

The Royal Society of Canada Expert Panel: End-of-Life Decision Making

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REPORT IN BRIEF— REPORT BY THE ROYAL SOCIETY OF CANADA EXPERT PANEL ON END-OF-LIFE DECISION MAKING

INTRODUCTION

Context

The last comprehensive federal public policy report on assisted death in Canada was published 15 years ago.ⁱ Since then much has taken place in this area. Advance directives legislation has been introduced and reformed in a number of provinces and territories.ⁱⁱ A substantial number of court cases have involved various aspects of assisted death. A number of these high-profile cases have captured public attention and been reported extensively in the national press; the names of Nancy Morrison, Samuel Golubchuk, Robert Latimer and Evelyn Martens are but a few examples known to many Canadians because of their connections to these widely-reported, high-profile end-of-life cases.ⁱⁱⁱ Beyond our borders, assisted suicide or voluntary euthanasia is now legal in at least seven jurisdictions. They are the Netherlands, Belgium, Luxemburg, Switzerland, Oregon, Washington State, and Montana.^{iv} In addition, prosecution policy in England and Wales has been clarified to make it clear that not all instances of assisted suicide will result in prosecution.^v

Despite all of this activity, three very important features of the landscape have not changed. First, public support for the decriminalization of assisted suicide and voluntary euthanasia remains high (a substantial majority of Canadians support the decriminalization of assisted dying). Second, the issue of decriminalization remains very contentious and polarized. Third, regardless of this support and no doubt in part because of this contentiousness, assisted suicide and euthanasia remain prohibited activities under the *Criminal Code of Canada*.^{vi}

It is, therefore, an apt time to revisit the public policy questions surrounding assisted death in light of new evidence and arguments. In 1995, a majority of the Special Senate Committee on Euthanasia and Assisted Suicide recommended continuing to treat euthanasia as murder (albeit with a lesser penalty) and keeping the assisted suicide

provision in the *Criminal Code*.^{vii} Will a careful consideration of these issues come to the same conclusions in 2010?

In order to address this question, and to both catalyze and contribute to a process of public reflection on these critically important public policy issues, the Royal Society of Canada established this Expert Panel on *End-of-Life Decision Making* with these objectives:

1. There is a large body of medical science evidence that, if summarized for the public, would be helpful to their consideration of the issue.
2. The public could also benefit from a presentation of evidence about actual experience from the various jurisdictions that permit physician-assisted death.
3. The public would also benefit greatly from having a careful, balanced review of various pros and cons of decriminalization of physician-assisted death from well-reasoned ethical and legal standpoints.
4. Many medical personnel would also benefit from having all the issues laid out in a comprehensive and sensitive way.
5. The panel should consider proposing policy recommendations for public consideration that are the results of its review.

The members of the panel are experts in the following areas relevant to the issues the panel was tasked to address: bioethics, clinical medicine, health law and policy, and philosophy.

The members of the panel met in person and conducted business via e-mail and phone. Panel members brought their own expertise and experience to the project and additional research was conducted as required. Drafts were circulated and edited through a collaborative and iterative process.

This document presents an overview of the unanimous final report of the End-of-Life Panel. It provides a summary of the contents of each chapter as well as the conclusions

drawn and recommendations made by the panel. The reader is directed to the [full report](#) for the full evidence and arguments upon which the recommendations are based.

The panel trusts the final report will serve as a marker for the beginning of a new conversation about end-of-life law, policy, and practice in Canada. The panel notes that the conversation will require mutual attention and respect and acknowledges the many important interests at stake and values in play. Passions run deep in discussions about end-of-life matters. However, even in the face of profound disagreements (about, for example, the values of autonomy and life), it is possible—and indeed necessary—for those involved in the conversation to listen carefully to all positions presented and to work together to find a policy position consistent with the core features of Canada’s parliamentary democracy and our *Charter of Rights and Freedoms*.^{viii} The panel hopes that, through this conversation, all stakeholders will find common ground to better respond to the wishes and needs of Canadians at the end of their lives.

Terminology

It is particularly important to define the terms employed in discussions about assisted death. Frequently people discuss these issues at cross-purposes, using the same term to describe different practices or using different terms to describe the same practice. This can lead to unnecessary and unproductive confusion and conflict. As there are, by necessity, no objectively true definitions of the terms needed to discuss assisted death, the panel stipulates the following definitions for the purposes of its report:

- “*Withholding of potentially life-sustaining treatment*” is the failure to start treatment that has the potential to sustain a person's life. An example is not providing cardiopulmonary resuscitation to a person having a cardiac arrest.
- “*Withdrawal of potentially life-sustaining treatment*” is stopping treatment that has the potential to sustain a person's life. An example is the removal of a ventilator from a patient with a devastatingly severe head injury after a motorcycle accident with no prospect of improvement.

- “*Advance directives*” are directions given by a competent individual concerning what and/or how and/or by whom decisions should be made in the event that, at some time in the future, the individual becomes incompetent to make health care decisions. An example is a woman who has signed a document that states that, should she fall into a persistent vegetative state, she does not wish to receive artificial hydration or nutrition. Or, as another example, a man who has signed a document that states that, when he is incompetent, he wishes his wife to make all health care decisions on his behalf. There are two kinds of advance directives: *instruction directives*, which establish what and/or how health care decisions are to be made; and *proxy directives*, which establish who is to make health care decisions.
- “*Potentially life-shortening symptom relief*” is suffering control medication given in amounts that may—but are not certain to—shorten a person’s life. An example is giving ever-increasing levels of morphine necessary to control an individual’s suffering from terminal cancer when the morphine is known to potentially depress respiration even to the point of causing death (but it is not known precisely how much is too much as the levels are slowly increased).
- “*Palliative sedation*” is an umbrella term used to explain intermittent and continuous as well as superficial and deep sedation. The most contested subtype of *palliative sedation* is known as “*terminal sedation*.”
- “*Terminal sedation*” is potentially life-shortening deep and continuous sedation intentionally combined with the cessation of nutrition and hydration.
- “*Assisted suicide*” is the act of intentionally killing oneself with the assistance of another. An example is a woman with advanced ALS who gets a prescription from her physician for barbiturates and uses the drugs to kill herself.

- “*Voluntary Euthanasia*” is an act undertaken by one person to kill another person whose life is no longer worth living to them in accordance with the wishes of that person. An example is a man bedridden with many of the consequences of a massive stroke whose physician, at his request, gives him a lethal injection of barbiturates and muscle relaxants.
- “*Unilateral*” means without the knowledge of or—less commonly—against the wishes of the patient or patient's substitute decision maker. An example is a physician who writes a Do Not Resuscitate order on a patient’s chart without consulting the patient or the patient’s substitute decision maker.
- “*Competent*” means capable of understanding and appreciating the relevant information and the nature and consequences of the decision to be made. It is important to note that competence is decision-, time-, and place-specific and that individuals may be competent for one decision (such as what to eat and drink) and not another (such as whether to refuse surgery) and may be competent one day and not the next.
- “*Voluntary*” means in accordance with the wishes expressed by a competent person or through a valid advance directive.
- “*Non-voluntary*” means without the knowledge of the wishes expressed by a competent person or through a valid advance directive.
- “*Involuntary*” means against the wishes expressed by a competent person or through a valid advance directive.
- “*Assisted dying*” is an umbrella term used to describe the full spectrum of conduct defined above that contributes to the death of an individual.

CHAPTER ONE — END-OF-LIFE CARE IN CANADA

The spectrum of issues associated with end of life—such as advance-care planning, assisted suicide and euthanasia—are matters of great public interest and concern. Determining the relative merits of various policy and legislative options depends as much upon a detailed understanding of current social attitudes and contemporary realities of death and dying in Canada as it depends upon legal and philosophical analysis. For an informed discussion of assisted suicide and euthanasia as last-resort interventions, it is important to understand current epidemiological, clinical and policy forces that can influence the need or desire to access these modalities at the end of life.

End of life can be understood as a continuum of events starting with the diagnosis of one or more serious illnesses or injury. Each of these conditions has a trajectory, some more predictable than others. The range of illnesses relevant to end-of-life decision making is broad; this range encompasses the leading causes of death in the population such as cardiovascular disease, pulmonary disease and cancer. There are many transitions in health status on the path from diagnosis to treatment and, finally, death. Understanding how this process works and how well it is managed in Canada will help to set the context for the consideration of the legal and ethical issues that attend decisions at the end of life. Facts inform the law and ethics, but they do not determine them.

There is good reason to be concerned with the state of end-of-life care in Canada. Canada ranked in the top 10 in a recent report from the Economist Intelligence Unit comparing the quality of death in 40 countries. Canada scored well for quality of end-of-life care and access to opiates for pain control. However, it was in the middle of the pack in terms of public awareness of end-of-life care and scored poorly in terms of costs. The report states that the “medicalization of death in Canada has engendered a culture where many people are afraid to raise the topic of death.”^{ix}

This chapter comprises several sections, including an examination of how and where Canadians are dying, as well as the changing demographic landscape (specifically an

aging and increasingly diverse population and exponential growth in chronic diseases relevant to end-of-life discussions). This chapter includes a survey of research and policy literature to identify important considerations in the provision of quality end-of-life care. Several elements of quality end-of-life care are important here, including both access to palliative care services to mitigate/manage symptoms and provide comfort to the dying, and the use of advance directives to ensure that treatment wishes at the end of life are respected when an individual is no longer competent to make decisions, or is incapable of expressing wishes. In this chapter, Canadian attitudes towards assisted suicide and euthanasia are examined and compared with other nations.

The research in this section is drawn from the academic literature and relevant non-academic sources such as government reports. Preference is given to Canadian reports, data sources and published studies. Systematic reviews of both relevant literature and recently published international studies are also included.

In this review of the literature, the panel identifies the following key features:

1. The vast majority of Canadians die in institutions in their old age.
2. The Canadian population is rapidly changing—it is becoming increasingly aged, but also more diverse.
3. Literature suggests that the attitudes and perspectives of the very old toward assisted suicide and euthanasia have not been ascertained, nor is the literature well-attuned to First Nations and the ethnically and culturally diverse populations now found in Canada. Hearing these voices is integral to an informed debate on end-of-life care.
4. Advance-care planning still remains a topic not sufficiently discussed by individuals, their families and their health care providers, with the vast majority of Canadians having neither proxy nor instruction directives. The absence of explicit dialogue between patients and health care providers is of concern to the panel.
5. The use of sedation as a modality of care at the end of life appears to be increasing without concurrent increasing clarity on the appropriateness of various

kinds of sedation in various circumstances. There is a pressing need for a set of national consensus guidelines.

6. A significant majority of the Canadian population appears to support a more permissive legislative framework for voluntary euthanasia and assisted suicide.

One final note must be made with respect to this literature review. The literature seems to cluster in the mid-1990s to early 2000s, around the time of the last Senate Subcommittee on Euthanasia and End of Life. The panel sees the need for much of this research to be updated with a greater focus on public engagement strategies that would provide the opportunity for deeper deliberations and more nuanced discussion than can be found in many of the studies conducted to date.

CHAPTER TWO—THE LEGAL LANDSCAPE

This chapter provides an overview of end-of-life law in Canada. As with the previous chapter and, given the interplay between the categories of assisted dying, the panel recognizes the need to review the full spectrum of end-of-life care. In this chapter, the panel describes the legal status of the withholding and withdrawal of potentially life-sustaining treatment, advance directives, the provision of potentially life-shortening symptom relief, terminal sedation, assisted suicide and voluntary euthanasia. The focus here is not on whether the law is defensible (that comes later), but rather on what the law is with all its inherent clarity, confusion, and controversy.

It is concluded that the legal status of some forms of conduct is clear, such as withholding and withdrawal of potentially life-sustaining treatment at the request of competent adults, assisted suicide, and voluntary euthanasia. Some are unclear, such as unilateral withholding and withdrawal, and terminal sedation. Some are very hotly contested, such as unilateral withholding and withdrawal, assisted suicide, and voluntary euthanasia. The panel then turns to a consideration of the ethics of the controversial forms of conduct. In the next chapter, the panel shifts the report's attention from exploring what the legal status is to an ethical analysis of what kind of normative grounding public policy should have and where that grounding takes us with respect to what the law should be.

CHAPTER THREE—THE ETHICS OF END-OF-LIFE CARE

Canada is a pluralist liberal democracy. Its vigorous defence of its citizens' basic freedoms, including freedoms of conscience, association and expression give rise to a situation in which Canadians predictably reach a wide range of conclusions about ethical issues. As far as the *source* of ethics is concerned, some Canadians believe that ethics should be grounded in the will of God, while others believe that it should have more secular bases. Canadian citizens reflecting on important ethical issues in a context of freedom of thought and expression also reach quite diverse conclusions as to the *contents* of ethics, of the values that ought to have pride of place. Some believe that it should be about the protection of individual autonomy. Others think that it should ultimately aim to maximize happiness and well-being.

The panel holds that in the context of such reasonable pluralism, the kind of ethical reflection that it engages in ought to be guided by values over which there is some significant degree of consensus within Canadian society.^x It ought to avoid taking sides on the kinds of deep disagreements that divide Canadians as far as the source and contents of ethics is concerned. In order to promote democratic discussion among Canadians, the panel sought to identify values over which Canadians broadly agree, and to trace what the implications of those values are for the issues related to end-of-life care.

How do we identify the ethical consensuses that exist in a democratic society like Canada in the context of deep and durable disagreement as to the ultimate grounds and ends of ethics? The panel holds that this should be done by looking to the ethical cornerstones of Canada's institutional order as a liberal democracy. A particularly rich fount of such values is our *Charter of Rights and Freedoms*, as well as the almost thirty years of legal and ethical reasoning that it has given rise to.

Of course, ethical reflection must also be informed by publically ascertainable facts (for instance, by epidemiological data such as is canvassed in Chapter One, and data from countries which have begun to deal with the issues identified above such as are provided

in Chapter Four). Canadians will only arrive at sensible policies and laws when ethicists and philosophers collaborate with empirical researchers, and make careful and responsible use of the data that they produce in order to enrich and to structure public debate. The facts matter; the uses made of them must not be clouded by prior ideological commitments.

To solve the problems identified in earlier chapters, our society's commitments to a range of central values must where possible be connected with the specific issues that arise in the context of end-of-life decision making. This requires careful philosophical reasoning whereby the panel tries to tease out, through argument, what the implications of our general ethical commitments are in specific issue areas. These philosophical arguments will, if successful, achieve a certain level of coherence both between general ethical commitments—as expressed, for example, in the language of the *Charter of Rights and Freedoms*—and laws and policies across different policy areas such as that of end-of-life care.

For some issues, these values, combined with the facts, lead us to justifiable conclusions about what the law should be. The panel holds that there is both sufficient consensus with respect to core values in the Canadian policy context and a sufficient grasp of the relevant facts that justifiable conclusions can be drawn about what the legal status of assisted suicide and voluntary euthanasia should be. Detailed arguments in support of these conclusions are therefore presented in this chapter.

For some issues, however, consensus on how to resolve competing ethical commitments or disagreements as to the relevant available facts is not yet available. Indeed, the values that in the panel's view constitute the unquestioned core of Canadian public political culture do not speak to all moral issues, and in particular they do not speak clearly to the debate surrounding assisted death in non-voluntary contexts, that is in cases of individuals who are no longer, or who have never been, able competently to formulate wishes relating to end-of-life care. The panel fully acknowledges that the consensus that we identify in Canada's political culture as a liberal democracy, and more specifically in

its foundational texts and judicial decisions, occurs against the backdrop of a pluralism of reasonable comprehensive conceptions of the good, some religiously grounded, others secular in nature. The panel also recognizes that the considerations contained in this report are not exhaustive of the philosophical landscape. Clearly some of these moral frameworks are comprehensive enough to apply to non-voluntary contexts. They are however insufficiently widely shared to constitute the basis for the kind of argument the panel wishes to develop in the report, which attempts to ground substantive positions on the issue of assisted death in broad normative consensus.

For these reasons, the panel does not, for example, address conclusions that might be derived from the tradition of consequentialist philosophical theorizing that gives pride of place to the notion of well-being. Very generally speaking, such theories are united by a commitment to the idea that actions and policies are justified in as much as they promote aggregate well-being. Now, as has recently been argued very eloquently by the Canadian consequentialist philosopher Wayne Sumner, autonomy-based and well-being-based arguments tend to converge in the case of competent individuals, because they are best situated to know what their level of well-being is, and how it should be promoted.^{xi} But one of the implications of well-being-based theories is also that they allow the theorists who hold them to extend arguments about assisted death into non-voluntary contexts, that is, into contexts in which individuals are no longer, or have never been, capable of competently formulating their wills.

While the panel fully recognizes the importance of the contribution made by well-being-based arguments to the philosophical literature on assisted death, it holds the view that such arguments are not sufficiently well grounded in Canadian public culture to allow grounding this analysis in such considerations. Conceptions of well-being are at present too diverse to ground a publically justifiable practice of assisted death in non-voluntary contexts on the basis of third-party assessments of the quality of life of a non-competent individual. Nor does the panel find guidance as to consensuses surrounding the concept of well-being that might exist in Canadian public political culture that might allow the panel to make the kind of argument in non-voluntary contexts that it feels able to make in

voluntary ones. To repeat, the intention of the panel is to articulate the implications of public values that are deeply ingrained in the Canadian public political culture and institutions.

Rigorous ethical reflection is required in order to achieve coherence between various ethical commitments. Democratic deliberation is required where a society's ethical commitments are unclear.^{xiii} Decision making about euthanasia will not always be able to ground itself in the value of individual autonomy, as there will be occasions when decisions will have to be made, for example, for patients in advanced stages of dementia and for patients who are in persistent vegetative states neither of whom have valid and relevant advance directives. It is clear that these decisions cannot always be made by referring to the patient's clearly expressed wishes (whether contemporaneous or prior). It is therefore not yet clear enough what values should guide decision making about non-voluntary euthanasia in this category of cases which, as the epidemiological data presented in Chapter Two made plain, will be increasingly frequently encountered in the years to come.

Canadians have experimented successfully with democratic deliberative mechanisms on a range of issues such as electoral reform^{xiii} and many others.^{xiv} This experience can be usefully drawn upon to organize deliberation on these issues in years to come. The panel's opinion is that an expert panel, such as this one, should not dictate the general compass Canadian society ought to use in addressing contested issues of value. The panel therefore does not deal with non-voluntary euthanasia as it is an issue that cannot yet be resolved through reference to the kind of consensus that exists to address voluntary contexts and to facts that provide a sufficient base for justifiable conclusions.

This chapter of the report examines the implications of what the panel takes to be core normative commitments of Canadians as evinced by their constitutional framework with regards to the issue of assisted death. The structure of the chapter is as follows. First, the chapter identifies the core values that are sufficiently well grounded in Canadian political and legal culture to form the basis of an argument concerning assisted death in the case of

competent agents. The panel holds that respect for individual autonomy and self-determination represents such a core value. The panel also recognizes the importance that the protection of vulnerable citizens and the promotion of "human dignity" have in our constitutional tradition, and in particular in Supreme Court decisions surrounding end-of-life care. This chapter therefore attempts to critically interrogate and to articulate these core values so as to give rise to a set of recommendations that best coheres with these core moral commitments. Second, the panel connects the conception of autonomy at work in the context of debates over assisted death with a conception that is already well entrenched in the theory and the practice of voluntary and informed consent. Third, an important distinction between moral and legal rights is introduced, according to which the determination of whether or not there exists a moral right to assisted death only establishes a presumptive, or *prima facie* case for the desirability of establishing a legal right. Fourth, the chapter sets out the basic argument in favour of decriminalizing assisted death in the case of competent agents on the basis of the value ascribed by Canadian political and constitutional culture to the value of autonomy. Finally, the panel considers the main arguments against decriminalization. Some of these arguments, considered *a priori*, in that they contest that there is a *prima facie*, moral right to assisted death. In particular, some arguments grounded in the value of human dignity take this form. As human dignity has been invoked often by the Supreme Court of Canada, the panel devotes particular attention to this concept. Other arguments against the decriminalization of the right to assisted death are *a posteriori*, in that they concede the existence of a *prima facie* moral right, but hold that other considerations weigh heavily against the recognition of a corresponding legal right.

One of the most important of this latter type of argument is grounded in the concern that the decriminalization of assisted death in the case of competent agents might set us down a slippery slope that will unavoidably place vulnerable persons at risk. Given the importance that the concern with the protection of the vulnerable rightly possesses in Canadian constitutional culture in general, and in the *Rodriguez* decision of the Supreme Court of Canada, that still forms the backdrop to much discussion of the right to assisted death in Canada, particular attention is devoted to such arguments.

The panel concludes:

1. That there is a moral right, grounded in autonomy, for competent and informed individuals who have decided after careful consideration of the relevant facts, that their continuing life is not worth living, to non-interference with requests for assistance with suicide or voluntary euthanasia.
2. That none of the grounds for denying individuals the enjoyment of their moral rights applies in the case of assisted suicide and voluntary euthanasia. There are no third-party interests, self-regarding duties, or duties toward objective goods that warrant denying people the right to assisted suicide and voluntary euthanasia. Prophesied undesirable social consequences are not sufficient to negate the right to choose assisted suicide and voluntary euthanasia. Rather, they should be taken into account in constructing the regulatory environment within which this right can be exercised.
3. That health care professionals are not duty-bound to accede to the request of competent and informed individuals who have formulated the uncoerced wish to die, but they may do so. If their religious or moral conscience prevents them from doing so, they are duty bound to refer their patients to a health care professional who will.

CHAPTER FOUR—INTERNATIONAL EXPERIENCE WITH LAWS ON ASSISTED DYING

Having reached the conclusion that there are persuasive arguments in support of the development of a legally permissive regime with respect to assisted dying in Canada, the panel turned its attention outward. Since Canada would not be the first country to embark on a path to a permissive regime, it is useful to examine and learn from the experiences of other nations. While the majority of countries throughout the world continue to regard assisted suicide and voluntary euthanasia as criminal offences, a small, but significant, number of jurisdictions now accommodate assisted suicide and/or voluntary euthanasia in

certain circumstances. In this chapter, the panel analyzes the experience of other countries in two ways.

First, the ways in which different countries have approached the issue of assisted dying are described. Second, the panel turns to the practical experience in these countries or states—in so far as there are available data—to see what happens in practice when assisted dying is, in some circumstances, allowed.

In this chapter of the report, the panel sought to describe the law in a number of jurisdictions where the approach to assisted dying (in one form or another) is somewhat permissive. It is evident from this survey that the societies which have acted on this issue are by no means homogeneous, yet they appear to share similar approaches to assisted dying. Whether or not it is voluntary euthanasia or assisted suicide that is involved (or indeed both), each jurisdiction (arguably with the exception of Montana, where the legal *status quo* came about in a very different way, and Switzerland where the provisions are primarily based only on intent) has premised permissibility (or lower likelihood of prosecution) on a number of conditions:

1. the request must be voluntary;
2. the request must be repeated (i.e., consistent over time);
3. the request must be certified by a physician;
4. the request must be wholly or at least in part carried out by a physician;
5. the person making the request must be legally competent.

Different, although similar, provisions exist regarding the reporting of assisted deaths and safeguards are built in to try to ensure that the above requirements are verified.

Despite the fears of opponents, it is also clear that the much-feared slippery slope has not emerged following decriminalization, at least not in those jurisdictions for which evidence is available. Nor is there evidence to support the claim that permitting doctors to participate in bringing about the death of a patient has harmed the doctor/patient

relationship. Nor is there evidence to support the claim that the decriminalization of voluntary euthanasia or assisted suicide has had a corrosive effect on palliative care. What has emerged is evidence that the law is capable of managing the decriminalization of assisted dying and that state policies on this issue can reassure citizens of their safety and well-being.

CHAPTER FIVE—PROPOSALS FOR REFORM

The previous chapters set the stage for this final chapter. There is a need and there are persuasive ethical arguments for reforms across the spectrum of end-of-life law and policy discussed to this point in the report. The panel offers recommendations with respect to the withholding and withdrawal of potentially life-sustaining treatment; potentially life-shortening symptom relief; terminal sedation; assisted suicide; and voluntary euthanasia. The panel also endorsed the recommendations contained within Senator Carstairs' Report Raising the Bar: A Roadmap for the Future of Palliative Care in Canada and offered two additional recommendations with respect to palliative care as this is a critical component in any system designed to provide end-of-life care.

- All relevant levels of government and health care institutions should educate the public on how to complete advance directives and the benefits of doing so, and health care providers on advance care planning and how to communicate about end-of-life care.
- All relevant levels of government should cover discussions about end-of-life planning under health insurance plans, and health care institutions should have staff skilled in those conversations available to patients.
- All relevant levels of government and health care institutions should improve administrative processes so advance directives and advance care plans are readily available to the patient's caregivers, regardless of where they are getting care.
- All relevant levels of government should fund and researchers conduct more research into how to facilitate the completions of valid and useful advance directives and to engage in advance care planning.

- All relevant levels of government, health care institutions and providers should work together to ensure resources that could better be used for palliative care are not diverted to unwanted acute care.
- Palliative care specialists should continue to expand their scope beyond cancer and specialists in other areas should continue to expand their understanding and use of palliative care.
- The federal government should revise the *Criminal Code* to make it clear that withholding or withdrawing potentially life-sustaining treatment after a legally valid refusal of such treatment does not constitute criminal negligence and will not attract criminal liability.
- Provincial and territorial governments should ensure that their consent legislation and health care professional regulators should ensure that their policies make it clear when, if ever, health care professionals have the legal authority to unilaterally withhold or withdraw potentially life-sustaining treatment.
- Health care educational institutions and regulators should ensure trainees and members understand their legal obligation to respect refusals of potentially life-sustaining treatment.
- Health care educational institutions and regulators should ensure their trainees and members understand their legal obligations in unilaterally withholding or withdrawing potentially life-sustaining treatment.
- The federal, provincial and territorial governments should educate the public on the right to refuse care and the legal status of the withholding and withdrawing potentially life-sustaining treatment (unilaterally or otherwise), so they can better advocate for themselves and their loved ones and communicate better with health care providers.
- Health care providers, regulators, and prosecutors should develop clinical practice and prosecutorial charging guidelines on potentially life-shortening symptom relief and terminal sedation.
- Health care providers, institutions, regulators, and prosecutorial services should educate both providers and the public so they understand health care professionals

must provide terminal sedation and symptom relief according to guidelines and they are protected from liability if they do.

- The federal government should modify the prohibitions on assisted suicide and voluntary euthanasia in the *Criminal Code* so that, in carefully circumscribed and monitored circumstances, they are legally permissible.
- Both assisted suicide and voluntary euthanasia should be available.
- A request for voluntary euthanasia or assisted suicide should only be respected when made by a competent person and where the request is voluntary and informed. Great care must be taken to ensure that these conditions are met. If a physician is uncertain about the competence of the person making a request, he or she must take all necessary steps (such as consulting with colleagues with greater experience or expertise) to resolve the uncertainty.
- Any age restrictions for access to assisted suicide or voluntary euthanasia should flow from the mature minor law in the particular jurisdiction.
- A diagnosis of “terminal illness” should not be required for access to voluntary euthanasia or assisted suicide.
- Written or otherwise recorded requests are preferable (they may be more reliable as evidence that a request was made and what it was for). Verbal requests are sufficient, if properly documented.
- Health care providers should be permitted to provide voluntary euthanasia and assisted suicide. They should not be obligated to provide assistance but, should they decide not to, they should be obligated to refer the person requesting assistance to a professional who will provide assistance. An open question is whether only health care professionals should be permitted to provide assistance. Research should be done to determine the mechanism best able to protect the patients while minimizing the limits on the autonomy of health care professionals and maximizing respect for the autonomy of those seeking assistance. Permission to provide assistance should only be granted to those who have the knowledge and skills necessary to ensure that the conditions for access have been met and with whom the oversight system can meaningfully function. The more restrictive the list of those who are permitted to provide assistance, the less that group should be

- permitted to refuse to provide assistance.
- The time required to elapse between initial request and granting of assistance should be that required to ensure that the person's request is voluntary and informed and that the individual is competent (or was competent at the time of making an advance directive) plus a short (e.g., 24 hours) to allow confidence that all conditions and procedural requirements have been met.
 - The federal government, in collaboration with the provincial and territorial governments, should establish a national oversight commission to monitor and report annually and publicly on voluntary euthanasia and assisted suicide in Canada. Requirements for assessments, declarations of request, statements of reasons for requests, and document filing should be set out in statute and be designed to minimize intrusion on the person seeking assistance, but also be sufficient to make possible effective oversight so as to ensure that only requests for assistance that fit within the autonomy-based analysis are respected and the public trust is maintained.
 - Unless or until voluntary euthanasia and assisted suicide are decriminalized, those with authority over prosecutorial policies in all provinces and territories should introduce such policies to provide guidance with respect to the exercise of prosecutorial discretion and to make clear the circumstances within which a prosecution in cases of assisted suicide or voluntary euthanasia would not be in order (that is, where there has been a free and informed decision to request assistance made by a competent individual).
 - Unless or until voluntary euthanasia and assisted suicide are decriminalized or prosecutorial charging guidelines are implemented as recommended, provinces and territories should consider implementing a restorative justice program for assisted suicide and voluntary euthanasia.

CONCLUSION

A review of the national press over the past eighteen months reveals how topical the issue of assisted death is in Canadian culture. On April 21, 2010, the latest in a long string of private members' bills to decriminalize assisted suicide and euthanasia was defeated in the House of Commons,^{xv} despite a 2010 poll indicating that a majority of Canadians support the legalization of euthanasia.^{xvi} On June 8, 2010, a major report was issued by Senator Sharon Carstairs revealing ongoing problems with access to quality palliative care for Canadians.^{xvii} In the same week as this Report is being released, a court in British Columbia is beginning to hear a challenge to the *Criminal Code* prohibitions against assisted suicide and voluntary euthanasia. A non-partisan Committee of the Quebec National Assembly has been studying the issues; following a lengthy public consultation process is due to release its report early in 2012. These are strong indications that Canadians are, and should be, engaged in a process of deliberation over the legal status of assisted death in Canada. The panel offers its report as its contribution to this important public policy debate.

ⁱ Canada, Special Senate Committee on Euthanasia and Assisted Suicide, *Of Life and Death -- Final Report* (Ottawa: Special Senate Committee on Euthanasia and Assisted Suicide, 1995), online: Senate of Canada <<http://www.parl.gc.ca/Content/SEN/Committee/351/euth/rep/lad-e.htm>>. [Accessed 2 August 2011].

ⁱⁱ An example of a new law is the Prince Edward Island *Consent to Treatment and Health Care Directives Act*, R.S. P.E.I. 1998, c. C-17.2 (proclaimed 2000) and an example of recent law reform with respect to advance directives is the Nova Scotia *Personal Directives Act*, S.N.S. 2008, c.8 and *Personal Directives Regulations*, N.S. Reg.31/2010.

ⁱⁱⁱ *R. v. Morrison*, [1998] N.S.J. No. 75, *R. v. Morrison*, [1998] N.S.J. No. 441; *Golubchuk v. Salvation Army Grace General Hospital*, [2008] M.J. 54, 2008 MBQB 49; *R. v. Latimer*, [1997] 1 S.C.R. 217; <http://www.cbc.ca/fifth/givedeathahand/life.html>. [Accessed 26 July 2011].

^{iv} Netherlands, *Termination of Life on Request and Assisted Suicide (Review Procedures) Act*, online: Dutch Ministry of Foreign Affairs – Netherlands Ministry of Foreign Affairs <http://www.healthlaw.nl/wtlovhz_eng.pdf> [Accessed 3 August 2011]; Belgium, *The Belgian Act on Euthanasia of May 28th, 2002*, trans. by Dale Kidd, online: Katholieke Universiteit Leuven Centre for Biomedical Ethics and Law <<http://www.kuleuven.ac.be/cbmer/page.php?LAN=E&FILE=subject&ID=53&PAGE=1>>; [Accessed 26 July 2011]; Switzerland, *Criminal Code of the Swiss Confederation*, art. 115, online: Legislationline <<http://www.legislationline.org/legislations.php?jid=49<id=15>>; [Accessed 26 July 2011]. Oregon, *The Oregon Death with Dignity Act*, 127 O.R.S. § 800 at §§ 805, 810, 815, 825, 830, 835, 840 (2007); Washington, *The Washington Death with Dignity Act*, Ch.70.245 RCW; Montana, *Baxter v. State of Montana*, Montana First Judicial District Court December 2008 and Supreme Court of Montana, 2009 MT449.

^v Details of this policy can be found at http://www.cps.gov.uk/publications/prosecution/assisted_suicide.html [Accessed 26 July 2011]

^{vi} *Criminal Code*, R.S.C. 1985, c. C-46.

^{vii} Canada, Special Senate Committee on Euthanasia and Assisted Suicide, *Of Life and Death -- Final Report* (Ottawa: Special Senate Committee on Euthanasia and Assisted Suicide, 1995), online: Senate of Canada <<http://www.parl.gc.ca/Content/SEN/Committee/351/euth/rep/lad-e.htm>>. [Accessed 2 August 2011].

^{viii} *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c.11.

^{ix} Economist Intelligence Unit. *The quality of death: Ranking end-of-life care across the world 2010*. Economist, London, 2010, 20.

^x Rawls, J.. *Political Liberalism*. New York: Columbia University Press, 1993.

^{xi} Sumner, W., *Assisted Death*. Oxford: Oxford University Press, 2011.

^{xii} Gutmann A, Thompson D. *Democracy and Disagreement*. Cambridge: Harvard University Press, 1996.

^{xiii} Warren ME, Pearse H. *Designing Deliberative Democracy: The British Columbia Citizens' Assembly*. Cambridge: Cambridge University Press, 2008.

^{xiv} Kahane D, Weinstock D, Leydet D, Williams M. *Deliberative Democracy in Practice*. Vancouver: The UBC Press, 2009.

^{xv} Bill C-384, *An Act to amend the Criminal Code (right to die with dignity)*, first reading May 13, 2009, defeated April 21, 2010.

^{xvi} Two-thirds of Canadians express support for legalizing euthanasia. Angus Reid Global Monitor: Montreal; Feb 2010. <http://www.angus-reid.com/>. [Accessed 26 July 2011]. ref

^{xvii} http://sen.parl.gc.ca/scarstairs/PalliativeCare/PalliativeCare_e.asp. [Accessed 26 July 2011].