

Expert Witnesses Speak Out Against Bias in Medical Assistance in Dying Report

The Special Joint Committee on Medical Assistance in Dying (which in Canada includes euthanasia and assisted suicide) completed its statutory review of the provisions of the Criminal Code relating to medical assistance in dying (MAiD) in February 2023. Its report *Medical Assistance in Dying in Canada: Choices for Canadians* provides parliament with 23 recommendations on five topics of study, including: the state of palliative care in Canada; protections for Canadians with disabilities; MAID for mental disorders as a sole underlying medical condition; MAID for mature minors; and advance requests for MAID.

The committee process and report ignored much of the input of the local, national, and internationally recognized experts and individuals with lived experience who expressed concern and caution. At committee hearings, these invited witnesses were routinely talked over, ignored, argued with, and at times, openly disparaged by committee members in favour of amplifying the ideology of MAID expansionists and pro-MAID lobby groups. We see this reflected in the report, which tends to prioritize opinions of experts and federal bureaucrats who argued for expansion of MAID. When concerns are mentioned, they are often preceded by or juxtaposed with more extensive quotes from experts and bureaucrats supporting expansion. Remarkably, for example, a physician without specific expertise on disability is quoted to allege a lack of negative impact of MAID laws on disabled persons.

We, individual experts who presented as witnesses before the committee, have come together to issue this response across the 5 areas of study in dissent to the committee's report recommendations:

The State of Palliative Care in Canada

Palliative care is a combination of expert medical care addressing physical, psychological and existential suffering and the practical supports to enable someone to live as well as they can for as long as they can. Sadly, this report fails to make any meaningful, substantive recommendations needed to improve both the access and quality of palliative care. In fact, each one of the recommendations specifically related to palliative care, Recommendations 5, 7 and 8, are all seriously flawed, while Recommendation 6 simply reiterates the 2018 [National Framework](#) on Palliative Care. This demonstrates the committee's deep misunderstanding of palliative care and disregard of expert witness advice.

Evidence presented from many nationally and internationally recognized palliative care experts was dismissed regarding why palliative care and MAiD should remain separate and distinct,

including the important role palliative care holds as both a clinical and legal safeguard for MAiD, the diversion of limited palliative care resources to support MAiD, and the potential for patients refusing palliative care services for fear it will hasten their death. The committee also ignored the reality of the power imbalance between healthcare professionals and patients, and how a healthcare professional raising the option of MAiD unsolicited may coerce those who lack support and feel a burden into considering they are better off dead.

Access to palliative care in Canada still depends on the medical diagnosis, where you live, and your socioeconomic status. Those who are Indigenous, incarcerated, homeless, disabled, a child, or live in a rural/remote region have even less access to palliative care. Even though [palliative care is a vital service](#) with clear economic, health and social benefits, and the 2018 National Framework on Palliative care was unanimously supported by parliamentarians, patients all across Canada continue to have limited access to this essential service.

Committee Recommendation 5

That the Government of Canada, through Correctional Service Canada, support approved track one MAID recipients being able to die outside a prison setting only for the event itself and any immediate preparatory palliative care that is required

Incarcerated individuals lack access to basic care, let alone access to specialized palliative care services when needed. To recommend palliative care only as preparation for MAiD (Recommendation 5) is disturbing. Access to palliative care in prisons, and all across Canada, should be a human right.

[Multiple studies have shown a lack of access to palliative care and high symptom burden among those granted MAiD](#). The accuracy of government reporting on the provision of palliative care for those receiving MAiD was called into question by many experts, cautioning that contact with palliative care was *not* synonymous with having received palliative care. But even these flawed statistics show that [21% of persons receiving MAiD for a terminal illness had contact with palliative care only in the last 2 weeks before MAiD](#). For most people, that means contact with palliative care was initiated after applying for MAiD. **Choosing to die from MAiD in the face of lack of timely, quality palliative care and supportive services is NOT a choice.** For those with a terminal illness, provision of early, quality palliative care should be a prerequisite for MAiD if it is to be an effective safeguard (contrary to the committee's Recommendation 7). Failure to provide palliative care early should be considered a [medical error](#).

Committee Recommendation 7

That, with the understanding that palliative care is not a prerequisite to access or receive MAID, the Government of Canada work in partnership with the provinces and territories on the following action items....

Committee Recommendation 8

That the Government of Canada, in collaboration with the provinces and territories, work to develop data systems to collect disaggregated data for Black, Indigenous, racialized, disabled, and 2SLGBTQ+ communities beyond the regulations that went into force January 1, 2023.

Experts testified that the federal government has the authority and should develop national palliative care standards and quality indicators tied to health care funding. The committee agreed with this recommendation and concluded in their report that, “improving data about access to palliative care and establishing standards by which the quality of palliative care is measured is an important step in improving palliative care”. Strangely, Recommendation 8 ignores

the committee’s own conclusions and instead recommends collecting disaggregated data for Black, Indigenous, racialized, disabled, and 2SLGBTQ+ patients receiving MAiD. This does nothing to improve palliative care. Either the committee did not understand their own conclusions before writing Recommendation 8 or this is another example of the committee ignoring expert advice and not understanding the nature of palliative care.

Polls show that the majority of Canadians prioritize expanding palliative care services over MAiD; want palliative care providers to have the requisite expertise; and they are worried that “[MAiD will be replacement for adequate social services in Canada.](#)”

Canadians should know that the Joint Parliamentary Committee has failed to consider compelling testimony by palliative experts, as well as polls from Canadians wanting access to timely and quality palliative care. The lack of significant action on access to quality palliative care across Canada will have a significant impact on Canadians with serious illness for years to come.

Protections for Canadians with Disabilities

The Report on MAiD by the Special Joint Committee ignored, diminished and misrepresented the statements of disabled witnesses who were allotted 5 minutes to contextualize and explain MAiD’s place in Canada’s history of eugenics and oppression of disabled people.

Understanding the body of knowledge and critical analysis of disabled scholars, academics, professionals, activists and community members should have been the Committee’s focus. The importance of this cannot be overstated. This body of research and analysis is not common knowledge. The conflating of disability with suffering is reflected in physician attitudes and assessments about quality of life.

Disabled people's knowledge is not yet part of most educational curricula because it is only in recent history that disabled people have been able to attend public schools and post-secondary institutions, let alone teach and do research in them. The lack of significance placed on the scholarship and community knowledge is symptomatic of the larger problem where the history and lived experiences of disabled people, particularly those who are poor or low income, racialized or otherwise marginalized, are ignored while the financially privileged, high-status professionals and policy makers are prioritized.

Historically, designating disabled people as unintended and undesired participants in Canadian society was explicit and codified. Today, much of the explicit language has changed but those values and beliefs remain embedded into our economy, culture, values, politics and design of every aspect of society.

Disabled people are the only people eligible for MAiD. Disability is a large umbrella term that includes people with chronic and mental illness of varying degrees as well as a range of impairments. All the language used in MAID legislation is a synonym for disability. To say that someone has a serious illness or disease is to say that person is disabled. Yet, questions and comments by the Special Joint Committee on MAiD members implied disability experts and community members were discriminating against disabled people by excluding them from eligibility.

The fact MAiD is only available to disabled people is not reflected within the process and report.

The Committee was not asked to remove the word disability (Recommendation 11). We oppose in the strongest possible terms removing the word disability from legislation that specifically targets disabled lives. That is deception not destigmatization. The committee recognized that removing disability is a completely performative step by saying it could be accomplished in a way that does not limit access to MAiD.

The still non-existent and non-specific Canada Disability Benefit (CDB) is irrelevant to this report. Who will benefit and how much is still unknown. At most the CDB may reduce poverty for some. Much like removing the word disability from a policy targeting disabled people, raising CDB is a deflection. Further, poverty, while significant in degree, harm and prevalence among disabled people, is only one manifestation of structural oppression.

As well, disabled people of all ages remain institutionalized due to Canada's failure to uphold the UN Convention of the Rights of Persons with Disabilities and provide disabled people with the accessible, affordable housing and support necessary to live in the community.

MAID in prison raises particular alarms. Canadian courts have consistently recognized the vast overrepresentation of Black and Indigenous people in our prisons, and the disproportionate rates of disability. This is a consequence of the insidious intersection of racism and ableism. Offering people an opportunity to leave prison – where they can spend time with their families – on condition that they sign up for MAID is enticement, especially where parole by exception is often not accessible.

There is comprehensive research demonstrating that ableism and other intersecting structural, institutional, and systemic oppressions along with bias, play a significant role in who becomes disabled and their subsequent diagnosis, treatment, and outcome. Similarly, we know people

Committee Recommendation 11

That the Government of Canada, through the Department of Justice, and in consultation with organizations representing persons with disabilities, explore potential amendments to the *Criminal Code* that would avoid stigmatizing persons with disabilities without restricting their access to MAID. Options considered should include replacing references to "disability" in section 241.2(2) of the *Criminal Code*, with attention to the potential legal ramifications of such an amendment across Canada.

from certain demographics do not lodge official complaints even when experiencing medical harm or negligent care.

In an era of Me Too, where we understand why women don't report, one wonders at what point is it the responsibility of policymakers to acknowledge these processes are neither always trusted nor effective measures, (and can be contributors) to the harm victims experience. The extensive literature on social and political determinants of health should raise a red flag. The state whose policies are the cause of acknowledged health inequities should not be offering to solve them by providing lethal injection.

Ableism forms the foundation of MAiD. Canadian MAiD for disabled people is discriminatory regardless of how many euphemisms are used to disguise reality or how much EDI (equity, diversity and inclusion) language is perversely co-opted or whether you try to erase the word disability (#SayTheWord disability). MAiD turns a protected class of citizens into a group targeted for euthanasia.

MAID for Mental Disorders as a Sole Underlying Medical Condition

The Joint Parliamentary Committee Report recommendations regarding MAID for sole mental illness conditions (MAID MD-SUMC) are deeply flawed and selectively ignore evidence while preferentially accepting personal opinions of witnesses ideologically favouring expansion. The Committee's recommendations place Canadians who would recover from mental illness at risk of avoidable premature death, and if enacted will be responsible for facilitating state provided deaths to marginalized and suicidal Canadians who would have recovered.

The Committee's ideological bias is demonstrated early in the report. In the Summary, the sole "theme" of concern the committee mentions regarding MAID MD-SUMC is "*the importance of MAID training materials for healthcare professionals*". The summary completely ignores the multitude of evidence-based concerns raised regarding risks of providing MAID to suicidal individuals facing social distress who could recover from their mental illness. This omission flags the blindspots of the Committee regarding MAID expansion. It also reveals the Committee's bias towards misdirecting the issue as being about the "need for training" while dangerously ignoring the lack of evidence regarding safety of providing MAID MD-SUMC in the first place. Given this bias, it is not surprising the Committee's recommendations support the millions of dollars of funding provided to organizations like the Canadian Association of MAiD Assessors and Providers that advocate for MAID expansion.

The Committee's ideological bias continues with how the section on MAID MD-SUMC is misleadingly framed. Under "Potential Discrimination", the Committee selectively only mentions concerns raised by witnesses favouring expansion that "*not allowing MAID MD-SUMC could be discriminatory*". The Committee selectively ignores the concerns raised by many other witnesses that **providing MAID MD-SUMC would itself be the ultimate form of discrimination**, by exposing

marginalized individuals to avoidable deaths based on faulty assessments by assessors wrongly reporting that an individual's mental illness was "irremediable".

While the report provides narrative comments about concerns raised by some witnesses regarding irremediability, suicidality and vulnerability, (Recommendation 13) ignores these concerns. Focusing on the "preparedness" of implementing MAID MD-SUMC in 2024 but presupposing that MAID MD-SUMC should be implemented, rather than pausing expansion pending proper review of evidence, reveals the Committee's ideological bias. This ignores unresolved concerns of evidence showing that: (1) mental illnesses cannot be predicted to be irremediable in any individual, yet assessing irremediability is the fundamental underpinning of MAID; (2) suicidality cannot be distinguished from requests for MAID MD-SUMC, and; (3) marginalized individuals, including women by a 2:1 margin, are particularly at risk of seeking premature death by MAID MD-SUMC for social suffering.

Committee Recommendation 13

That, five months prior to the coming into force of eligibility for MAID where a mental disorder is the sole underlying medical condition, a Special Joint Committee on Medical Assistance in Dying be re-established by the House of Commons and the Senate in order to verify the degree of preparedness attained for a safe and adequate application of MAID (in MD-SUMC situations). Following this assessment, the Special Joint Committee will make its final recommendation to the House of Commons and the Senate.

The Committee's rejection of brain science in favour of ideology is concretely demonstrated in the Mature Minors section. Despite citing evidence "*that the frontal lobe of the brain, which plays a key role in risk assessment and decision-making, is not fully developed until well into adulthood*", the Committee discounts this based on selective individuals' opinions that "*adolescents suffering from serious illnesses tend to possess an uncommon level of maturity*". This deference to personal opinions favouring expansion, and rejection of actual evidence, similarly informs the Committee's recommendations on MAID MD-SUMC.

Framing "discrimination" in a one-sided way, claiming it would be discrimination not to allow MAID MD-SUMC, has been openly voiced by Committee members themselves since before the hearings began. Indeed, the senator who introduced the sunset clause to ensure Bill C-7 would allow for MAID MD-SUMC sat on the Joint Committee and has repeatedly publicly made this claim while dismissing concerns about risks of MAID expansion. This same senator, who fellow Committee members might give credence to regarding MAID MD-SUMC since he is also a psychiatrist, demonstrated this selective bias in his speech proposing the sunset clause, in which he references organizations seen as ideologically favouring MAID expansion such as the Canadian Psychiatric Association (which never raised evidence-based concerns about suicidality in Bill C-7 consultations on mental illness and death) and the Association des médecins psychiatres du Quebec (which admitted irremediability in mental illness could not be determined but favoured expansion anyway, suggesting assessments be "ethical" decisions rather than scientific ones).

In our opinion the Committee failed to engage in unbiased review with academic integrity. Given the biases embedded throughout the Special Joint Committee process, there is little reason to believe that the Special Joint Committee being proposed to reconvene five months before MAID MD-SUMC implementation would be any less biased.

In ignoring known evidence-based risks of providing avoidable death to marginalized and potentially suicidal individuals suffering from social distress who could recover, while favouring MAID expansion to increase autonomy of the more privileged, the Committee is condoning a form of eugenics through expanding MAID in Canada.

MAiD for Mature Minors

The conclusions of the report pertaining to the expansion of MAiD to allow Mature Minors to access Track 1 is disgraceful (Recommendation 16). The Special Joint Committee on MAiD has ignored pertinent issues regarding the safety of the current MAiD regime for Track 1 and disabled persons. MAiD should not be extended to children. Further, the committee additionally fails to provide necessary safeguards for this unfortunate recommendation despite the evidence of experts.

Committee Recommendation 16

That the Government of Canada amend the eligibility criteria for MAID set out in the *Criminal Code* to include minors deemed to have the requisite decision making capacity upon assessment.

Committee Recommendation 17

That the Government of Canada restrict MAID for mature minors to those whose natural death is reasonably foreseeable.

The committee fails to provide an age minimum as a temporary safeguard (Recommendation 17). The suggestion by one expert to redirect attention away from the elusive concept of a mature minor to instead attend to a child or youth's "decisional capacity" is dangerous. By so doing, this expert is unwittingly suggesting that we blind ourselves to the nature of the individual, specifically that child, and instead simply apply the same criterion for capacity that one does to an adult.

The committee failed to draw attention to the fact that there is a paucity of evidence that assessment techniques for decisional capacity of a minor are sufficiently rigorous or reliable. The existing data on capacity assessments in adults highlights that among psychiatrists (who receive capacity assessment training and are assumed competent at time of licensure) the inter-rater reliability of decision-making capacity is low to moderate at best. Similar questions have not even been studied in children.

The committee paid lip service to the importance of safeguards, failing to provide any robust recommendations pertaining to safeguards and undermining natural safeguards in the life of minors. Multiple witnesses expressed concern regarding the current lack of robust safeguards in the existing Track 1 and 2, and strongly cautioned the committee against extending the current legislation to minors at this juncture. The committee's recommendations undermine the ability of those individuals most responsible for protecting the child, the child's parents, or caregivers (Recommendation 19). By making no provision for parental consent to treatment, the fundamental safeguard in a minor's life is effectively nullified.

Committee Recommendation 19

That the Government of Canada establish a requirement that, where appropriate, the parents or guardians of a mature minor be consulted in the course of the assessment process for MAID, but that the will of a minor who is found to have the requisite decision-making capacity ultimately take priority.

Further, the committee heard that many disabled children, those in the foster care system and indigenous youth are often victims of trauma and abuse and may perceive their life as less valuable than others because of these experiences that often echo larger structural inequities, while lacking the adult means to attempt to address or escape them. Evidence informs us that not all family environments are loving, safe places and this is especially true for disabled children who experience disproportionately higher rates of abuse and violence and children in care who experience particularly high rates of violence while in the care of the system.

The committee failed to act as mature adults who recognize that minors are a group with unique disadvantages arising inherent within human development, and thereby are dependent upon adult legislators to create laws that effectively protect minors from systemic abuses. Instead of taking adult responsibilities to establish the safety of the legislation, the committee drew attention to the limited involvement of youth voices in the discussion, while simultaneously amplifying the message that at least some youth sampled purportedly support expansion to minors, while briefly noting and downplaying that there was indeed a diversity of opinion among youth.

Finally, while acknowledging service gaps faced by youth in this country, the committee fails to strongly advocate on behalf of minors to ensure adequate access to medical services for all youth regardless of geographic location, ethnicity, disability, or other marginalizing factors especially palliative, disability and mental health care and home and community supports. The committee would be better served to have advocated to the government of Canada to address the significant disparities that exist for children to access palliative care, disability supports, and mental health services. As it stands, the Canadian Charter of Rights and Freedoms provides no provision for right to death, and to the extent that the committee advocates for children's right to death, they undermine the safety and security of both vulnerable and suffering children in this country.

Advance Requests for MAiD

“Medical assistance in dying” was initially promoted as an exercise of personal autonomy. We were told that persons able to consent to their own death should be allowed to do so.

To permit MAID for persons unable to consent would require solid evidence that prior consent remains valid. The Special Joint Committee on MAiD report fails to provide it. This contrasts with the Council of Canadian Academies Report’s [CCA] detailed analysis of the evidence on Advance Requests for MAID, which the government commissioned to inform parliamentary deliberations, but which is largely ignored in the Special Joint Committee on MAiD report.

The discussion on advance request is prefaced with opinion polls and the relative number of witnesses for or against it, as if popularity trumps data. The dearth of Canadian health care providers expert in geriatrics is reflected in the witnesses for the panel: clinicians with expertise in caring for the elderly were underrepresented. Most witnesses quoted in the report were MAID advocates and providers, or academics in other fields, none of whom care for patients with advanced dementia. The report’s understanding of practical aspects is weak, reflecting this lack of real expertise.

Several witnesses raised grave concerns about the validity of written advance consent to death. They explained differences between contemporaneous and advance consent. They emphasized the distinction between advance requests to limit medical interventions and those to actively cause death. They cited advance care planning literature, which shows no evidence of written advance directives predicting future wishes accurately, but rather that people’s wishes evolve over time as they adapt to their disease or disability. Some emphasized the disability paradox, i.e. the tendency to have a much more negative perception of the quality of life prior to becoming disabled than afterwards. Several concluded that persons who die by MAID through an advance request will not have consented, and their death will instead be based on a third-party decision.

The report dismisses these concerns with the disingenuous sentence: “**Some witnesses were of the opinion that providing advance consent is not true consent, suggesting that it cannot be fully informed and it cannot be withdrawn.**” The evidence-informed arguments put forward by several witnesses and in the CCA report, that advance requests for MAID do not constitute clear consent, are not mere ‘opinions’. Advance consent cannot be informed in the way that contemporaneous consent can be—and even that form of consent faces challenges. It is self-evident that it cannot be withdrawn once the person is incapable. Most would conclude therefore that it is not true consent. Witnesses pointed out that it therefore runs counter to the

Committee Recommendation 21

That the Government of Canada amend the *Criminal Code* to allow for advance requests following a diagnosis of a serious and incurable medical condition disease, or disorder leading to incapacity.

emphasis on ‘clear consent’ in the Supreme Court’s *Carter* decision. The parliamentary report glosses over it.

The discussion on whether dementia can be “happy” or not is irrelevant to the question of consent, makes no mention of the many measures available to reduce the suffering of people with dementia, and seems to be simply a springboard to the ableist and paternalistic conclusion that death is preferable to life with dementia, regardless of whether the person can consent to it.

The report itself, unlike the minority report, fails to acknowledge the legal argument that surreptitious medicating and providing MAID to persons with cognitive decline on the basis of advance requests violates the Convention on the Rights of Persons with Disabilities [CRPD]. In contrast, the report quotes from a legal memorandum broadly accepting that MAID expansion does not violate the CRPD, thereby contradicting a letter by the United Nations Special Rapporteur on the rights of persons with disabilities, the Independent Expert on the enjoyment of all human rights by older persons, and the Special Rapporteur on extreme poverty and human rights and ignoring earlier concerns expressed in a report of the Special Rapporteur on the Rights of Persons with Disabilities.

Testimony highlighted the Dutch evidence of practical and ethical challenges of implementing advance requests. The Netherlands is the only jurisdiction that allows this for persons who are not permanently unconscious. Data from the Netherlands shows that physicians are not able to comply when they cannot affirm consent or discern suffering, and the vast majority of families are not able to support the advance requests for MAID. It is remarkable that these concerns are not even mentioned in the report.

Committee Recommendation 23

That the Government of Canada work with the provinces and territories and regulatory authorities to develop a framework for interprovincial recognition of advance requests.

The report further fails to discuss the challenge of lack of expertise for the implementation of its recommendations. Many geriatric experts would be needed to follow the Special Joint Committee on MAiD recommendations, from the time of completing the advance directive to the delivery of MAiD. Only those inexperienced in dementia care can believe otherwise.

The recommendations on MAID by advance request reflect the activism of witnesses and politicians, not the prudence and knowledge necessary in considering such a life and death matter.

Summary

We, the undersigned, speaking each to our own expertise, who testified at the Special Joint Committee on MAiD, reject this report which misconstrues, misrepresents, minimizes, and completely ignores key evidence necessary to protect Canadians. The 23 recommendations fail to provide Canadians with the required safeguards to prevent harm and wrongful death and introduces larger segments of the Canadian population to potential harms instead of supporting Canadians to live well and flourish.

Signatories

Palliative Care section:

Harvey Max Chochinov OC OM MD PhD FRCPC FRSC
Distinguished Professor of Psychiatry, University of Manitoba
Senior Scientist, CancerCare Manitoba Research Institute

Baroness Finlay of Llandaff FRCP, FRCGP, FMedSci, FHEA, FLSW
Professor of Palliative Medicine and Crossbench Peer, House of Lords

David Henderson MD CCFP (PC)
Senior Medical Director, Palliative Care, Nova Scotia Health
Assistant Professor, Dept. of Family Medicine, Dalhousie University

Leonie Herx MD PhD CHE CCFP (PC) FCFP
Chair & Associate Professor, Division of Palliative Medicine, Department of Medicine,
Queen's University

Romayne Gallagher MD, CCFP(PC), FCFP
Clinical Professor, Division of Palliative Care, University of British Columbia
(And testified for Advance Directives)

Ebru Kaya MBBS, MRCP (UK)
Associate Professor of Medicine, University of Toronto

José Pereira MBChB, CCFP (PC), MSc, FCFP, PhD
Professor and Director, Division of Palliative Care, Department of Family Medicine,
McMaster University

Disability Section:

William Adair M.S.M.

Krista Carr
Executive Vice-President, Inclusion Canada

Ramona Coelho, MD, CFPC
London, Ontario

Karen Ethans, M.D., FRCPC
Associate Professor, Internal Medicine, Section of Physical Medicine and Rehabilitation,
University of Manitoba

Catherine Fazee OC, D.Litt., LLD. (Hon.)
Professor Emerita, Toronto Metropolitan University, School of Disability Studies

Isabel Grant, F.R.S.C.
Professor, Peter A. Allard School of Law, University of British Columbia, Vancouver Campus

Michelle Hewitt
Disabled woman
PhD Candidate, University of British Columbia, Okanagan Campus
Chair, Disability Without Poverty

Sarah Jama
Founding Executive Director, Disability Justice Network of Ontario

Heidi Janz, Ph.D
Associate Adjunct Professor, John Dossetor Health Ethics Centre, University of Alberta

Kerri Joffe
ARCH Disability Law Centre

Megan Linton, MPPA

Gary and Trish Nichols
Family of Alan Nichols who died by MAiD but did not meet MAiD eligibility requirements

Gabrielle Peters
Disabled writer, policy analysis and community activist
Co-founder: Disability Filibuster, Dignity Denied

David W. Shannon C. M., O. Ont., LLM
Barrister-and-Solicitor

Professor Tim Stainton, MSW PhD
School of social work & Director, Canadian Institute for Inclusion and Citizenship,
University of British Columbia

Mental Illness:

Ellen Cohen
Advocate, National Mental Health Inclusion Network

K. Sonu Gaind, MD, FRCPC, DFAPA
Chief of Psychiatry, Sunnybrook Health Sciences Centre
Former President, Canadian Psychiatric Association
Honorary Member, World Psychiatric Association
Professor, University of Toronto

Mark Henick
Mental health and anti-stigma advocate

Eric Kelleher MB, BMedSci, MRCP, MRCPsych, MCPsychI, Dip (Cog Psy), PhD
Consultant Liaison Psychiatrist, Cork University Hospital & Mercy University Hospital.
Honorary Clinical Senior Lecturer, University College Cork

Sean D. Krausert
Executive Director, Canadian Association for Suicide Prevention

John Maher MD FRCPC
President, Ontario ACT Association
Editor-in-Chief, Journal of Ethics in Mental Health

Brian L. Mishara, Ph.D.
Director, Centre for Research and Intervention on Suicide, Ethical Issues and End-of-Life
Practices, Professor, Psychology Department, Université du Québec à Montréal

Georgia Vrakas, Ph.D., psychologue & ps.éd.
Professeure agrégée
Département de psychoéducation
UQTR | Campus de Québec

Mature Minors:

Neil Belanger
Chief Executive Officer, Indigenous Disability Canada

Tim Ehmann MD FRCPC
Child & Adolescent Psychiatrist

Myeengun Henry
Former Chief, Chippewas of the Thames First Nation
Law Society of Ontario Indigenous Advisor
Ontario Provincial Police Indigenous Advisor
Southern First Nations Health Access Traditional Healer

Ahona Mehdi (she/they)
Disability Justice Network of Ontario (DJNO)

Rod McCormick, PhD
Kanienkehaka
Principal Investigator, Omshaashi Network Director of the Indigenous All My Relations Centre

Maria Alisha Montes
MBBS BCh BAO, MPH, FRCP

Elizabeth Sheehy, LLB, LLM, LLD (hons), F.R.S.C., O. Ont.
Professor Emerita of Law, Faculty of Law, University of Ottawa

Advance Directives:

Michael Bach, PhD
Managing Director, IRIS – Institute for Research and Development on Inclusion and Society
Adjunct Professor, Disability Studies, Toronto Metropolitan University

Jonas-Sébastien Beaudry, DPhil

Alice Maria Chung, MDCM, FRCPC
Geriatric Medicine

Catherine Ferrier, MD, CCFP (COE), FCFP
Division of Geriatric Medicine, McGill University Health Centre

Assistant Professor, Department of Family Medicine, McGill University

Romayne Gallagher MD, CCFP(PC), FCFP
Clinical Professor, Division of Palliative Care, University of British Columbia
(And testified for Palliative Care)

Trudo Lemmens, LicJur, LLM bioethics, DCL
Professor and Scholl Chair in Health Law and Policy, Faculty of Law and Dalla Lana School of Public Health, University of Toronto

Félix Pageau, M.D., F.R.C.P.C., Geriatrician, MA in philosophy and ethics
Chercheur régulier au Centre d'excellence en vieillissement de Québec et VITAM - Centre de recherche en santé durable, Université Laval, Québec et CIUSSS de la Capitale-Nationale
Chercheur associé à l'Institut d'éthique biomédicale de Bâle, Université de Bâle, Bâle, Suisse.
Former fellow of the MacLean Center for Clinical Medical Ethics, University of Chicago, USA
Responsable de l'Axe Éthique et Santé, Faculté de philosophie de l'Université Laval, Québec
Membre du Comité national d'éthique sur le vieillissement, ministère des Aînés et des Proches aidants, Québec