REBUTTAL BRIEF OF PROF. DOWNIE/DR. GUPTA DOCUMENT

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on behalf of the Expert Advisory Group on MAID

Prior to the vote for Bill C-314, a group of parliamentarians received on October 14, 2023, a brief by Prof. Jocelyn Downie and Dr. Mona Gupta, entitled "RESPONSES TO COMMON CONCERNS ABOUT MAiD MD-SUMC." That document, containing erroneous and misleading statements, clearly aimed to influence parliamentarians to support a planned expansion of MAiD for mental illness in March 2024, hence we consider it important to rebut the inaccurate points they put forward.

This brief rebuts the key assertions made by Prof. Downie/Dr. Gupta. We refer to their October 14 document for their verbatim text/assertions. Each section starts in **bold,** with verbatim comment(s) from their document of a statement or concern Prof. Downie/Dr. Gupta claim to be addressing, followed by their assertion(s) on that statement; our rebuttals follow below in *italics*.

A summarized version of this document was submitted to the special joint parliamentary committee as a formal brief to adhere to the 1,000 word limit requested of submitted briefs. This full version should be considered the definitive document as it provides detailed context.

(i) From D-G document: "If MAiD MD-SUMC is allowed, a person will be able to walk into an Emergency Room and get MAID when they are going through a difficult time. This is false."

Rebuttal

This is a misleading straw person distortion. It is a caricature of the actual concerns of those advising caution. The real concerns are:
(1) those suffering from mental illness will be told their situation is "irremediable", when evidence shows those predictions cannot be made, and over half the time the assessor making such a prediction will be wrong;
(2) assessors will claim they are not providing MAID for mental illness to suicidal people, but in reality evidence shows they will be unable to separate suicidal wishes fueled by mental illness symptoms from psychiatric MAID requests.

Additionally, the Prof. Downie/Dr. Gupta response to this invented claim hides the fact that individual assessors have remarkably broad discretion in offering MAID. There are already documented cases of someone in distress going to the emergency room for psychiatric help,

and becoming more distressed when hospital staff bring up MAID: https://globalnews.ca/news/9888810/suicidal-bc-woman-medically-assisted-death/

The case of Alan Nichols also illustrates that persons who were initially diagnosed as suicidal may end up receiving MAID without a terminal illness diagnosis, and without clarity as to the basis of the approval. Expert commentators have raised concern about the relative short time between emergency admission with diagnosis of suicidality and termination of life in his case.

(ii) From D-G document: "A person with MD-SUMC could ask for MAiD and receive it the next day. This is false. MD-SUMC MAiD requests will follow the Track 2 safeguards. The Track 2 safeguards require a minimum of 90 days to elapse between the request approval and provision."

Rebuttal

*This is another straw person argument [those advising caution are not basing concerns on MAID for sole mental illness being received "the next day"]. We would however note that the 90 day period on track 2 refers to the time required for "the assessment". We do have concern that some may interpret that this means the *assessor* needs to say their initial clinical assessment of the patient started 90 days before MAID is provided and that the patient does not need to have requested MAID at the start of that 90 day period. Thus, there are reasonable concerns that some assessors may interpret this as if 90 days *do not* need to elapse between request approval and provision. Additionally, the 90 days can be shortened if loss of capacity is deemed imminent. In the context of mental illness, this potential shortening also raises concern. The 90 day requirement *DOES NOT* mean the patient needs to "reflect" on their MAID request for 90 days.*

There is established reason for concern that some may consider the 90 day assessment period does not require any minimum time between the patient's actual written MAID request and the patient receiving MAID. This was highlighted in the investigative report by the Fifth Estate in January. It suggested that Dr. Joshua Tepper set a date for MAID provision and then indicated he started his assessment more than 90 days prior, despite the patient's actual request not occurring till much later (less than 90 days prior to the MAID provision date that had been set) (note that, after the family got involved, Dr. Tepper withdrew from the care/MAID process of the patient and called off the planned MAID day procedure).

Importantly, getting proper psychiatric care often takes much longer than 90 days; and some prominent MAID assessors (Dr. Ellen Wiebe, who has provided several hundred MAID provisions) have said they would consider a person on a long enough waiting list for care to qualify for MAID. We consider this 90-day safeguard a very weak safeguard.

Finally, the 2022 CAMAP document, "The Interpretation and Role of 'Reasonably Foreseeable' in MAiD Practice", essentially provides guidance to assessors for essentially 'converting' Track 2 MAID requests to Track 1, and for proceeding with Track 1 MAID

(thereby bypassing all Track 2 safeguards, including the 90 day period) ***even if assessors do not agree the patient should be on track 1****. Specifically, CAMAP advises:*

> *"A person may meet the 'reasonably foreseeable' criterion if they have demonstrated a clear and serious intent to take steps to make their natural death happen soon or to cause their death to be predictable. Examples might include stated declarations to refuse antibiotic treatment of current or future serious infection, to stop use of oxygen therapy, to refuse turning if they have quadriplegia, or to voluntarily cease eating and drinking."*
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> *"It is the Provider who has the responsibility to assess RFND. The law does not require the Assessor to assess RFND although in most provinces the Assessor is required to give their opinion. The law does not require that the Provider and the Assessor agree on the issue of RFND. However, CAMAP's recommendation is that if the Provider is of the opinion that the person has an RFND but the Assessor disagrees, the Provider should consider seeking a third opinion from another clinician."*

According to CAMAP, a patient on Track 2 without a foreseeable death (i.e. a patient with sole mental illness) could therefore be placed on Track 1, bypassing any Track 2 safeguard, if they indicated intent to for example stop eating and drinking; and even if any Assessor though the patient should not be on Track 1, if the final Provider thinks the patient should qualify for Track 1, they are legally allowed to provide MAID without any Track 2 safeguards, in accordance with CAMAP guidance.

While Dr. Gupta and CAMAP have provided reassurances of adequate safeguards, the above speaks against adequate safeguards in law being in place. The regulations and guidance outlined above are inadequate to prevent patients suffering from sole mental illness from being provided MAID inappropriately during periods of despair. We are further concerned that, rather than providing guidance urging caution prior to providing MAID, CAMAP's recommendations have been crafted to allow the most permissible interpretation of law possible.

(iii) From D-G document: "A request for MAiD based on a mental disorder as a sole underlying medical condition is fundamentally different (for example, in respect of assessing incurability and suicidality) from a request based on a chronic physical condition or a request based by persons who have a significant mental disorder and a physical disorder at the same time. No one has provided any evidence to support this statement."

<u>Rebuttal</u>

Prof. Downie/Dr. Gupta outright ignore the significant evidence that has been provided, and that every psychiatrist should know, that shows the crucial differences regarding requests for sole mental illness and other medical disorders, including:

- *Evidence of not being able to predict irremediability of mental illnesses in any individual (less than 50% accuracy of predictions in mental illness, which is*

completely different from far more predictable medical disorders; and we don't even understand the biological basis of mental disorders).

- *Evidence of not being able to distinguish suicidality from mental illness from motivations for MAID for sole mental illness. While this may indeed already be a challenge more broadly in the context of some MAiD requests, evidence shows it is heightened in the context of mental illness. The assertions of Dr. Gupta, and others like Senator Kutcher, who claim these distinctions can be made "since they are core competencies of psychiatry" are based on a total lack of evidence. Prof. Downie/Dr. Gupta further ignore that no illnesses other than mental illnesses have suidicality as an actual potential diagnostic criterion.*
- *Evidence of different populations receiving MAID MD-SUMC compared to those receiving it for other conditions, including the particular risk of marginalized persons being at higher risk of premature death.For example the 2:1 gender gap ratio of women to men getting MAID for mental illness in Europe is *different* from the 1:1 gender equity ratio of those getting MAID for medical end of life conditions, and parallels the 2:1 gender gap of women:men who attempt suicide when mentally ill (most of whom do not end up taking their lives by completing suicide).*

(iv) From D-G document: "People can access MAiD in Canada because they are living in poverty. No one who has made this claim has provided any evidence that this is the case."

<u>Rebuttal</u>

This is again a straw person argument: no one says that persons receive MAID solely because they live in poverty. But any disability can provide a "foot in the door" as the medical condtion qualifying for MAID, and poverty can and has been accepted as a significant motivating, and even main factor in seeking MAiD. Prof. Downie/Dr. Gupta's claim ignores mounting public evidence, of which they must be aware. There are documented cases of people having received MAID explicitly indicating they were driven by poverty, not by their illness symptoms. When questioned about people being approved for and receiving MAID for social suffering, Konia Trouton, the current CAMAP president, admitted in the 2023 Walrus article that the suffering people get approved for MAID for does not have to be related to illness suffering.

Prof. Downie/Dr. Gupta claim that the MAID for mental illness expansion is safe by quoting evidence related to MAID for end of life medical conditions, while actively ignoring MAID for sole mental illness data from Europe that show that populations seeking psychiatric MAID have unresolved socio-economic suffering, and this in jurisdictions such as Belgium, which have more robust social programs than Canada, and (unlike Canada) have an explicit requirement that physicians must agree that no medical options remain. The denial by Prof. Downie/Dr. Gupta of the existence of such evidence, which has been repeatedly mentioned previously, raises concerns about the academic integrity of their assertions.

Prof. Downie/Dr. Gupta claim that patients with mental illness will not be at risk of seeking MAID fueled by social suffering, when in reality there are no safeguards preventing poverty, housing insecurity, loneliness, etc, from significantly fueling MAID requests of those suffering

from mental illness (and those with mental illness unfortunately also have higher rates of social suffering).

We note that Prof. Downie/Dr. Gupta further cite "evidence" from a Downar et al article, claiming that "the evidence shows that, at a population level, socioeconomic deprivation and service gaps appear, statistically, to be protective against [i.e., inversely correlated with] MAiD." *Parliamentarians should be aware that the "evidence" and conclusions in the cited Downar et al paper have been strongly refuted by a peer-reviewed rebuttal in the same journal; and that concerns about the flawed scholarship and biased conclusions in the Downar et al article prompted an unprecedented signing on of over 170 scholars, clinicians and researchers as signatories to rebutting the Downar et al article that Prof. Downie/Dr. Gupta use to support their claims [link here: https://www.liebertpub.com/doi/10.1089/jpm.2023.0581].*

(v) From D-G document: "People will be able to refuse all psychiatric treatment and access MAiD. The federal government's Expert Panel on MAiD and Mental Illness, Health Canada's MAiD Practice Standards Task Group, and the CAMAP MAiD curriculum all state that in order to establish that a person has an incurable mental disorder a person will have had to have an extensive treatment history."

Rebuttal

*This is a misleading reassurance, unfortunately given by those who were themselves in positions to recommend and insist that Canada must introduce additional safeguards. As both Dr. Gupta and Prof. Downie must know, Canada's MAID legislation *does not* require a person to have had access to or tried treatment. Gupta's 2022 Expert Panel explicitly said "no further legislative safeguards are required". Suggestions and reassurances are not safeguards, and unlike other countries Canada's law does not have safeguards requiring that physicians must agree that standard treatments have been accessed and tried prior to MAID. Prof. Downie/Dr. Gupta's claim that a person "will have had to have an extensive treatment history" may be something they desire, but it simply does not exist as an actual requirement or safeguard. Whether approved MAID requests will have required access to care and robust treatment attempts will depend on individual idiosyncratic practice and ideologies of individual assessors. The emphasis in Health Canada's Model Practice Standard (developed by Prof. Downie/Dr. Gupta) on the fact that treatment refusal does not impede access to MAID, coupled further with the recommendation that anyone who objects to a specific application of MAID becomes a conscientious objector (and thus needs to provide an effective referral in several provinces), augment the concern that even in the absence of an extensive treatment history, MAID will be provided. Prof. Downie/Dr. Gupta's false reassurance is doubly concerning given that Dr. Gupta's own 2022 panel, from which two members resigned out of concern about the lack of sufficient safeguards, failed to recommend legislative safeguards requiring past treatments before being eligible for MAID.*

(vi) From D-G document: "Clinicians will not know if they should engage in suicide prevention efforts when a person with a mental disorder makes a request for MAiD. This statement is false."

Rebuttal

Prof. Downie/Dr. Gupta ignore evidence showing groups seeking MAID for mental illness in Europe overlap with those who are suicidal from mental illness symptoms and would benefit from suicide prevention, and Prof. Downie/Dr. Gupta further ignore that there is no evidence assessors can distinguish these groups. The simplistic argument that 'clinicians must and do already respond to expressions of suicidality' is meaningless, since this does not mean assessors can tell the above issues apart; it just means they have the hubris to think they can do something that evidence tells us they cannot.

(vii) From D-G document: "Canada has the most liberal MAiD regime in the world - This is false."

Rebuttal

Canada was the first jurisdiction not to require the patient to be in a state of treatment futility, or even to require the person has had access to or tried any treatments. The lack of these safeguards (which Gupta's own expert panel failed or refused to recommend) is more liberal than other jurisdictions, and it bears repeating that very few jurisdictions allow MAiD outside the end-of-life context, and even less for sole reasons of mental illness. Canada's law, regulations and policy also over-emphasize the need for access to MAID, and underplay the need for protection against premature death.

(viii) From D-G document: "Other countries have greater protections for people with mental disorders. This is false. No country in the world that allows assisted dying has a mental disorder exclusion clause. No country in the world that allows assisted dying has separate eligibility criteria or safeguards for people with mental disorders. In fact, Canada's mental illness exclusion clause has taken us on a path that is out of step with other countries."

Rebuttal

This is a deceptive argument. Many jurisdictions that allow some form of assisted dying other than the Benelux countries restrict MAID to end of life conditions, thus MAID for sole mental illness is not permitted in those jurisdictions. Prof. Downie/Dr. Gupta implying there is not greater protection in those jurisdictions since they do not have a specific exclusion clause for mental illness is deceptive, since those with sole mental illness do not qualify for MAID in those jurisdictions anyway, even in the absence of a specific exclusion. Indeed, Canada's own initial law in 2016 did not have separate safeguards for persons with mental disorders since our initial laws contained a safeguard requiring the person to have a reasonably foreseeable natural death (RFND), which for all intents and purposes meant sole mental illnesses would not qualify for MAID. Canada no longer has that initial RFND

safeguard, which is precisely why a safeguard excluding MAID for sole mental illness becomes relevant. In addition, other jurisdictions (including ones allowing MAID for mental illness), the law explicitly requires physicians to agree that no medical treatment options remain/there is treatment futility/or similar wording, unlike Canada that lacks such a safeguard.

(ix) From D-G document: "The majority of psychiatrists are against MAiD for persons with mental disorders - No evidence has been presented to support this statement. In fact, Canada's two largest psychiatric associations (the Canadian Psychiatric Association [CPA] of with [sic] approximately 2500 members and the Québec Psychiatric Association [AMPQ] with approximately 1200 members) have both take the position that people with mental disorders should have the same rights as people affected by other medical conditions. The Centre for Addiction and Mental Health, one of Canada's largest psychiatric institutions, has reversed its previous opposition to MAiD for persons with mental disorders in a public statement in March of 2023."

<u>Rebuttal</u>

This is a false claim by Prof. Downie/Dr. Gupta (in fact virtually every assertion made in this claim is demonstrably and explictly false). Evidence has been presented on multiple occasions demonstrating that most psychiatrists are opposed to the planned 2024 MAID for sole mental illness expansion. Additionally, Prof. Downie/Dr. Gupta remarkably claim the CPA and the AMPQ Quebec association are "Canada's two largest psychiatrist associations" with 2500 and 1200 members, respectively. In reality, the Ontario Medical Association (OMA) Section on Psychiatry has over 2000 psychiatrist members, much larger than the AMPQ and about the same number of psychiatrists as the CPA (some of the "2500" members Prof. Downie/Dr. Gupta cite are not psychiatrists but residents in training).

In 2021 the OMA Section on Psychiatry conducted a survey of its members after Bill C-7 and the sunset clause were implemented, to understand psychiatrists' views regarding pending expansion following the sunset clause (unlike the CPA, which has not surveyed its members post Bill C-7 and the sunset clause; and which previously had not consulted members for nearly 2 years on MAID prior to leadership issuing its ideological Position in March 2020).

In the OMA survey Psychiatrists in the OMA Section on Psychiatry, by a 2:1 margin, opposed MAID for sole mental illness (despite over 80% supporting MAID in some situations for other medical illnesses, which indicates they were not conscientious objectors, but they oppose expanding MAID for sole mental illness).

Manitoba recently surveyed its psychiatrist group and similarly found only 1/3 psychiatrists there supported MAID for mental illness.

Prof. Downie/Dr. Gupta's refusal to acknowledge or even admit any of this, which is evidence they must be aware of since it has been presented multiple times, is remarkable, as is their claim that somehow 1200 (the number of AMPQ psychiatrists) is larger than 2000 (the number of OMA Section on Psychiatry psychiatrists).

*Even most members of the Quebec AMPQ association cited by Prof. Downie/Dr. Gupta would likely *not* support expansion of MAID for sole mental illness as it is planned for March 2024. As referenced in the 2020 AMPQ Discussion Paper co-authored by Dr. Gupta, while the AMPQ member survey showed that "54% of the 263 respondents were open to MAID MD-SUMC at least in some circumstances while 36% were opposed in all situations", it also showed that respondents believed additional safeguards should be required including "there should be a minimal duration of active treatment (years) and a minimal duration of experience with the condition (years)". As already mentioned above, the 2022 Expert Panel chaired by Dr. Gupta recommended against any additional legislative safeguards, and did not recommend any minimum required length, number or types of treatment before providing MAID for mental illness; and there is no requirement in law that the person receiving MAID needs to have accessed or received treatments. Results from its own survey suggest that even most AMPQ members would likely not support the MAID expansion planned for 2024, which fails to include any safeguards to ensure people could only qualify for MAID for sole mental illness if they had suffered for years, and had had access to multiple treatments.*

*Regarding the CPA, CPA leadership adopted their current Position, that those with mental disorders should have the same options for MAID as available to all patients, in March 2020 without any membership consultation whatsoever in the preceding two years. The CPA repeatedly references member engagement involving surveys, presentations and a time-limited task force when questioned about their Position (current CPA Chair Alison Freeland attempted to cite this engagement as recently as her November 7, 2023 testimony). However all that member engagement took place from 2016 through 2018 (and the CPA member survey conducted during that time showed that, by a 2:1 margin, psychiatrists supported *excluding* mental illness as a sole indication for MAID). From fall 2018 through to March 2020 and the release of its Position on MAID and mental illness, CPA literally had zero consultations, surveys, or even any communication with members whatsoever regarding MAID and mental illness (despite the fact that the September 2019 Truchon ruling foreshadowed that the previous reasonably foreseeable death safeguard could be removed, having significant implications for potential MAID for mental illness applications). Any suggestion that the CPA Position was informed by membership consultations or views is simply disingenuous. CPA members learned of the CPA Position at the same time it was released publicly in March 2020, with zero member engagement in the preceding two years. Since release of its Position Statement in March 2020, even now over three years later, CPA leadership has not asked or surveyed its members whether or not they agree with the CPA's Position.*

*Finally, Prof. Downie/Dr. Gupta's assertion that CAMH "has reversed its previous opposition to MAiD for persons with mental disorders in a public statement in March of 2023" is equally troubling, inaccurate, and misleading. CAMH did issue a statement in March 2023, however that position *was not* a "reversal of CAMH's previous opposition" as Prof. Downie/Dr. Gupta boldly and falsely assert. CAMH affirmed it has not changed its public position on MAID for mental illness; and that the March 2023 revision was developed in response to the fact that MAID for mental illness was scheduled to be implemented in March 2024 by virtue of the sunset clause, and the CAMH March 2023 statement was issued to provide guidance*

*as MAID for sole mental illness was going to soon be provided according to legislation (but was not an "endorsement" of expansion). It *was not* a "reversal of its previously expressed opposition" as Prof. Downie/Dr. Gupta falsely characterize it.*

(x) From D-G document: "Allowing MAiD MD-SUMC is a further expansion of eligibility for MAiD. This is false."

Rebuttal

As articulated in the Society of Canadian Psychiatry brief:

> *"While Canada's initial MAID laws and Bill C-14 did not specifically identify mental illnesses as an exclusion, they contained an initial safeguard that for all intents and purposes had the effect of precluding sole mental illnesses from eligibility for MAID. Mental illnesses in and of themselves rarely, if ever, lead to foreseeable natural death, thus they would not meet Bill C-14's "reasonably foreseeable natural death" (RFND) requirement. Furthermore, Bill C-14 does explicitly mention initiating a future review to study issues related to situations when mental illness was the sole underlying medical condition (which was subsequently undertaken by the Council of Canadian Academies), along with review of issues related to mature minors and advance requests, and clearly none of these three situations (sole mental illness, mature minors, and advance requests) were envisioned as situations that would qualify for MAID under Bill C-14.*
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> *Bill C-7's specific exclusion of sole mental illness as an eligibility criterion for MAID was a response to the removal of the RFND safeguard following the Truchon ruling. Enacting the sunset clause to allow MAID for sole mental illnesses in 2024 clearly would represent an expansion of Canada's MAID laws."*

Any claim, as repeatedly made by Prof. Downie, that somehow the introduction of MAiD MD-SUMC 'restores' the law and the eligibility for MAID to how it was as a result of Carter ignores the division of powers between the legislature and the courts and is a remarkable distortion of how law making operates.

(xi) From D-G document: "An exclusion clause for MAiD MD-SUMC is constitutional - This is false."

Rebuttal

It reveals a lack of humility for a legal scholar and a psychiatrist to claim that a reasonable interpretation of law (including the Charter and case law) endorsed by many legal scholars and legal practitioners is 'false'. The constitutionality, or lack of constitutionality, of an exclusion clause for MAID for sole mental illness has not been tested in the courts. Many legal scholars (over 3 dozen, including leading constitutional, equality law, (mental) health law, and disability law scholars) have argued there is no clear legal requirement for

government to expand MAID to mental illness (https://www.law.utoronto.ca/blog/faculty/letter-federal-cabinet-about-governments-legal-claims-related-maid-mental-illness). The letter states: "it is premature to argue that the Charter requires access to MAiD for persons whose sole underlying medical condition is mental illness. It is in our view also reckless to suggest that a constitutional right to MAiD should and would be recognized by our Supreme Court when there has been no meaningful review of the evidence suggesting that psychiatrists can predict for whom mental illness will be irremediable, the impact on suicide prevention, the impact on the health care and lived experience of persons experiencing mental illness, and the challenge of balancing access to MAiD with the protection of the life of those who are otherwise not approaching their natural death. In fact, there is for that reason on the contrary a strong argument to be made that the Charter requires adequate and equal protection against premature death of all persons with disabilities."

Prof. Downie/Dr. Gupta's assertions that they know that an exclusion clause for sole mental illness is "not constitutional" simply represents their opinion, aligned with a seemingly strongly entrenched commitment to expand MAiD in Canada. Downie has made such misleading assertions repeatedly, claiming the matter of MAID for mental illness has already been decided by the courts before. In November 2020 parliamentary testimony she publicly asserted that Carter and Truchon rulings required that MAID be provided for sole mental illness (despite neither case involving mental illness and Carter explicitly excluding persons with 'psychiatric illness' from the 'parameters [of its] reasons'), with Prof. Downie asserting in public testimony that: "the Minister of Justice has repeatedly said the government needs more time — I assume with respect to the question of how to implement MAID MD-SUMC rather than whether, as the whether question has already been answered by the courts in Carter and Truchon."

(xii) From D-G document: "The Canadian MAiD system is not ready for safe implementation of MAiD MD-SUMC. This is false."

Rebuttal

This is again an example of lack of humility, or hubris, to simply claim that the informed opinion of many leading mental health care professionals, deeply knowledgeable of the system, are 'false'. It is turning an evaluative claim, based on detailed knowledge of mental health care practice and the existing system in place, into a falsifiable fact.

The Canadian MAID system is not ready for safe implementation of MAID for sole mental illness, a fact that strikingly even CPA Chair Alison Freeland acknowledged in November 7 testimony. Under direct questioning Dr. Freeland acknowledged "I don't think I can say from a CPA perspective that all the readiness is there", despite CPA itself maintaining an ideological stance similar to Prof. Downie/Dr. Gupta that MAID for mental illness should be provided as of March 2024. It is disconcerting that medical experts who acknowledge the lack of readiness of the system fall back on an imagined constitutional obligation to be ready. The lack of being "ready for safe implementation" reflects the ongoing absence of evidence

that MAID for sole mental illness can be safely implemented.

Those charged with establishing safeguards have repeatedly denied this lack of evidence, and actively ignored existing evidence, and instead provided false and dangerous reassurances of safeguards that do not exist. The continued false reassurances, which ignore known evidence, may reflect an overly strong commitment to the implementation of MAiD for mental illness by some who have been deeply involved in advisory committees and structures. Prof. Downie/Dr. Gupta felt that MAID for sole mental illness was ready to implement last year, in March 2023, so their continued claim it is ready to implement in 2024 is nothing new. While Dr. Gupta claimed in her November 7, 2023 testimony that those who caution about expansion of MAID for mental illness have "contributed nothing", Gupta herself continues to provide dangerous assurances of safety that does not exist, while ignoring or actively denying key evidence, and refusing to recommend actual safeguards despite having been in positions to do so.

We are concerned Prof. Downie/Dr. Gupta's contributions reflect tunnel vision that refuses to see or acknowledge the actual state of "unreadiness" we are in for providing MAID for mental illness in just a few months.

The Expert Advisory Group (EAG) on MAiD issued its first report in February 2020 and reconvened following release of the federal Panel on MAID and Mental Illness report in May 2022. The EAG consists of diverse experts, psychiatrists and clinicians, including those involved in MAiD teams, psychologists, legal experts, medical ethicists and researchers, Indigenous leaders, those with lived experience and other cross sectionalities.