suffering. In other countries where MAID is legalized, it is most often only available for those who are dying. Regardless, all other jurisdictions require that physicians determine that there are no other options of care left to pursue. It is a last resort only.

Physicians who know that there are reasonable treatment options for their patients have a professional duty to instill hope and support resilience and not to stimulate a desire to die. My professional integrity as a physician compels me to offer recommendations to promote the health and well-being of my patients. If I am required to present death as an option alongside evidence-based standards of medical care, this compromises my ability to provide good care to my patients. Doctors need to be able to work with integrity and have our consciences' rights respected.

● (1220)

For the sake of vulnerable Canadians and the practice of medicine, I urge this committee to make significant amendments to this proposed legislation.

Thank you.

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

You were exactly on that five-minute dot. That's really appreciated.

Last but not least, we'll go to Dr. Tarek Rajji from the Centre for Addiction and Mental Health.

Please go ahead, Doctor. You have five minutes, starting now.

Dr. Tarek Rajji (Chief, Geriatric Psychiatry, Centre for Addiction and Mental Health): Thank you.

Members of the Standing Committee on Justice and Human Rights, thank you for the opportunity to appear before you to discuss Bill C-7 and specifically the amendment that “persons whose sole underlying medical condition is a mental illness are not eligible” for MAID.

My name is Dr. Tarek Rajji. I am a psychiatrist. I'm the chief of the adult neurodevelopment and geriatric psychiatry division at CAMH, the Centre for Addiction and Mental Health in Toronto.

CAMH is Canada’s largest mental health teaching hospital and one of the leading research centres in the field. CAMH uses its expertise in clinical care, research, education and system-building to improve the lives of people impacted by mental illness, including those with substance use disorders.

Since 2015, a working group of CAMH staff with expertise in psychiatry, social work, law, ethics, public policy and lived experience have been deliberating regularly on MAID and mental illness. It is our collective expert opinion that Bill C-7 gets it right.

We agree that there should be a temporary prohibition on MAID for those whose only medical condition is mental illness until, as the bill’s preamble states:

> ...further consultation and deliberation are required to determine whether it is appropriate and, if so, how to provide medical assistance in dying to persons whose sole underlying medical condition is a mental illness in light of the inherent risks and complexity of the provision of medical assistance in dying in those circumstances...

The reason we support this temporary prohibition is that there is currently a lack of consensus in the mental health field to determine when an individual has an irremediable mental illness.

To explain further, to be eligible for MAID, an individual must have a “grievous and irremediable” medical condition. Their illness, disease or disability must be incurable, irreversible or irrecoverable and cause intolerable suffering.

The grievousness of an illness is subjective, and there is no doubt that some people with mental illness experience intolerable psychological and sometimes physical suffering due to their symptoms.

The irremediableness of an illness, however, is an objective determination that must be based on the best medical evidence available. CAMH’s concern is that there are currently no established criteria that define if and when a mental illness should be considered irremediable. That is because there is simply not enough evidence in the mental health field at this time to predict the trajectory of any one person’s mental illness and to ascertain whether an individual has an irremediable mental illness.

This means that the irremediable criteria would be open to interpretation by each MAID assessor, and any determination that a person has an irremediable mental illness would be inherently subjective and therefore arbitrary. This could put people with mental illness at risk of accessing MAID when they do not meet the eligibility criteria.

Therefore, CAMH strongly recommends that evidence-based criteria be developed prior to any decision to lift the temporary prohibition on MAID for people whose only medical condition is mental illness. These criteria should establish a consensus definition for when a mental illness should be considered irremediable for the purposes of MAID.

CAMH recommends that the government appoint an expert working group to develop these criteria within a reasonable time frame, recognizing the complexity of the task. The working group should develop the criteria in consultation with a broad range of experts in the mental health field, including people with lived experience of mental illness and family members. The introduction of these evidence-based criteria should be accompanied by training for MAID assessors. CAMH would be happy to participate in the development and dissemination of the criteria.

Thank you again for the opportunity to speak with you today on this complex and nuanced topic. I am happy to answer any questions.

The Chair: Thank you very much, Dr. Rajji, for your concise remarks. I really appreciate them.

Having exhausted the witness list, I will now go into our round of questions. The first round is six minutes per member.

We'll start with Mr. Cooper. You have six minutes, sir.

Mr. Michael Cooper (St. Albert—Edmonton, CPC): Thank you very much, Madam Chair, and thank you to the witnesses.

Dr. Herx, I want to drill down into some of the safeguards this legislation would remove, starting with the 10-day reflection period.

The letter you signed along with other physicians makes reference to the possibility of same-day death. During the debate at second reading, the government dismissed that possibility. Can you elaborate on that concern with respect to the elimination of the 10-day reflection period?

● (1225)

Dr. Leonie Herx: Yes. Thank you for the opportunity.

Obviously, this is the work that I do on the front lines every day with patients who express a desire to die as part of normal grieving, anger, frustration and sometimes despair at facing a devastating diagnosis. Most often, these wishes for death are fleeting and transient in nature.

In fact, Dr. Harvey Chochinov, a renowned psychiatrist in Canada, has shown that these death wishes can be transient even over a shorter period of time, 12 to 24 hours. Elimination of the 10-day waiting period doesn't allow a person time enough for reflection to change their mind.

Many times we see patients change their mind when they have access to good care and supports and an ability to see their lives in a different way, as having meaning. Wishes for death are often driven by fear and anxiety rather than uncontrolled physical symptoms.

Helping a person receive support to work through their new diagnosis is very important. A person with a “reasonably foreseeable death” under this new legislation could be having a really bad day and be in despair because they haven't seen a loved one or because, as we've seen, social isolation and loneliness have been amplified through the COVID-19 pandemic.

Out of those depths of despair, their worst day could become their last day in the absence of a required reflection period to make sure that this is actually what a person wants and that it's not a transient desire coming out of their not having adequate supports or time to really understand what they're asking for.

Mr. Michael Cooper: Right.

Dr. Leonie Herx: It's very important that the 10 days be upheld. In fact, some would say the period should be even longer. Dr. Chochinov's work shows that the desire to die is actually relinquished over about a two-week period when there is proper support.

Mr. Michael Cooper: Thank you for that answer. Maybe you could comment on the suggestion by the government that in an actual setting, same-day death would never happen.

Before, however, you comment on or respond to this idea, which we've heard the government say in some of the debates in the House, I want to also ask you about the removal of the requirement to have two witnesses and the reduction of the requirement to just one, with the proviso now, under the legislation, that a health care professional could be a witness.

Are you concerned about issues of conflicts of interest or undue influence on vulnerable patients?

Dr. Leonie Herx: Absolutely. I am very concerned, as are many of my colleagues, about possible coercion, either subtle or overt, from health care professionals. As we've seen and as I've reported already, many persons have had MAID suggested to them because of their circumstances.

We also have instances of medical professionals involved in MAID suggesting to persons that they should get it sooner because they might lose capacity.

I already witness every day issues of coercion in which professionals are suggesting to patients that they should get MAID sooner because they might miss their opportunity. Having two independent witnesses is very important to make sure that people are not being pressured by the health care team to choose MAID, whether because of lack of resources or perceived poor quality of life, as I mentioned earlier.

Mr. Michael Cooper: Thank you for that.

I'd also be interested in your comments on risks associated with advance consent.

Dr. Leonie Herx: I think it's very difficult to have advance consent for MAID. When a person loses capacity, they don't actually know what they're agreeing to at that time. Every week I see patients who have requested MAID and who actually end up getting MAID, even though they don't have capacity. There is sometimes a disagreement between me and a MAID assessor or provider about what capacity the patient has.

For example, a patient would change his mind from time to time about whether he wanted to go to a hospice and have a natural death wherein his pain was well controlled or have “the needle”, as he called it. He wasn't able to differentiate between those two and would flip from one to the other even hour to hour, which is a very consistent process in delirium, when you're not fully comprehending and understanding what you're asking for.

At a time when people are getting MAID through an advance directive, how do we know, when they lack capacity, that it's still what they want and that they still understand what they're getting? I don't think that's possible.

● (1230)

Mr. Michael Cooper: How much time do I have, Madam Chair?

The Chair: You have 15 seconds, Mr. Cooper.

Mr. Michael Cooper: I have 15 seconds. Well, I guess my time has expired.

The Chair: Thank you very much for that.

We'll now move to Mr. Virani for six minutes.

Go ahead, Mr. Virani.

Mr. Arif Virani (Parkdale—High Park, Lib.): I'll start by just saying hello to an old friend and debating colleague from McGill University. It's nice to see you, Mona Gupta. I'll try not to call you Mona. I'll call you Dr. Gupta in this platform. I recollect that those of us who thought we were smart were debaters and went to law school, but those of us who were actually smart went to medical school, so we know what category you firmly fit into.

True to form, Dr. Gupta, you've actually teased out some of my questions. I had a look at the charter statement. I had a look at some of your work on this issue about mental disorders, mental illnesses and so on. You canvassed a couple of points that are raised in the charter statement, but there are a few others that I want to put to you. I'd like for Dr. Rajji to also comment.

Other components as to why—

The Chair: Sorry, Mr. Virani; can you please move your mike closer to your mouth?

Thank you.

Mr. Arif Virani: Yes. I apologize for that.

With regard to the other components or considerations that went into our reasons for excluding mental illness, one is that the exclusion is not outright. You know that it can be coupled, as you mentioned in your comments, with some other disorder or condition.

Two is that this issue has actually been legislated in Belgium, the Netherlands and Luxembourg, and we've seen rising cases of medically assisted dying in those jurisdictions, including in some areas that seem fairly grey to neutral observers.

The third point is—and this is just me as a layperson, and there are many more laypersons than doctors in this committee who understand this—that when suicidal ideation, contemplating suicide, is just a manifestation of a condition, does that necessarily need to nuance our approach to mental illness as mental illness or mental disorder as mental disorder?

Could you comment on those three aspects? Then I'll ask Dr. Rajji, perhaps, to comment as well.

Thank you, Dr. Gupta.

Dr. Mona Gupta: I think part of what motivated what I was trying to bring to the committee today is the fact that people who have mental disorders and physical disorders can access medical assistance in dying now and have already accessed medical assistance in dying, and that these types of clinical situations raise exactly the same kinds of concerns that the government indicates in its charter document. If we're able to assess capacity now, if we're able to assess irremediability now in cases of medical and physical comorbidity, it's not clear to me why we wouldn't be able to do it when a mental illness is the sole underlying medical condition.

In order to nuance, I think, an exclusion, if that's the government's wish, there has to be a characteristic that is really unique to that group of people. Clinically, I don't think there is one.

As for the experience of assisted dying in the Benelux countries, this remains a marginal practice relative to the practice of what's called there “euthanasia and assisted suicide”. I think a rise in the number of cases does not, in and of itself, suggest any phenomenon one way or the other. Cases of assisted dying, in general, rise over time. That's something that we've seen in our own jurisdiction. That's something the Commission sur les soins de fin de vie has documented since it began keeping data in 2015. In and of itself, a rise doesn't tell me anything specific. The fact is that it remains a marginal practice. In Belgium in particular, in fact, the cases have declined over the last four years. The practice is so marginal and the case numbers are so small that I don't think these small increases and decreases in either direction really tell us very much.

As to the last point about suicidal ideation, this is something that's come up a lot in this debate. I think this is a very fair point. Every day in psychiatry, we meet people who have suicidal ideas. Every day in the course of clinical care, we have patients who have mental disorders and who also have physical disorders, who have to make high-stakes clinical decisions that could even be life-threatening decisions. They may have been suicidal in the past. They may have made suicide attempts in the past. Clinically, our role is to see if they are capable of making that decision now and to try to understand their suicidal thinking over time and over the trajectory of their illness. That's something we do now. That's something we will have to continue to do.

You'll see this when you receive our document from Quebec. The idea that someone's going to come to an emergency room in acute crisis because of the end of a relationship and with suicidal thoughts and that they're going to access and receive MAID on that day is not what we have in mind by a structured and rigorous practice. We're talking about people who have suffered over decades and have, really, had access to a very complete armamentarium of available treatments; we're not talking about suicidality.

● (1235)

Mr. Arif Virani: Thank you very much, Dr. Gupta.

I want to add Dr. Rajji into this conversation, but I also note that you, as a member of the Council of Canadian Academies, know that the preliminary report itself was not conclusive on this aspect and you suggested further study.

Dr. Rajji, could you comment on that?

Also, Dr. Gupta, could you just say in 10 seconds whether you agree this should be put off to a further parliamentary review or not?

Dr. Tarek Rajji: I just want to clarify, Mr. Virani. Do you want me to comment on the question of further studying or on all the points you raised before?

Mr. Arif Virani: It's a little bit of both. I appreciate that you are pressed for time, but I'm interested in the further study point as well as the other points that I raised.

The Chair: Be very brief, Dr. Rajji. We're very, very short on time. Thank you.

Dr. Tarek Rajji: I want to underscore the fact that there is no consensus in our field about how we define “irremediable mental illness”. The fact that there are different opinions, and strong different opinions, speaks to the fact that there is no consensus. That's what the CCA, after a month of deliberations, concluded.

I think the point I was making in my presentation was that a finding of irremediable mental illness needs to be based on scientific evidence. When we talk about some of the most severe conditions in mental illnesses, like psychotic illness, and when long-term studies show that up to 30% of people go into recovery in the long term from these conditions, that's not a minority. That tells us about the weakness now of even predicting the trajectory at the individual level.

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

Mr. Virani, unfortunately we're out of time for you. We'll move on to Monsieur Thériault.

[*Translation*]

You have the floor for six minutes.

[*English*]

Go ahead, Monsieur Thériault. Your time starts now.

[*Translation*]

Mr. Luc Thériault: Thank you, Madam Chair.

I want to thank all the witnesses for their enlightening presentations.

Dr. Gauthier, you have 35 years of experience. Your clinical experience in neurodegenerative diseases enables you to state today that you can recognize free and informed consent that's valid beyond any doubt. You spoke about the stages that measure the progression of the disease.

I want you to explain how, based on your experience, you can recognize when free and informed consent is provided in cases of cognitive degenerative diseases.

Dr. Serge Gauthier: Thank you for your question.

For some neurological diseases, there are well-known clinical stages, which usually last several years. At the start of these diseases, people are encouraged to make plans for their financial and personal affairs. Medical assistance in dying may soon be part of these plans.

Of course, we'll see only in a few years whether we can act upon the choice that a person made five years beforehand. In other words, this 84-year-old woman, whose very organized text that I read to you shows her level of education and her clear-mindedness, is choosing to seek medical assistance in dying at a stage that will occur in four or five years.

For the committee's purposes, I'm simply asking whether you can add the concept of disease stages as part of the planning process for medical assistance in dying. This must be done without going into detail, because each disease has different stages. In the next few years, new treatments may emerge that will change the progression of the diseases. What won't change, however, are the references points, the key points in the progression of most of these diseases. I'm thinking of the loss of mobility and the first pneumonia, for example. These things won't change, even if therapeutic advances are made.

● (1240)

Mr. Luc Thériault: Until what stage would it be possible to establish an advance directive or request?

Today, you take it for granted that everyone knows the stages of these diseases, such as Alzheimer's disease. You wrote a remarkable book on the topic. I'd like you to provide a few more details.

In your experience, until what point could an advance directive be considered valid?

Dr. Serge Gauthier: Thank you for the question.

Usually at the onset of the disease, after diagnosis, people are asked to write down their choices. They usually do this in front of a notary and in the presence of family members. They must then designate the individuals responsible for them, a proxy or a trusted person. In some cases, they must give specific instructions on the disposal of assets. They must also record their personal care preferences in anticipation of when it will be needed.

We're talking here about stage 3 out of 7, in the case of Alzheimer's disease. Stage 3 is mild cognitive impairment. However, new biological tests now enable us to diagnose the cause of these mild disorders.

The next stage is mild dementia, which usually occurs at stage 4 out of 7. At this stage, people still drive their cars, but in familiar places. They need help managing their taxes or their more complex finances, but they're still independent.

There's no real debate about whether these people are competent at these two stages, meaning stages 3 and 4 out of 7.

Mr. Luc Thériault: Thank you. That's very interesting.

In terms of mental illness as the sole criterion for exclusion, the more evidence that I hear, the more I feel obligated as a legislator to look further into the issue.

There's a difference between mental illness, schizophrenia and Alzheimer's disease. Not all cognitive disorders can be categorized in the same way.

As legislators, we must establish beyond a shadow of a doubt a patient's capacity to give free and informed consent and to confirm the validity of this consent. However, in light of what I've heard to date, I can't yet comment on the issue of mental illness.

That's why we definitely want to continue the reflection process after the bill is passed. We want to do this now, and not in four years. This reflection process could include the whole issue of neurodegenerative diseases.

Dr. Serge Gauthier: I completely agree.

Mr. Luc Thériault: I'm finished, Madam Chair.

[*English*]

The Chair: Thank you.

[*Translation*]

Thank you, Mr. Thériault.

[*English*]

Dr. Gauthier, we are out of time.

We'll move on to Mr. Garrison for six minutes.

Mr. Randall Garrison: Thank you very much, Madam Chair.

I want to start by thanking the witnesses for appearing today, and I stress that I respect the expertise that each brings to this question. In their testimony today, they have raised many issues that I believe need to be dealt with in the broader review, the statutory review that is required, and I'm hopeful that among the parties we can soon reach an agreement about the mandate and timing for that general review to take place.

I want to put two concerns on the record before I ask my question. One, it's important that members of the committee distinguish between those who have actually worked as MAID assessors and providers and those who have not.

The second concern that I wish to raise is even more serious. I'm always concerned when witnesses appear before the committee under the protection of Parliamentary immunities and make accusations about other individuals that amount to, in this case, allegations of malpractice. We have to be very careful when we listen to the testimony of those who have made such accusations rather than referring those cases to professional bodies or to the police, if that's appropriate. Those who make those accusations.... We should seriously consider all the testimony being presented, given what I would call unethical testimony that we've heard from at least one witness today.

I'm going to turn to something more positive now. I want to thank Dr. Rajji for his fair and constructive suggestion on the question of how we, as a committee, will deal with the concept of mental illness as an underlying condition in this legislation.

Dr. Rajji, how big a task do you think it is to have a working group that would establish evidence-based criteria? How long would that take, and how large an undertaking is it?

● (1245)

Dr. Tarek Rajji: Mr. Garrison, thank you for this question.

It is a complex task. It's not a small task, and I think it will have to take, to my mind, as long as it needs to take. The complexity and implications and the strong different opinions play into the timing, and I think the group has to be quite diverse. It has to include the professionals, the psychiatrists and other mental health professionals that... Such an amendment is actually affecting their practice and touching some of the core issues in their field, which is understanding the concept of suicide and what suicide is. What does it mean to have suicide when someone is asking to receive MAID? Are they asking for suicide or not?

It has to also include family members. It has to include people with lived experience themselves. It has to include the other professionals, whom we call allied health professionals, who may not be the most responsible initially, but who also are affected by this practice, and we may need other stakeholders.

Without reaching a consensus about the definition of irremediable criteria, it will be very hard to apply these criteria if we don't know how to define it.

Mr. Randall Garrison: Thank you, Dr. Rajji.

Can I ask Dr. Gupta for her reaction to this suggestion of an expert working group?

Dr. Mona Gupta: There's no harm in spending more time thinking about these issues; they are complicated issues. I think a lot of work has already been done on these questions and I think that if we look at countries where this practice is permitted, we see that the lack of consensus doesn't go away, so we can continue to study, but I don't know that we're going to learn a lot more that's new.

I think we are already assessing irremediability in the context of mental disorder; we're just doing it with patients who have other conditions as well. I think we can learn from those experiences to help inform the practice with people who have a mental disorder and no other condition, but these complex cases are already being assessed, and people have already accessed MAID as a result, so I think that the exclusion criteria will just prevent a very small number of people from having access.

Mr. Randall Garrison: Then your advice would be that it would be safe to remove this prohibition on mental illness as the sole underlying condition, but also that we could study this further at the same time.

Dr. Mona Gupta: Another alternative would be to say that there are some really specific safeguards and best practices that we want to get right in this area and we want to give ourselves that time to do it, but let's discipline ourselves and put a deadline on that exclusion clause so that it can't be indefinite. We can say that if this is really what we want to do, then let's be focused on that task and let's ensure that at the same time we respect the wishes, as Mr. Ménard pointed out, of individuals on a case-by-case basis according to their clinical circumstances, which is what both laws always required for every other patient.

Mr. Randall Garrison: Thank you.

Dr. Rajji, would you agree with Dr. Gupta that we could remove this provision while we're still studying it without great risk?

Dr. Tarek Rajji: No, I don't agree with this, because the specific point here is that we're asking assessors and clinicians to apply criteria during the assessment that have not been defined for a mental illness. I think it's the same when we talk about the age criteria and talk about the capacity criteria. There are definitions. These have been well defined; however, we have not defined what it means to have an irremediable mental illness, so we don't go with the amendment before agreeing as a society on the definition of irremediable mental illness.

● (1250)

Mr. Randall Garrison: Thank you, Dr. Rajji.

The Chair: Thank you very much for that.

Seeing that we have just 10 minutes left for questions, instead of doing a full round, at my discretion I will give two minutes each to the speakers I have up next to ask any questions that they like.

I have Mr. Lake, Mr. Kelloway, Monsieur Thériault and Mr. Garrison for two minutes each. If you can please stick to that timing, that would be great.

Go ahead, Mr. Lake. You have two minutes.

Hon. Mike Lake (Edmonton—Wetaskiwin, CPC): That seems like a strange decision to make, because I had a lot to say, but you're the chair.

First off, I can't believe how fast this committee is studying this matter. This is just, to me, unbelievable that you're racing.... It was interesting to hear the witnesses, every one of them, having to be cautioned against going too fast because they all had so much to say, and for some reason we're racing against time on one of the most complex issues that I've seen in my 15 years as a member of Parliament.

Listening to Ms. Herx's story about Candice was just heartbreaking. I have a 25-year-old son with autism, and I'm trying to get an understanding.... I had some questions, and it's not possible to get an answer in two minutes. I was expecting to have more time for asking how someone with a developmental disability would even indicate...what the criteria would be for their capacity to indicate their willingness to choose medical assistance in dying.

Rarely do I see unanimity in the disability sector, but there's almost unanimity about the fact that this is moving ahead way too fast and that there are way too few protections for people with disabilities.

In the 40 seconds that are left in my time, maybe somebody could give a comprehensive answer to that. Maybe Ms. Herx could give a comprehensive answer to that, because that's how long we have to study something this important.

The Chair: Thank you very much for your comments, Mr. Lake.

Dr. Herx, you have 30 seconds. Go ahead.

Dr. Leonie Herx: I don't think it will be possible to address—

Hon. Mike Lake: That's completely insane—

Dr. Leonie Herx: Yes.

The Chair: Dr. Herx, what I would recommend is that you provide written remarks to the committee with respect to the questions that have been raised by Mr. Lake, if that's possible. It is obviously open to all witnesses on the committee to provide written clarifications or written answers if something has been missed.

Thank you very much for that, Mr. Lake.

Now we'll go to Mr. Kelloway for two minutes. Go ahead, Mr. Kelloway.

Hon. Rob Moore: I have a point of order.

The Chair: Go ahead, Mr. Moore.

Hon. Rob Moore: Madam Chair, you didn't let her answer the question. She had 30 seconds, and then you spoke for 30 seconds. Please let the....

Number one, we agreed on a timing for these committee meetings, and we're in a five-minute Conservative slot. The witness has 30 seconds to answer. You can't filibuster her answer, so could we please allow 30 seconds for Mrs. Herx to answer?

The Chair: For clarification, Mr. Moore, Dr. Herx had said that she would not be able to answer in those 30 seconds, and so I had clarified for her that she is able to give a complete and full answer by writing in to the committee so that's she's not rushed with respect to providing whatever comments she has to make, and I'll stick to that ruling.

Thank you for raising that flag, Mr. Moore. Go ahead, Mr. Kelloway.

Mr. Mike Kelloway (Cape Breton—Canso, Lib.): Thanks, Madam Chair—

Hon. Rob Moore: I have a point of order.

The Chair: Go ahead, Mr. Moore.

Hon. Rob Moore: Madam Chair, we are in a five-minute Conservative time slot. Just because it happens that the meeting is going to end when it's Conservatives' turn to speak....

Mr. Lake has five minutes to ask this witness, or any witness, the questions. You can't just make things up as we go along. We've agreed, as a committee, that this is a five-minute spot, and divvying it up is not how these committees work.

● (1255)

The Chair: Thank you for raising your concerns, Mr. Moore. We do try to operate as flexibly as we can, obviously, given the committee room times, but I take your point, so I'll ask the clerk how much longer we have this room. We'd like to ensure that we're able to get through all of the questions with the time that we have.

The Clerk of the Committee (Mr. Marc-Olivier Girard): Madam Chair, I believe that if the committee goes a little bit beyond 1:00, it would be okay.

The Chair: Thank you very much, and thank you, Mr. Moore, for your very kind intervention.

Mr. Lake, I believe you now have the opportunity to ask your five minutes of questions, two of which you've taken, so you have three.

Hon. Mike Lake: I believe I only took a minute and a half, and then the witness gave up the other 30 seconds.

The Chair: Of course. Please go ahead.

Hon. Mike Lake: My question to Ms. Herx stands.

What would be the criteria for someone with a developmental disability to determine capacity for them to indicate that they want medical assistance in dying?

Dr. Leonie Herx: I think that's a very complicated issue, Mr. Lake.

It would take consultation with a capacity assessment expert and specialists who are familiar with young adults with disabilities to be able to spend.... A large amount of time would be required to really understand how to best communicate with this person and what level of understanding they have about their unique circumstances and their treatment options.

I can say that as the stakes get higher for decisions, such as a termination of a person's life—I don't think it gets any higher than that—the amount of time it takes to assess capacity needs to be equal to that. The head of the complex capacity assessments at McGill University has told me that her most complex cases take several hours to really understand the person's capacity. It's a very complicated situation.

Most MAID assessors do not have formal capacity training, at least in my experience, and that's the same experience that my colleague at McGill has expressed. Even when we ask for psychiatry to be consulted in these complex cases, it's not always happening. In fact, in examples that I've experienced, I've recommended capacity assessment because I didn't feel the person had medical decision-making abilities, and that was not followed. I even documented it in the medical record and raised my concern with the MAID team. That person went ahead and got MAID anyway. I was told that they do their own assessments for capacity.

I think it's very complicated, and we should be relying on experts when it comes to a matter of life and death.

Hon. Mike Lake: Ms. Gupta, the disability community, and many in the developmental disability community specifically, have raised significant concerns about this issue, the fact that these changes are being made very quickly and that there are very few protections for people with developmental disabilities.

Do you think that those concerns are valid?

Dr. Mona Gupta: Thank you, Madam Chair. Thank you for the question.

Any group of persons who have raised concerns about whether there are adequate safeguards, how a law is being implemented and practised, are certainly to be taken seriously, and they are certainly to be considered valid and to be explored.

I think the tension we have with medical assistance in dying is that we have identifiable groups of people who may have characteristics of vulnerability or not have characteristics of vulnerability, but we also have individuals who are requesting assistance in dying, and they have their own characteristics of their own lives and their own conditions.

I think one of the difficulties we run into is how we make considerations and safeguards that take into consideration the vulnerabilities of groups while also respecting the lived experience and autonomy of individuals.

The Chair: Thank you very much, Dr. Gupta. I appreciate that.

We'll go on to Mr. Kelloway now for five minutes.

Go ahead, Mr. Kelloway.

Hon. Rob Moore: I have a point of order, Mrs. Chair.

The Chair: It's Madam, if that's okay. I'm not a Mrs.

Go ahead, Mr. Moore.

Hon. Rob Moore: Madam Chair, what are we doing here? We agree as a committee when we are going to meet. We agree as a committee, we vote as a committee, on what the order of questioning is.

We are all busy people, including our witnesses. We're in a committee that's scheduled to go from 11 o'clock to one o'clock. It's now one o'clock, so why are we doing...? It seems to me that there's a bit of a situation of not being willing to follow the rules unless it's going to disadvantage Conservative members of Parliament who are trying to ask questions and trying to do it within the rules.

We've set out, as a committee, the rounds of questioning, the amount of time it would take and when our meetings end. Our meeting ends at one o'clock. I find it extraordinary that we come to one o'clock.... Witnesses have things to do. I have things to do. I presume that the other members of Parliament have things to do. However, now we're somehow going into another round of questioning when the meeting is over.

● (1300)

Mr. Arif Virani: Madam Chair, could I speak to that point?

The Chair: Yes, go ahead, Mr. Virani.

Mr. Arif Virani: I'll confess to a bit of confusion, because six minutes ago the chair was, I believe, being faulted for not permitting Mr. Lake to ask his full round of questioning. You then intervened with the clerk, who indicated that we have the room available. I thought there was consensus among committee members and the witnesses to continue so that we could could conclude a full round of questioning, which is what I thought Mr. Moore was originally raising a concern about. Now it seems that the exact opposite concern is being raised.

I would ask for some clarity, because I personally believe, and I believe my Liberal colleagues believe, that if people want to ask a full round of questions and if the witnesses in the room are available, we should continue so that we can do just that.

Thank you.

The Chair: Thank you, Mr. Virani.

Before I come to you, Mr. Garrison, I will say, Mr. Moore, that in addressing the concerns you raised at the last meeting about running over time, I had tried to divvy up whatever time was remaining to keep your schedule in mind to make sure that we had an equitable distribution of time for all the members on the committee. That's what I was trying to do.

With your intervention and with the clerk's clarification that we do have the room for another full round of questions, I am happy to make that decision and to allow for another full round of questions.

Go ahead, Mr. Garrison, on this point of order.

Mr. Randall Garrison: Thank you very much, Madam Chair. I think we would need unanimous consent to proceed beyond our scheduled time. While I would very much like to hear more from the witnesses and while I have more questions, like everyone else, I have schedules to keep. If I'm being asked to consent to extend the time, I would not agree.

The Chair: Okay. Thank you, Mr. Garrison.

Go ahead, Mr. Moore.

Hon. Rob Moore: No. We've agreed on speaking times. We've agreed on the rounds. We've agreed that it goes Conservative, Liberal, Bloc, NDP, and then back to Conservative. Changing the rules as we go is not going to be conducive to our being able to have productive committee meetings.

We've heard from witnesses. We've done our rounds of questioning. It's the end of the meeting, and there's not consent to continue the meeting any longer beyond our schedule.

The Chair: Thank you, Mr. Moore.

My understanding is that it is not unanimous that we proceed with extending the committee meeting or not. It is by a majority, so I ask the committee now if a majority of the committee would like to continue the meeting to finish the second round of questions. Unless there's further debate, we'll ask the clerk to administer a vote at this time, whether it's recorded or on division.

(Motion agreed to: yeas 6; nays 5 [*See Minutes of Proceedings*])

The Chair: Thank you.

At this time, then, I guess we are done with this meeting today.

Mr. Clerk, please send out a reminder to all the members of the committee to please sign in at least 15 to 20 minutes before the meeting starts so that we can start in a timely fashion and continue the meeting in a timely fashion as well. Thank you, everyone.

I would like to take this moment to thank our witnesses for their time today. We really appreciate it. Again, I will remind you that if there are things that you have not been able to get on the record today and clarifications that you would like to provide, please do submit your written submissions to the clerk so that we can get them on the record and can include them in our deliberations on Bill C-7.

I thank you, everybody, for your time. The meeting stands adjourned.

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