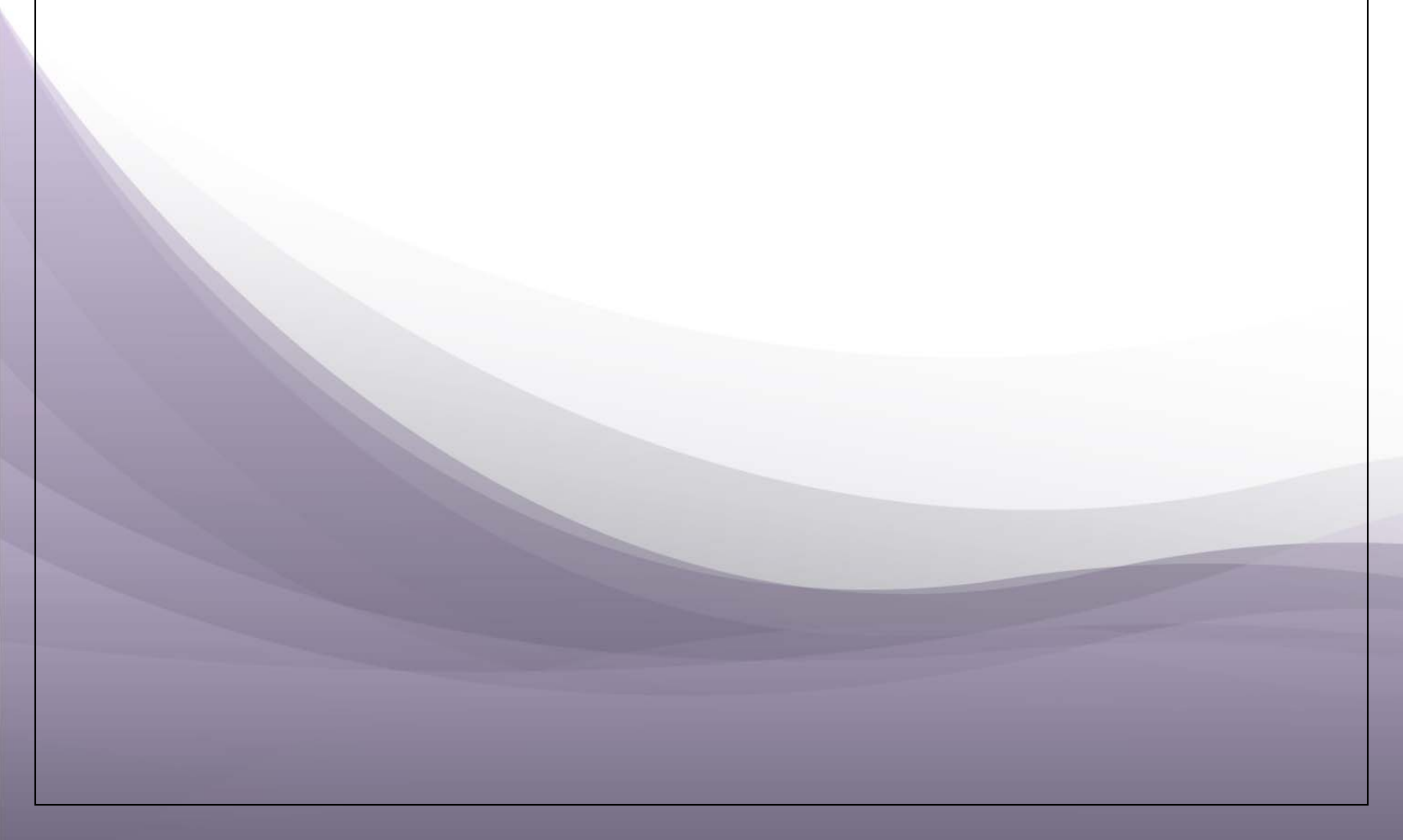


Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying

Final Report
November 30, 2015



Letter from the Co-Chairs

On behalf of our colleagues on the Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying (Advisory Group), we are pleased to submit this report of final key recommendations to the eleven participating provinces and territories, via the Ontario Minister of Health and Long-Term Care and Attorney General.

We have done our best, under challenging time constraints, to consult with as many stakeholder groups and individual experts as possible. Although physician-assisted dying is legal in many other jurisdictions, we believe we have come up with recommendations that will create a uniquely Canadian approach to this important issue.

The recommendations included are based on the best available evidence and the diverse expertise of the Advisory Group members.

Thank you for the opportunity to provide advice on this important issue.

Sincerely,

Dr. Jennifer Gibson
Co-Chair

Maureen Taylor
Co-Chair

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Acknowledgments

The Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying wishes to acknowledge the 11 provinces and territories that came together with a vision of creating a pan-Canadian approach to physician-assisted dying. These partners provided vital support and feedback to our secretariat throughout the process and it has been a highly collaborative and rich experience.

We would especially like to thank the secretariat provided to us by the Ontario Ministry of Health and Long Term Care (MOHLTC) and the Ministry of the Attorney General. This team of bright individuals worked long hours, evenings and weekends, to coordinate, research, strategize and keep us to deadline. It cannot be easy to follow the track changes of nine editors, but they managed this without complaint. We are grateful for their patience, their guidance and their dedication.

Finally, our work could not have been accomplished without the individuals and groups across Canada, who shared their time, expertise, and experience with us. Although we heard a diversity of views and perspectives on how physician assisted dying should be implemented, we also observed a tremendous generosity of spirit and willingness to engage, understand and bridge across differences.

Foreword

Twenty years ago Sue Rodriguez asked “Whose body is this? Who owns my life?” Having been diagnosed with Amyotrophic Lateral Sclerosis, Rodriguez wanted the option of aid in dying when her suffering became unbearable. Her request to the Supreme Court of Canada was denied by a narrow margin in 1993, but since then polls have consistently demonstrated growing public support for the option of medically-assisted death. The highly visible efforts of Canadians such as Gloria Taylor, Kay Carter and Dr. Donald Low, to exercise control over their lives and deaths have contributed to a seismic shift – both legal and social – in our country’s approach to end-of-life decisions.

The Government of Quebec took the lead on this issue, launching extensive public consultations and non-partisan discussions which resulted in Bill 52 – *An Act respecting end-of-life care*. In Québec, physicians will start offering qualifying patients the option of medical aid in dying in December 2015.

The rest of Canada will not be far behind.

On February 6, 2015, the Supreme Court of Canada rendered its decision in *Carter v Canada (Attorney General)* (“Carter”).

The Supreme Court unanimously struck down the *Criminal Code* prohibitions against assisted dying to the extent that they prohibited physician-assisted dying for a competent adult person who (1) clearly

consents and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition. The Court held that the prohibition on physician-assisted dying deprived the claimants and others suffering from grievous and irremediable medical conditions of the right to life, liberty and security of the person. The Court further held that this prohibition was overbroad and could not be justified in a free and democratic society.

The declaration of invalidity was suspended for 12 months (until February 6, 2016) to allow federal, provincial and territorial governments to respond, should they so choose, by enacting legislation consistent with the parameters set out in the Supreme Court's decision. Complementing any potential federal response, each province and territory must decide whether to enact legislation and/or adopt policies to clarify the rules affecting the provision of physician-assisted dying in its jurisdiction in light of the Supreme Court's decision.

Stakeholders hold diverse opinions on physician-assisted dying. While the majority of Canadians are supportive of the *Carter* decision, the idea of physician-assisted dying remains ethically challenging for some. As well, important values are at stake (and potentially in conflict) with respect to various elements that comprise the proposed regulatory framework for physician-assisted dying. Acknowledgement of the differing ethical positions on physician-assisted dying in general and a careful ethical analysis of specific issues related to implementation must accompany the development of any policies, legislation and regulations.

Given this context, on August 14, 2015, eleven participating provinces and territories appointed a nine member Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying ("Advisory Group"). Participating jurisdictions include: Alberta, British Columbia (as an observer), Manitoba, New Brunswick, Newfoundland and Labrador, Northwest Territories, Nova Scotia, Nunavut, Ontario, Prince Edward Island, Saskatchewan, and Yukon.

A federal External Panel, established to provide options for a federal legislative response to *Carter*, was recently asked to deliver a report by December 15, 2015, outlining feedback received to date, but without any policy advice or legislative recommendations. With this in mind, our report includes recommendations that ask provinces and territories to advocate for certain changes to federal legislation.

Overview of Recommendations

The Advisory Group is grateful to the large number of individuals and groups from across the country who shared their time, expertise, experience and advice with us as we developed our final recommendations. Below we provide an overview of our key recommendations.

Physician-assisted dying is a critical social policy issue for our generation. We believe strongly that the introduction of physician-assisted dying should be part of a larger discussion about high quality and

equitable access to end of life care in Canada. Specifically, we recommend that provincial, territorial and federal governments should work together to develop a pan-Canadian strategy for palliative and end-of-life care. This strategy would include physician-assisted dying as part of a continuum of services and supports to Canadians at the end of life.

Effective February 6, 2016, all provinces and territories must ensure access to physician-assisted dying. Provinces, territories, and the federal government, along with professional regulatory authorities, should work together toward the common goal of a harmonized, effective, and equitable regulatory framework for physician-assisted dying. This will involve an array of actions by a variety of government, regulatory, institutional and professional actors detailed in our report. A strong legislative response is essential.

Although the *Carter* decision refers only to physician-assisted dying, and we adopt this term in our report, the Advisory Group feels strongly that other health professionals – notably nurse practitioners, registered nurses and pharmacists – will need to be involved in the process of physician-assisted dying. Given increasing emphasis on interprofessional team practice as a standard of care in some settings, consideration of other health professionals will be necessary to ensure equal access and high quality of care. This is reflected in our recommendations.

Our recommendations place the patient at the centre. We have outlined a pathway for the provision of physician-assisted dying, including who should have access, how patients may request physician-assisted dying, how eligibility criteria should be assessed, and where physician-assisted dying may be provided. We recommend safeguards to protect vulnerable populations, including those who may face social factors that may impair a patient's ability to make a truly autonomous choice. These safeguards include assessment by two physicians, reflection to ensure all eligibility criteria are met, robust assessment of competency and consent, and a witnessed patient declaration form that serves as a formal request for physician-assisted dying.

The *Carter* ruling underscored the need to reconcile the interests of patients and providers. As we explain in this report, health care providers have the freedom to object to the provision of physician-assisted dying for reasons of conscience, but they are required to provide information about *all* end-of-life options, including physician-assisted dying. Conscientiously objecting health care providers are also required to either provide a referral, a direct transfer of care to another health care provider, or to contact and transfer the patient's records through a third party, agency or service which would have a duty to ensure the safe and timely transfer of care of the patient to a non-objecting provider.

Health institutions, including regional health authorities and other institutional providers (e.g., hospitals, hospices and long-term care facilities) are critical enablers of effective and equitable access to physician-assisted dying. Non-faith-based institutions should have an obligation to provide physician-assisted dying and faith-based institutions should have an obligation to either provide physician-assisted dying or make arrangements for a safe and timely transfer of the patient to a non-objecting institution. Regardless of how the process unfolds, we believe that there must be continuity of care for the patient.

It is essential for a properly functioning regulatory framework that there is robust and independent oversight: to monitor compliance with relevant laws, policies and standards; to inform continuing development of policies and practices; and to ensure public confidence in the integrity of the system. We recommend two levels of oversight: a Review Committee at the provincial/territorial level and a pan-Canadian Commission on End-of-Life Care at the national level.

Finally, physician-assisted dying is new to Canada. There is a need to build and sustain effective capacity, including through research and continuing quality improvement, health professional education and training, and public education and engagement.

List of Recommendations

Section/Sub-Section	Recommendations
End-of-Life and Palliative Care	
	Recommendation 1: Provinces and territories, preferably in collaboration with the federal government, should develop and implement a pan-Canadian strategy for palliative and end-of-life care, including physician-assisted dying.
Collaboration and Coordination	
	Recommendation 2: Provinces and territories should collaborate and coordinate with all relevant organizations and institutions as soon as possible to ensure the smooth and timely implementation of physician-assisted dying in Canada.
Access	
Critical Enablers of Access to Physician-Assisted Dying	Recommendation 3: All provinces and territories should ensure access to physician-assisted dying, including both physician-administered and self-administered physician-assisted dying. The recommendations set out in Appendix 3 should be implemented through provincial/territorial legislation. Recommendation 4: Provinces and territories should require all regional health authorities to have an effective publicly-funded care coordination system in place to ensure patient access to physician-assisted dying. Recommendation 5: Provincial/territorial governments should publicly fund physician-assisted dying. Recommendation 6: Provincial/territorial governments should not allow physician-assisted dying to be on the exclusion list for interprovincial reciprocal billing. Recommendation 7: Provinces and territories should request that the federal government amend the <i>Criminal Code</i> to explicitly protect those health professionals who provide

Section/Sub-Section	Recommendations
	supporting services during the provision of physician-assisted dying. This clarity will ensure the viability of a team-based approach to the provision of physician-assisted dying. Recommendation 8: Provinces and territories should request that the federal government amend the <i>Criminal Code</i> to allow the provision of physician-assisted dying by a regulated health care professional (registered nurse or, if applicable, physician assistant) acting under the direction of a physician, or a nurse practitioner. Provinces and territories should in turn ensure that no regulatory barriers exist that would prevent these health care professionals from providing physician-assisted dying. Recommendation 9: Provinces and territories should ensure that health professionals are protected from liability for acts or omissions done in good faith and without negligence in providing or intending to provide physician-assisted dying. Recommendation 10: Provinces and territories should evaluate whether legislative or regulatory amendments are necessary to require life insurance claims to be paid for deaths resulting from physician-assisted dying. Where necessary to achieve that result, amendments should be made.
Pathway to Provision	
Request and Documentation	Recommendation 11: Provinces and territories should establish requirements to ensure a patient declaration form is completed and witnessed by an independent party. Recommendation 12: Provinces and territories should request that the federal government make it clear in its changes to the <i>Criminal Code</i> that at any time following the diagnosis of a grievous and irremediable condition, a request for physician-assisted dying made through a valid patient declaration form may be fulfilled when suffering becomes intolerable.

Section/Sub-Section	Recommendations
	Recommendation 13: Within one year, provinces and territories, in collaboration with the federal government, should study whether patient declaration forms completed prior to the diagnosis of a grievous and irremediable medical condition might also be considered valid. Recommendation 14: Substitute decision makers should not be given the legal authority to consent to/authorize physician-assisted dying on behalf of an incompetent patient. Recommendation 15: Provinces and territories should create a patient information form that gathers demographic data on those requesting physician-assisted dying and the reasons for the request. Recommendation 16: To support case review and system oversight, data should be collected from the patient's initial request to the time of signing the death certificate and/or the completion of that patient's request (e.g., patient withdrawal of request, physician denial of requests).
Assessment of Eligibility	Recommendation 17: Access to physician-assisted dying should not be impeded by the imposition of arbitrary age limits. Provinces and territories should recommend that the federal government make it clear in its changes to the <i>Criminal Code</i> that eligibility for physician-assisted dying is to be based on competence rather than age. Recommendation 18: "Grievous and irremediable medical condition" should be defined as a very severe or serious illness, disease or disability that cannot be alleviated by any means acceptable to the patient. Specific medical conditions that qualify as "grievous and irremediable" should not be delineated in legislation or regulation. Recommendation 19: Provinces and territories should request that medical regulatory authorities develop guidance/tools for physicians in order to ensure that criteria for access to physician-assisted dying have been met and procedural

Section/Sub-Section	Recommendations
	safeguards have been respected. Recommendation 20: Physicians should use existing processes in the health care system to assess competency and consent. Recommendation 21: Access to physician-assisted dying should be available only to those who are eligible for publicly-funded health services.
Review	Recommendation 22: Two physicians must assess the patient to ensure that all criteria are met. Recommendation 23: Where there is limited physician supply, provinces and territories should enable virtual physician assessments and visits using telemedicine services (or other video-based consultations), or if necessary, transport reviewing physicians to the patient for the second assessment. Recommendation 24: For decisions related to competency, existing mechanisms in the health care/legal system by which patients can appeal competency decisions should be used. Recommendation 25: We do not recommend that an appeal process be established to respond to situations where the attending and/or reviewing physician conclude that the eligibility criteria (other than competency) have not been met. In this circumstance, patients should not be precluded from seeking assistance from other physicians.
Provision	Recommendation 26: We do not recommend a prescribed waiting/reflection period. Rather, the time between initial request and declaration will vary according to the time it takes for the attending and reviewing physician to be confident that the declaration is free and informed and made by a competent individual. Recommendation 27: Physician-assisted dying should be available wherever patients live (including in hospitals, long-

Section/Sub-Section	Recommendations
	term care facilities and at home), except certain conscientiously objecting facilities. Recommendation 28: There should be no requirement that a physician be present at a self-administered assisted death.
Reporting	Recommendation 29: Following the provision of physician-assisted dying, physicians should file a report with a Review Committee to support the review of each individual case. This review will ensure transparency and confirm compliance with existing policies and procedures. Recommendation 30: Physician-assisted dying should be listed as the manner of death on medical certificates of death across all provinces and territories and the name of the medical condition that qualified the patient for physician-assisted dying should be listed as the cause of death.
Role of Conscientiously Objecting Health Care Providers	
Duty to Inform	Recommendation 31: Conscientiously objecting health care providers should be required to inform patients of all end-of-life options, including physician-assisted dying, regardless of their personal beliefs. Recommendation 32: Conscientiously objecting health care providers should be required to appropriately inform their patients of the fact and implications of their conscientious objection to physician-assisted dying. Any ongoing treatment of the patient must be provided in a non-discriminatory manner.
Duty to Care for the Patient	Recommendation 33: Conscientiously objecting health care providers should be required to either provide a referral or a direct transfer of care to another health care provider or to contact a third party and transfer the patient's records through the system described in Recommendation 4.

Section/Sub-Section	Recommendations
Role of Institutions	
Duties of Institutions	Recommendation 34: All institutions should be required to inform patients/residents of any institutional position on physician-assisted dying, including any and all limits on its provision. Recommendation 35: Provinces and territories should prohibit any requirement by institutions that patients give up the right to access physician-assisted dying as a condition of admission. Recommendation 36: Provinces and territories should prohibit any requirement by institutions that physicians refrain from the provision of physician-assisted dying external to the non-participating institution. In addition, employment conditions or privileges should not be negatively impacted in any way.
Duties of Non Faith-based Institutions	Recommendation 37: Non faith-based institutions, whether publicly- or privately-funded, must not prevent physician-assisted dying from being provided at their facilities.
Duties of Faith-based Institutions	Recommendation 38: Faith-based institutions must either allow physician-assisted dying within the institution or make arrangements for the safe and timely transfer of the patient to a non-objecting institution for assessment and potentially, provision of physician-assisted dying. The duty of care must be continuous and non-discriminatory.
Oversight	
	Recommendation 39: Provincial and territorial governments should establish a Review Committee systems to review all cases of physician-assisted dying after the provision of the service to ensure compliance with relevant federal/provincial/territorial legislation and health professional regulatory standards, transparency and accountability.

Section/Sub-Section	Recommendations
	Recommendation 40: Provincial and territorial governments should (preferably in collaboration with the federal government) establish a pan-Canadian Commission on End-of-Life Care to provide system oversight and to report to the public.
Research and Continuing Quality Improvement	
	Recommendation 41: There should be coordination across funders and federal/provincial/territorial governments on a research strategy to inform implementation and continuing development of end-of-life care, including physician-assisted dying, in Canada.
Health Professional Education and Training	
	Recommendation 42: Professional organizations, regulatory authorities and universities should collaborate with each other and with patient groups to develop appropriate curricula and continuing education programs and training for students, physicians and health professionals that are related to the provision of physician-assisted dying.
Public Education and Engagement	
	Recommendation 43: Provinces and territories should provide public education about physician-assisted dying and apply best practices for public engagement to inform the continued development of end-of-life care law, policies, and practices.

INTRODUCTION

Advisory Group

Mandate

Our mandate is to provide non-binding advice to participating Provincial-Territorial Ministers of Health and Justice on issues related to physician-assisted dying. The advice is meant to assist provinces and territories in deciding what policies and procedures should be implemented within their jurisdictions in response to the Supreme Court's decision in *Carter*.

In developing our recommendations, our starting point was the *Carter* decision and we have (to the best of our abilities) provided recommendations that are consistent with the *Criminal Code*, the Canadian *Charter of Rights and Freedoms*, provincial/territorial Human Rights Codes and other applicable laws. We reviewed key health care policy questions related to, among other issues, eligibility criteria, conscientious objection, procedural safeguards, access and oversight. As part of this review, we invited written submissions from key stakeholder groups in the fields of health care, law and ethics, and from a range of patient, professional, regulatory and health care provider perspectives. We also sought extensive additional input and advice from targeted experts and stakeholders.

We recognize that provincial and territorial governments will retain final decision-making authority over whether to accept our recommendations and how physician-assisted dying should be implemented within their respective jurisdictions. This advice is not binding on participating or non-participating jurisdictions, and each government will maintain its authority to respond to the *Carter* decision as it deems appropriate.

Composition

Advisory Group members hold a wide variety of positions on physician-assisted dying and bring a range of professional expertise on key clinical, legal and ethical issues (see Appendix 1 for full biographies).

Jennifer Gibson (Co-Chair) - Director of the University of Toronto Joint Centre for Bioethics and Associate Professor in the Institute of Health Policy, Management, and Evaluation at the University of Toronto

Maureen Taylor (Co-Chair) - Physician Assistant in Infectious Diseases and Medical Journalist

Doug Cochrane - Patient Safety and Quality Officer for British Columbia and Chair of the BC Patient Safety and Quality Council

Jocelyn Downie - Professor in the Faculties of Law and Medicine at Dalhousie University

Ruth Goba – Human Rights Lawyer/Commissioner, Ontario Human Rights Commission

Nuala Kenny - Professor Emeritus of Bioethics at Dalhousie University and Former Ethics and Health Policy Advisor to the Catholic Health Alliance of Canada

Arthur Schafer - Director of the Centre for Professional and Applied Ethics at the University of Manitoba

Trevor Theman - Registrar of the College of Physicians & Surgeons of Alberta

Karima Velji - President of the Canadian Nurses Association and Integrated Vice President, Mental Health Services, for London Health Science Centre and St. Joseph's Health Care London

Process

The Advisory Group conducted its work from late August to November 2015. This included four face-to-face meetings in Toronto and numerous teleconferences. Our work was informed by background briefings on physician-assisted dying and significant stakeholder engagement.

Background Briefings

Background briefings included:

- a legal analysis of the Supreme Court decision and a review of the division of powers with respect to law and health care between Canada's federal government and its provinces and territories;
- a comparative analysis of the implementation of physician-assisted dying internationally in Belgium, the Netherlands, Luxembourg, Switzerland, Oregon, Washington State and Vermont;
- a literature synthesis on key issues related to physician-assisted dying; and
- a review of publicly-accessible policy documents regarding physician-assisted dying from Canadian provider and other stakeholder groups.

Stakeholder Engagement

The Advisory Group engaged a broad range of stakeholder perspectives in two phases. In the first phase, we invited over 250 stakeholder groups in September 2015 to complete written submissions on a wide range of issues related to the implementation of physician-assisted dying in Canada. Invited stakeholders included: provider associations, professional regulators, faith-based groups, patient, social, and legal advocacy groups, health institutions, and academic and other groups (see Appendix 2 for a list of stakeholders consulted). Stakeholders provided input and advice on issues related to:

- eligibility criteria;
- procedural safeguards;
- the role of physicians and other health care providers;
- conscientious refusal by health care providers;
- the role of institutions;
- access issues;
- settings for the provision of physician-assisted dying; and
- case review and system oversight.

In the first phase, we also met with representatives from the Government of Québec to learn about that province's experience with public and stakeholder consultations, crafting legislation, and working with health care professionals, facilities and others on the implementation of physician-assisted dying, and with the Governments of Nunavut, Yukon and the Northwest Territories to gain an understanding of the unique issues of the northern territories regarding the implementation of physician-assisted dying.

In November 2015, the Advisory Group conducted a second phase of consultations to clarify specific implementation issues. The Advisory Group invited panel discussions (in-person or by phone) with experts and national stakeholders over two days in Toronto. These sessions brought together stakeholders with divergent positions on the implementation of physician-assisted dying and created an opportunity for meaningful dialogue between those holding conflicting views.

Deliberations

The Advisory Group comprised a diversity of perspectives on physician-assisted dying, which we sought to reconcile through our deliberations in light of the background briefings and stakeholder input. In some cases, this involved re-considering and sometimes putting aside deeply-held personal views to find common ground in the interest of Canadian patients and the public.

These recommendations represent our best advice for implementing a comprehensive system to respond to the decriminalization of physician-assisted dying in Canada.

We acknowledge that our recommendations will have to be revisited and may need to be revised upon action taken by the federal government in the near future. We urge provinces and territories to work closely with the federal government, with each other and with health professional regulatory authorities to ensure an efficient approach to planning, communication and implementation, as well as a harmonized regulatory framework. It is the Advisory Group's firm belief that synchronized regulation of physician-assisted dying is critical to the public interest.

We also recognize that time constraints may impede the full implementation of some recommendations by February 2016. However, we believe that it is incumbent upon provinces and territories to put in place a regulatory framework by February 2016 that best protects those who are vulnerable and ensures access for those who are eligible for physician-assisted dying.

Legal Context

Supreme Court Decision

Our recommendations were developed in response to the Supreme Court's decision in *Carter*. In its decision, the Court held that "Section 241(b) and s. 14 of the *Criminal Code* unjustifiably infringe s. 7 of the *Charter* and are of no force or effect to the extent that they prohibit physician-assisted death for a competent adult person who (1) clearly consents to the termination of life and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition." Where the above-noted criteria are met, the *Carter* ruling serves as an exception – for physician-assisted dying – to the general prohibitions in the *Criminal Code* against aiding and abetting a person to commit suicide and consenting to having death inflicted upon them.

It is notable that the Supreme Court did not limit the ruling to those unable to take their own lives, to cases of terminal illness, or to people near death. The Court's declaration is also not restricted to physical illnesses, diseases or disabilities, and includes mental illness.

The Supreme Court agreed with the British Columbia Supreme Court that the risks sometimes associated with physician-assisted dying – especially the potential risks to vulnerable people – "can be limited through a carefully designed and monitored system of safeguards." Although the Supreme Court did not outline the framework for such a system in the *Carter* decision, it expressed confidence that such a system could be implemented in Canada.

The Court noted that "nothing in its decision would compel physicians to provide assistance in dying", but also said that "the *Charter* rights of patients and physicians will need to be reconciled." The Court expressly left open the question of how to reconcile the rights of patients who seek physician-assisted dying with the religious or conscientious objections of physicians to participate in it. The Court was silent on the issue of whether institutions have any right to refuse to allow the provision of physician-assisted dying or otherwise participate in the provision of physician-assisted dying.

Several key terms were also left undefined in the Court's decision, including "adult" and "grievous." While the Court did not explicitly define "irremediable", the Court did clarify that "irremediable... does not require the patient to undertake treatments that are not acceptable to the individual."

Division of Powers

It is important to understand the federal and provincial/territorial division of powers to appreciate fully the context of our recommendations and any possible provincial/territorial action on physician-assisted dying.

In Canada, health is an area of shared federal and provincial/territorial jurisdiction. The federal Parliament may enact laws in relation to health care under its criminal law power (e.g., restricting

controlled drugs, prohibiting certain practices). The provinces and territories, on the other hand, may legislate in relation to health care with their powers over health insurance, the regulation of health professions, and hospitals.

If there is no inconsistency between a valid federal law and a valid provincial/territorial law relating to health, then both laws apply. In the event of an inconsistency between a valid federal law and a valid provincial/territorial law, the federal law applies and the provincial/territorial law is inoperative to the extent of the inconsistency. “Inconsistency” in this case means either that there is a conflict in operation between the two laws (e.g., the federal law says a person must do something while the provincial/territorial law says the person must not do that thing) or that the provincial/territorial law frustrates the purpose of the federal law.

The federal Parliament may (subject to the *Charter*) use its criminal law power to stipulate the circumstances under which physician-assisted dying is permitted and to prohibit physician-assisted dying in other circumstances. Provinces and territories cannot enlarge or restrict the circumstances in which physician-assisted dying is permitted beyond those validly provided for by Parliament. The criminal law power allows Parliament not only to enact prohibitions, but also gives Parliament a measure of regulatory authority as well. However, because there are some health matters of exclusive provincial jurisdiction, there is a limit to how detailed or “regulatory” the federal law can be. As outlined in the Supreme Court’s reference to the *Assisted Human Reproduction Act*, criminal laws for the protection of health must address a “legitimate public health evil” rather than merely set uniform national standards for otherwise-beneficial medical activities. Parliament could establish physician-assisted dying rules aimed at reducing a risk of serious harm (e.g. rules ensuring that consent is unambiguous), but could not set medical standards unrelated to any risk of harm (e.g., Parliament could not regulate the referral or transfer-of-care obligations of physicians who object to physician-assisted dying on religious or conscientious grounds).

It is not possible to identify in the abstract a “bright line” past which valid federal criminal law turns into an invalid interference with provincial control over health. If the federal government sought to enact detailed regulations concerning the practice of physician-assisted dying (e.g., prescribing only certain permissible methods or drugs to be used in carrying out physician-assisted dying), it would need to be able to respond to any legal challenge to its regulatory authority by demonstrating with persuasive evidence that such regulations were aimed at addressing a legitimate public health evil. Provided that provincial/territorial laws were not inconsistent with valid federal legislation or with the *Charter*, provinces and territories could regulate aspects of physician-assisted dying not prohibited by federal law. For example, provinces and territories could enact legislation to regulate in relation to at least:

- eligibility (including rules regarding who may determine eligibility);
- determining competency and obtaining consent;
- safeguards to protect the vulnerable;
- settings in which physician-assisted dying is permitted;

- provider participation, including health institutions and both physicians and non-physician health professionals;
- means of delivery of physician-assisted dying;
- insurance (life and professional liability);
- certification of death; and
- reporting requirements and quality review.

Statement of Principles and Values

In developing our recommendations, we relied on a number of principles, values and existing rights, freedoms, responsibilities and obligations that exist in our health care systems. Some of these are enshrined in the *Charter of Rights and Freedoms* or provincial/territorial Human Rights Codes, while others are expressed in the Codes of Ethics of health care provider organizations. They all informed our work and form the basis for the recommendations in this report.

Individual and Institutional Rights and Duties

- The right to patient autonomy in end-of-life care decision-making
- The rights of freedom of conscience and religion
- The duty of health care providers to care for patients and not abandon them
- The right of Canadians to equitable access to health services
- The right to protection from discrimination as outlined in provincial Human Rights Codes
- The right to privacy
- When rights conflict, they must be reconciled

Pan-Canadian Principles

- Physician-assisted dying is one option in the end-of-life care continuum
- Canadians need access to high-quality palliative and end-of-life care
- Canadians need a harmonized system across the country
- Health care providers need clear guidance on rules, regulations and reporting requirements
- Transparency should be an ongoing goal whenever possible

In developing our recommendations, we also relied upon a set of beliefs with respect to regulation.

We believe that there are three critical actors in the regulatory system for physician-assisted dying: the federal government, the provincial/territorial governments, and the health professional regulatory bodies.

We believe that harmonization of regulation across jurisdictions is critical to the public interest and that an effective and efficient oversight system is essential to ensure responsible governance and trust in the regulatory system. A weak regulatory system would fail to meet the reasonable expectations of Canadians, including patients seeking physician-assisted dying and their loved ones.

We believe a strong legislative response is needed to ensure access to physician-assisted dying for all individuals who meet the eligibility criteria, to ensure that physician-assisted dying is provided only to individuals who meet the eligibility criteria, and to reconcile the sometimes competing interests of health care providers and institutions and patients (see Appendix 3 for a full list of recommendations that the Advisory Group believes should be implemented through

provincial/territorial legislation). We also believe that health professional regulatory authorities will play a critical role in the implementation of physician-assisted dying and their role in implementation will help to integrate physician-assisted dying into existing end-of-life processes and mechanisms (as much as possible and consistent with the physician-assisted dying legislation).

We believe that intergovernmental and cross-jurisdictional collaboration is essential. Of significance is the willingness by the new federal government to work collaboratively, as expressly set out in the Mandate Letter of the federal Minister of Justice, which urges the Minister to “lead a process, supported by the Minister of Health, to work with provinces and territories to respond to the Supreme Court of Canada decision regarding physician-assisted death.” We strongly encourage the provinces and territories to take up this invitation. Physician-assisted dying rests at the intersection of jurisdiction between the federal and provincial/territorial governments, as well as at the intersection of jurisdiction between the provincial/territorial governments and the professional regulatory authorities. Where there is a legitimate argument to be made that jurisdiction is shared or overlapping, we take the view that regulation should happen at the level with the greatest capacity for harmonization across the country, accountability, efficiency, and capacity for effective enforcement.

We believe the following three features are at the core of our call for a pan-Canadian regulatory framework:

1. Core elements established through the *Criminal Code*;
2. Additional procedural safeguards and provisions to ensure access established through provincial legislation (preferably based on a single model statute); and
3. Additional guidance for health care professionals established through their regulatory authorities (preferably based on model standards and guidelines developed collaboratively by the regulatory authorities).

Finally, we believe that physician-assisted dying should be integrated into existing end-of-life processes and mechanisms as much as possible. When faced with offering a new service, it can be tempting to create new systems to accompany the service. While physician-assisted dying is unique in some ways, it is also similar in many ways to existing procedures and can and should be treated as such. Physician-assisted dying should be treated as one appropriate medical practice within a continuum of services available at the end-of-life. Where we recommend different or additional processes or mechanisms, it is because we have concluded that they are necessary to appropriately balance the competing interests and values at stake and to ensure that the regulatory framework assures the trust of Canadians.

RECOMMENDATIONS

End-of-Life and Palliative Care

RECOMMENDATION 1: Provinces and territories, preferably in collaboration with the federal government, should develop and implement a pan-Canadian strategy for palliative and end-of-life care, including physician-assisted dying.

Canadians need better access to quality palliative and end-of-life care, and should be made more aware of the options currently available to them. These were common refrains in the written submissions we received, the face-to-face consultations we conducted, and during our own deliberations.

Many provinces and territories have long been working to improve access to quality palliative and end-of-life care within their own jurisdictions. The Advisory Group strongly recommends that this work be expedited and that provinces and territories develop and implement a pan-Canadian strategy to ensure consistent standards and adequate resources for meeting what should be a national priority.

We also heard some stakeholders suggest that a patient could not truly give free or properly informed consent to physician-assisted dying without first being aware of and having access to adequate palliative care. The Advisory Group understands that the validity of patient consent lies at the heart of the assessment of eligibility for physician-assisted dying and that lack of access to quality palliative care might, in some specific cases, threaten various elements of a valid consent. However, withholding physician-assisted dying from everyone until palliative care is available and offered to all is not the appropriate response, as it denies those who are eligible the right to die in the manner they choose. Instead, society should work tirelessly to improve access to quality palliative care and health care providers should ensure that, in each individual case, any consent to physician-assisted dying is free and informed and made by a competent individual within the constraints of the system.

Despite our recognition of the importance of a pan-Canadian strategy for palliative and end-of-life care, we do not believe the implementation of physician-assisted dying should be delayed. We believe that a better approach is to ardently promote palliative care while ensuring that health care providers are aware of the potential concerns related to patient consent (to physician-assisted dying) and are equipped to effectively address these concerns while respecting patient autonomy. Better palliative care should not be seen as a pre-condition for the development of a system that permits physician-assisted dying, but rather as a complement to improved end-of-life care.

Collaboration and Coordination

RECOMMENDATION 2: Provinces and territories should collaborate and coordinate with all relevant organizations and institutions as soon as possible to ensure the smooth and timely implementation of physician-assisted dying in Canada.

Many stakeholders who spoke to the Advisory Group were concerned about the uncertain impact of physician-assisted dying on the health care system and the negative consequences for patients and the public of a patchwork of approaches across the provinces and territories. The introduction of physician-assisted dying across Canada will inevitably raise issues that cannot easily be anticipated by government working alone. Early and active engagement with all impacted areas of the health care system will be required to identify and resolve these issues quickly.

The Advisory Group believes that the successful introduction of physician-assisted dying in Canada will require coordinated action by a number of organizations and institutions with various responsibilities within our health care systems. Provinces and territories should reach out to these groups immediately to ensure that all policies and planned changes within each jurisdiction are well-aligned and understood and that gaps and challenges are identified as quickly as possible. Key stakeholder groups include health care provider associations, health care facilities and institutions, insurers, the Canadian Institute for Health Information, the Vital Statistics Council of Canada, clinical specialty groups, academic institutions (e.g., faculties of medicine, nursing and pharmacy), and accreditation bodies.

We direct the attention of provincial/territorial governments to the actions around which collaboration and coordination is necessary to create a comprehensive system for physician-assisted dying (See Figure 1).

Figure 1. Necessary Activities of Other Organizations and Institutions

Health Authorities
• Develop plans for enabling access (e.g., privileges, payment, managing transfers of care)
Associations of Health Care Institutions
• Develop or revise institutional policies and procedures for physician-assisted dying to be consistent with the law
Health Institutions
• Develop or revise institutional policies and procedures for physician-assisted dying to be consistent with the law • If faith-based and objecting to physician-assisted dying, develop plan for transfer of patients to another institution
Professional Associations
• Revise Codes of Ethics to be consistent with the law
Specialty Clinical Groups (e.g., Critical Care, Family Medicine, Palliative Care)
• Develop clinical practice guidelines for physician-assisted dying
Royal College of Physicians and Surgeons of Canada, College of Family Physicians of Canada, and analogous bodies for Registered Nurses (including Nurse Practitioners) and Pharmacists
• Develop physician-assisted dying competencies • Develop physician-assisted dying education programs
Accreditation Bodies
• Develop standards regarding physician-assisted dying for professional schools (e.g., Medicine, Nursing, Pharmacy) • Develop standards regarding physician-assisted dying for health care institutions
Professional schools (e.g., Medical, Nursing, Pharmacy, Social Work, Law, etc.)
• Develop undergraduate, postgraduate, and continuing education curricula and materials on clinical, legal, and ethical aspects of physician-assisted dying
Vital Statistics Council for Canada and Provincial/Territorial Registrars of Vital Statistics
• Revise “agreed data set” for reporting to the Canadian Institute for Health Information • Develop data access plan for Review Committees and researchers
Canadian Institute for Health Information
• Design data collection and access systems to flow information from governments to researchers in consultation with Canadian researchers as well as researchers who conduct the regular studies in permissive jurisdictions
Insurers (Health Professional Liability Insurers, and Life and Health Insurers)
• Develop explanatory materials regarding life insurance coverage • Develop explanatory materials regarding liability insurance coverage for health professionals

Access

Barriers to Access

During our stakeholder consultations, we learned that there are many reasons why patients within the same province or territory might not have equitable access to the same health services, some of which are common to many health care services and some of which may be unique to the provision of physician-assisted dying.

Representatives of territorial governments and northern/remote communities repeatedly raised the issue of geography and the uneven distribution of health care professionals. Rural communities can also suffer from inadequate health infrastructure or resources. These access issues are not unique to the provision of physician-assisted dying. Indeed, we anticipate that the challenges already associated with the delivery of adequate health care in certain areas of the country will present themselves with the introduction of physician-assisted dying as well.

The introduction of physician-assisted dying brings with it the possibility of unique barriers to access. These may include inadequate training of health professionals on its appropriate implementation, fear of legal liability among physicians and other health professionals, and issues of conscience. Some stakeholders raised the possibility that cultural factors may affect access to physician-assisted dying in some settings and fear of social stigma in small communities may dissuade health care professionals from participation in the procedure. Other impediments to access may include language barriers, concerns about professional liability insurance or life insurance policies, and the costs of physician-assisted dying services.

Critical Enablers of Access to Physician-Assisted Dying

In this section, we recommend a series of critical enablers of access that are specific to physician-assisted dying. However, we believe it is important to recognize that ongoing attempts to improve access to an array of health care services and supports will also help to provide effective access to physician-assisted dying.

RECOMMENDATION 3: All provinces and territories should ensure access to physician-assisted dying, including both physician-administered and self-administered physician-assisted dying. The recommendations set out in Appendix 3 should be implemented through provincial/territorial legislation.

RECOMMENDATION 4: Provinces and territories should require all regional health authorities to have an effective publicly-funded care coordination system in place to ensure patient access to physician-assisted dying.

Physician-administered and self-administered physician-assisted dying is ultimately a communal responsibility of society, governments and health care professions. It should never rest solely on the

shoulders of individual health care providers or facilities. The burden of finding a physician or institution that is willing to assess and ensure eligibility and provide access to physician-assisted dying should never fall to the patient alone, regardless of their geographic location or whether they are in a hospital, hospice, or engaging with another part of the health care system.

We recommend the creation of a publicly-funded care coordination system to link patients with an appropriate provider of physician-assisted death. This system must be given the resources and legal authority necessary to ensure that patients do not face access barriers because of geography or physician supply or objection. This system would ensure that people in rural and remote communities have equitable access to physician-assisted dying (e.g., through physician visits and/or telemedicine services) and that those without a current primary care provider or with a conscientiously objecting physician still have the opportunity to receive care from a provider who will consider their eligibility for physician-assisted dying.

We recommend that this system be modelled on successful examples used in other health care services (e.g., cancer care, organ transplantation). We envision them as “patient navigators”, people who have an understanding of the field, knowledge of health care providers who are willing to provide physician-assisted dying to individuals who meet the eligibility criteria, and the interpersonal skills, resources, and legal authority to facilitate the transfer of care between health care providers (including the transfer of medical records so as to protect the identity of the health care providers accepting the patient). While the system’s initial role would be to connect patients to physicians and manage the transfer of patients, over time they may also assist with helping patients understand the range of end-of-life options available, including palliative care.

RECOMMENDATION 5: Provincial/territorial governments should publicly fund physician-assisted dying.

We believe that provincial/territorial governments should take steps to ensure that access to physician-assisted dying is not dependent on a patient’s ability to pay for the service. This will require that physician-assisted dying, including all aspects from counselling about end-of-life options to assessments and provision, are included as insured services under provincial and territorial health insurance plans.

RECOMMENDATION 6: Provincial/territorial governments should not allow physician-assisted dying to be on the exclusion list for interprovincial reciprocal billing.

Interprovincial billing agreements exist between provinces and territories for medically necessary insured hospital inpatient and outpatient services rendered in publicly-funded hospitals. All provinces and territories with the exception of Québec also participate in reciprocal billing arrangements for the payment of insured medically necessary physician services.

These agreements cover insured hospital and physician services for Canadians who are temporarily away from their province/territory of residence but are within Canada (e.g., travelling or on an approved absence for work or educational purposes). The agreements and the supporting billing system endeavour to ensure that the province or territory providing the service directly bills the patient's home province or territory, and that the patient is not required to pay directly for health services (provided the patient presents a valid health card). A small number of procedures have been placed on an exclusion list for interprovincial reciprocal billing. Physician-assisted dying is not analogous to the other services on the exclusion list and so should not be on this list.

While we recommend that all provinces and territories have a policy of providing access to physician-assisted dying, we recognize that in order to provide access to physician and hospital services in some rural and remote northern and border communities, there may be reliance on out-of-province/territory patient transfers and the interprovincial billing arrangements that support the related physician and hospital services. In addition, some individuals may wish to move from one province or territory to another for the last weeks or months of their lives in order to be near loved ones and caregivers. The Interprovincial Reciprocal Billing Agreement should not be allowed to create a barrier to access to physician and hospital services for them.

Our overall goal in making Recommendations 5 and 6 is to ensure that physician-assisted dying is an insured service for all eligible patients within Canada who qualify for publicly-funded health services. These recommendations would also mitigate concerns about international medical tourism within Canada, while still recognizing that some Canadian communities may not have the capacity to offer physician-assisted dying to their own residents, and that some patients may wish to move elsewhere within Canada towards the end of their lives.

RECOMMENDATION 7: Provinces and territories should request that the federal government amend the Criminal Code to explicitly protect those health professionals who provide supporting services during the provision of physician-assisted dying. This clarity will ensure the viability of a team-based approach to the provision of physician-assisted dying.

Our health care systems function best when teams of providers with diverse skills and scopes of practice work together to provide the best possible care for patients. The *Carter* decision permits physicians to provide physician-assisted dying within the circumstances of the decision, but is silent on the role of other health professionals. To ensure that all health professionals can provide quality care within their scope of practice as part of a team-based approach, we recommend that the federal government provide additional clarity in the *Criminal Code*. These *Criminal Code* changes should ensure that health professionals can provide the support services they normally would, including but not limited to a pharmacist dispensing a prescription, a nurse drawing medication into a syringe, or a personal support worker giving a patient prescribed medication.

RECOMMENDATION 8: Provinces and territories should request that the federal government amend the Criminal Code to allow the provision of physician-assisted dying by a regulated health care professional (registered nurse or, if applicable, physician assistant) acting under the direction of a physician, or a nurse practitioner. Provinces and territories should in turn ensure that no regulatory barriers exist that would prevent these health care professionals from providing physician-assisted dying.

While Recommendation 7 deals with the invaluable role other health professionals should be allowed to play in supporting the provision of physician-assisted dying, this recommendation deals specifically with the provision itself. Nurse practitioners have independent scope of practice to assess the patient and prescribe medication when appropriate. Where access to physicians or nurse practitioners is limited other regulated health professionals (registered nurses or, if applicable, physician assistants), acting under the direction of a physician, should be able to write the prescription or give the injection without exposure to criminal liability.

Given that, in the *Carter* decision, the Supreme Court referred only to physician-assisted dying, it will be important for any *Criminal Code* amendments to explicitly permit regulated health professionals (registered nurses or, if applicable, physician assistants) acting under the direction of a physician, and nurse practitioners, to facilitate adequate access across Canada. Without this clarity, non-physician professionals would face uncertainty about their role and would potentially be exposed to liability for providing physician-assisted dying. It will be essential that provincial/territorial scope of practice legislation does not create barriers to these health professionals providing physician-assisted dying.

Throughout this report, our recommendations refer to physicians when discussing the provision of physician-assisted dying. If the *Criminal Code* changes advocated for in this recommendation are adopted, these recommendations should be read to include regulated health professionals (registered nurses or, if applicable, physician assistants) acting under the direction of a physician, and nurse practitioners.

RECOMMENDATION 9: Provinces and territories should ensure that health professionals are protected from liability for acts or omissions done in good faith and without negligence in providing or intending to provide physician-assisted dying.

We view the appropriate protection of health care providers from liability as a way to promote access to physician-assisted dying. We heard from many stakeholder groups that if health professionals feel they are exposed to liability, they will be much less likely to provide physician-assisted dying.

This recommendation has two aspects. First, provinces and territories should ensure that necessary legislative or regulatory amendments are made to codify this protection. Health professionals who provide physician-assisted dying need to know that their participation will not expose them to liability as long as they are not negligent and act in good faith within the rules set out to support the implementation of physician-assisted dying. Second, provinces and territories should ensure that health care providers' liability insurance does not discriminate against providers based on whether or not they provide physician-assisted dying. Provinces and territories should work with the Canadian Medical Protective Association and other insurers of health professionals, and make any necessary legislative or regulatory changes to ensure that liability coverage is not affected by whether the provider participates in physician-assisted dying.

RECOMMENDATION 10: Provinces and territories should evaluate whether legislative or regulatory amendments are necessary to require life insurance claims to be paid for deaths resulting from physician-assisted dying. Where necessary to achieve that result, amendments should be made.

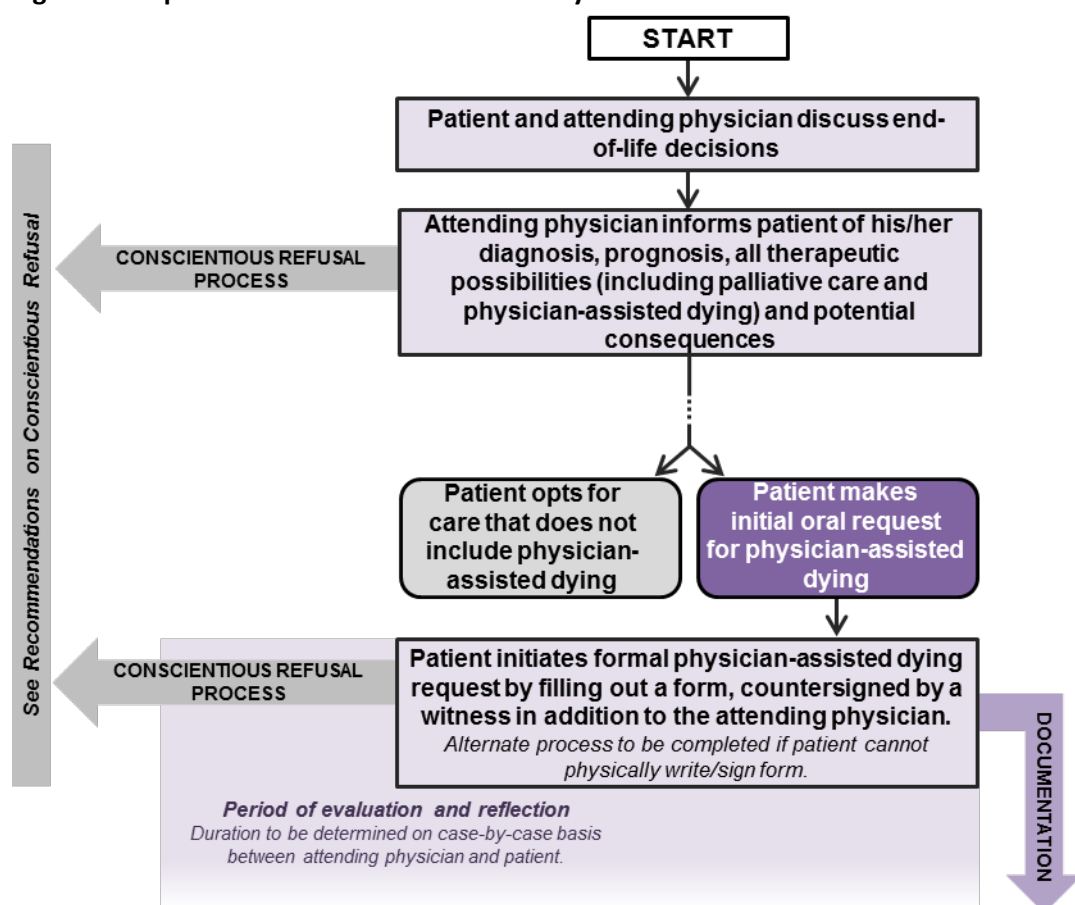
Life insurance payments can be critically important to beneficiaries after a patient has died. Provinces and territories should ensure that beneficiaries do not have life insurance claims rejected solely on the grounds of the benefactor receiving physician-assisted dying.

Pathway to Provision

In this section, we outline the process by which a patient may initially discuss their end-of-life options, request physician-assisted dying, go through a rigorous assessment process, and then, where the eligibility criteria are met and procedural safeguards observed, be provided with physician-assisted dying. Throughout this section, we will highlight areas where we have added additional safeguards to existing processes to protect patients and ensure that consent for such an important decision is free and informed and made by a competent individual. Graphical depictions of our proposed patient pathway are included throughout this section. A full version is included as Appendix 4. The pathway below describes the most common scenario; however, a modified approach may be required in some cases. Once we have outlined the standard patient pathway, we will examine the role of health care providers and faith-based institutions who object to physician-assisted dying for reasons of conscience.

Request and Documentation

Figure 2. Request and Documentation Pathway



The patient-physician relationship is founded on mutual trust, respect, knowledge, and understanding between the patient and his or her health care provider. Through the relationship, the physician gains a

medical and psychosocial understanding of the patient and the reasons for his or her wishes with respect to health care. This relationship is the basis for assessments of competency, knowledge of the medical condition or conditions affecting the patient, and the impact and natural evolution of potential treatments. This relationship provides the patient with an understanding of his or her condition and treatment options and provides the physician with the knowledge needed to assess the patient's competency in making a request for physician-assisted dying. This relationship may take time to develop.

In the context of the patient-physician relationship and the principles of their profession, health care providers have several duties that apply regardless of their personal position on physician-assisted dying. These duties include the duty to inform, the duty to care for patients, and the duty of non-abandonment. In practice, this means that any physician has a duty to discuss all end-of-life options with their patients, including physician-assisted dying, even if they themselves would not be willing to participate in it.

When a patient raises the issue of physician-assisted dying, his or her physician should engage in a meaningful dialogue with the patient on diagnosis, prognosis, all end-of-life options (including palliative care and physician-assisted dying) and their potential consequences. If the patient is willing and agrees, these conversations should also involve the patient's family and caregivers. Based on these discussions, if the provider is willing to participate in physician-assisted dying, they should move on together to the next step on the pathway. If the physician is unwilling to participate, or if in an institution that does not provide physician-assisted dying, the physician should trigger the conscientious objection process (see Recommendations 31-38 below).

Revocation

The patient can, at any time, rescind his or her request for, or consent to, physician-assisted dying either verbally or in writing.

Patient Declaration Form

RECOMMENDATION 11: Provinces and territories should establish requirements to ensure a patient declaration form is completed and witnessed by an independent party.

The patient declaration form, developed by provinces and territories or an oversight body established by provinces and territories, must clearly state that the patient has been informed about his or her condition and all available options, understands the information and appreciates the consequences of the decision, and has requested physician-assisted dying. If the declaration is being completed before the patient is experiencing enduring intolerable suffering, it must also include a statement clearly explaining what the patient considers to constitute enduring intolerable suffering.

The patient declaration form must be signed by the patient and countersigned by an independent witness and the attending physician. Where a patient cannot physically write or sign the patient

declaration form, an alternative means may be used, such as a video recording. A documented patient declaration witnessed by an independent party will serve as formal confirmation of the patient's wishes and a means of providing assurances to the attending physician and other interested parties that the patient has clearly requested and consented to physician-assisted dying.

Timing of Completion of Declaration

RECOMMENDATION 12: Provinces and territories should request that the federal government make it clear in its changes to the Criminal Code that at any time following the diagnosis of a grievous and irremediable condition, a request for physician-assisted dying made through a valid patient declaration form may be fulfilled when suffering becomes intolerable.

RECOMMENDATION 13: Within one year, provinces and territories, in collaboration with the federal government, should study whether patient declaration forms completed prior to the diagnosis of a grievous and irremediable medical condition might also be considered valid.

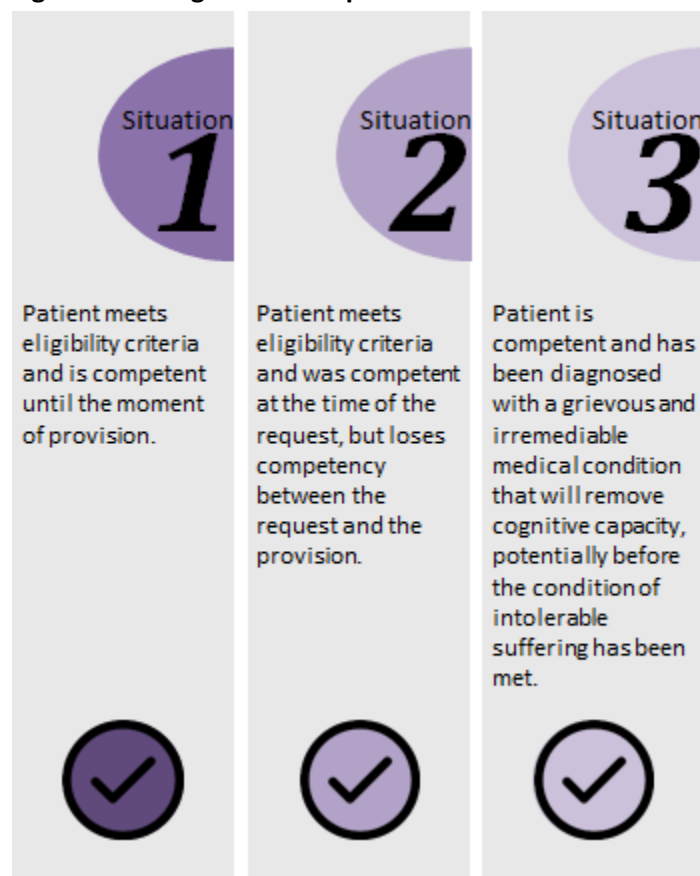
We have carefully considered the question of when the requirement for competency must be met. We have considered four possibilities and determined that physician-assisted dying should be permitted in three of those situations.

Provinces and territories should advise the federal government to make clear in the *Criminal Code* that physician-assisted dying is permissible where:

- a) the patient is competent at all times from the initial request to the moment of provision of assistance;
- b) although competent and having a grievous and irremediable condition and experiencing intolerable suffering at the time of the completion of the patient declaration form, the patient lost competence between the completion of the patient declaration form and the provision of assistance; or
- c) although competent and having been diagnosed with a grievous and irremediable condition, but not yet experiencing intolerable suffering, at the time of the completion of a patient declaration form, the patient lost competence between the completion of the patient declaration form and the onset of the enduring intolerable suffering.

We note that *Carter* requires that physician-assisted dying be provided to a competent adult. Scenario (a) above is clearly allowed under the Supreme Court of Canada's decision. However, the Supreme Court's decision is silent on scenarios (b) and (c) above.

Figure 3. Timing of the Completion of a Declaration



The first situation is the most straightforward: a patient who has a grievous and irremediable condition and is experiencing intolerable suffering and is competent until the moment of provision. This person should qualify for physician-assisted dying.

The second situation involves a patient who, although competent and having a grievous and irremediable condition and experiencing intolerable suffering at the time of the completion of the declaration form, loses competency between the completion of the form and the provision. In this case, we believe that the person should be eligible for physician-assisted dying.

The third situation is more complex. It may occur when a patient has been diagnosed with a condition that will remove

competency, such as dementia, and has concerns about the quality of his or her end-of-life in that future. The patient is not experiencing intolerable suffering, but has been diagnosed with a grievous and irremediable medical condition. Should this patient be permitted to complete a patient declaration indicating that he or she would like to receive physician-assisted dying when certain conditions that the patient believes would constitute enduring intolerable suffering are met, even if the patient will no longer be competent when those conditions are met? Our answer is yes.

Particularly for certain degenerative diseases, we feel that to require that these patients be competent at the time physician-assisted dying is delivered would force many of them to trigger the act earlier in the course of their disease than necessary. Some people may be more comfortable with their diagnosis knowing that physician-assisted dying will be available to them after they lose competency. In such cases, physicians will need to take extra care to ensure that the patient understands and freely consents to his or her decision. The physician and patient should discuss the normal progression of the disease and how patients often respond and adapt to the disease. These conversations should continue throughout the progression of the disease (or up to the point of losing competence) to assess and confirm that the patient maintains his or her decision with respect to the future provision of physician-assisted dying.

We recognize that rules about advance directives vary across the country and, therefore, where a patient wishes to consent to physician-assisted dying in advance, the Advisory Group recommends that a standardized patient declaration form requesting physician-assisted dying be used instead of existing mechanisms. The patient's symptoms and/or presentation at the time of the provision of the assistance will need to be assessed against the criteria for intolerable suffering set out by the patient in advance.

There is a fourth, possible situation that we considered which involves a person who has not yet been diagnosed with a grievous and irremediable medical condition, but has completed a patient declaration form. We did not come to agreement on whether such a declaration should be considered valid consent for the purposes of eligibility for physician-assisted dying. Some members of the Advisory Group believe that this is consistent with existing practice with respect to advance care directives and so should be permitted, while others believe it is not possible to give informed consent to physician-assisted dying prior to a diagnosis of a grievous and irremediable medical condition. We therefore recommend that provinces and territories work with the federal government to consult further on this issue within the coming year and update legislation if needed by February 2017.

Substitute Decision-Makers

RECOMMENDATION 14: Substitute decision makers should not be given the legal authority to consent to/authorize physician-assisted dying on behalf of an incompetent patient.

Many stakeholder groups emphasized the paramount importance of patient autonomy as justification for respecting requests for physician-assisted dying. Allowing substitute decision makers to authorize/consent to this procedure on behalf of a patient leaves open the possibility that a patient's life could be ended in contravention, or without the explicit knowledge, of his or her wishes.

Patient Information Form

RECOMMENDATION 15: Provinces and territories should create a patient information form that gathers demographic data on those requesting physician-assisted dying and the reasons for the request.

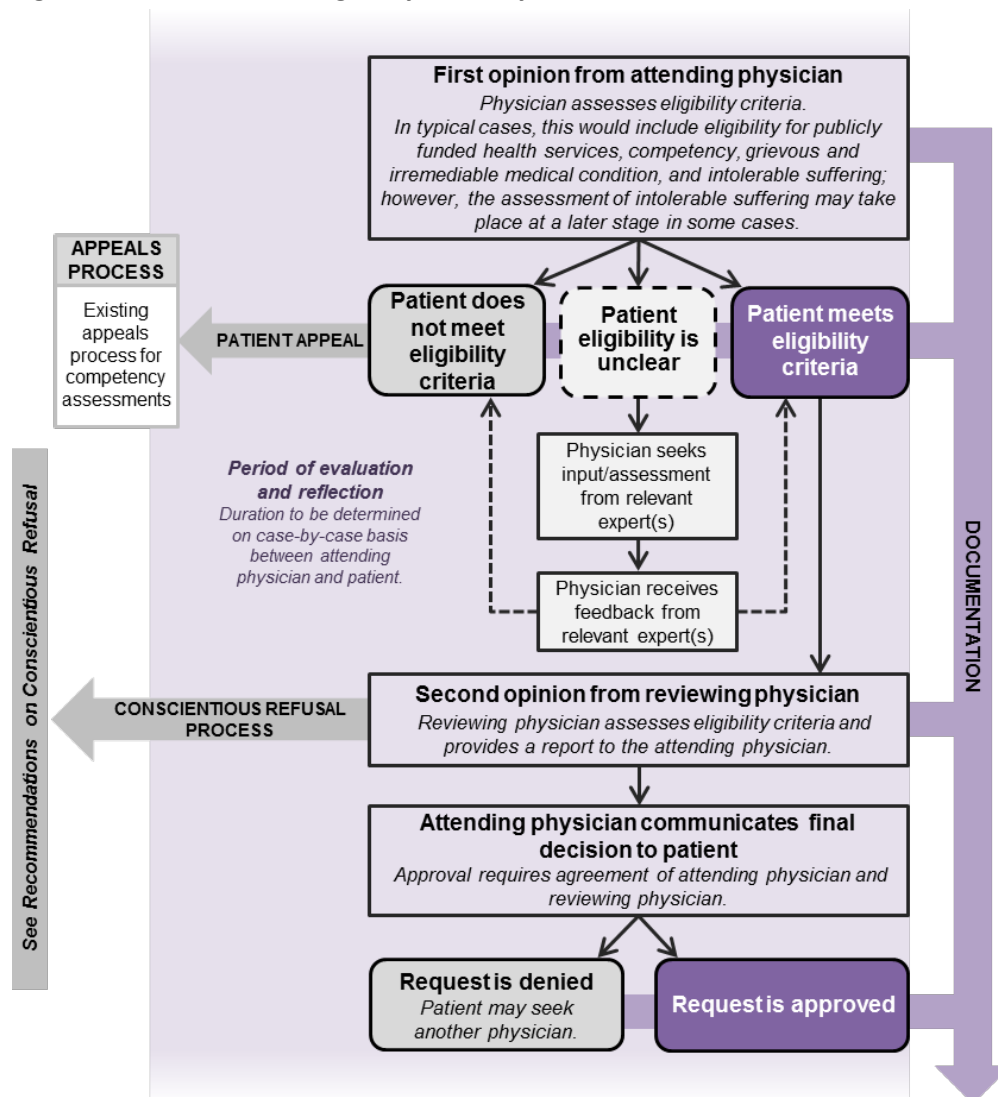
Patients who request physician-assisted dying should be asked to complete a simple form that outlines demographic information and their reasons for requesting physician-assisted dying. This information will be required by provinces and territories as part of an oversight system to be outlined later in this report. The de-identified information will also be relevant to researchers who choose to study the implementation of physician-assisted dying in Canada.

RECOMMENDATION 16: To support case review and system oversight, data should be collected from the patient's initial request to the time of signing the death certificate and/or the completion of that patient's request (e.g., patient withdrawal of request, physician denial of requests).

Data should be collected from the patient's initial request to the time of signing the death certificate. In addition to the data gathered through the declaration form and information form, data should also be collected on the number of, and grounds for, refusals of patient requests for physician-assisted dying and the number of patients permitted physician-assisted dying that chose not to proceed. Data should be gathered by the attending physician as part of the request and assessment process and provided to the Review Committee and Oversight Body, outlined below.

Assessment of Eligibility

Figure 4. Assessment of Eligibility Pathway



The willing attending physician must ensure that the patient is eligible for physician-assisted dying based on the eligibility criteria set out in the *Carter* decision. According to the Court, a patient must be 1) an adult person 2) with a grievous and irremediable medical condition (including an illness, disease or disability) 3) that is causing enduring suffering that is intolerable to the individual in the circumstances of his or her condition. The court also required that the adult person be competent and clearly consent to the termination of life.

Adult Person

RECOMMENDATION 17: Access to physician-assisted dying should not be impeded by the imposition of arbitrary age limits. Provinces and territories should recommend that the federal government make it clear in its changes to the Criminal Code that eligibility for physician-assisted dying is to be based on competence rather than age.

The *Carter* decision applies to a “competent adult person,” but does not include a definition of adult. In assessing whether someone is an adult person, an arbitrary age limit such as 18 years old provides no valid safeguard. Instead, it is important that willing physicians carefully consider the context of each request to determine whether the person has the information needed, is not under coercion or undue pressure, and is competent to make such a decision.

Competence and consent to treatment laws vary among provinces and territories. In some cases, decisional competence is based on age, but in others, age is irrelevant to whether the patient has the legal authority to make decisions about his or her treatment.

An ideal regulatory framework for physician-assisted dying would have uniform eligibility rules. Indeed, many provider groups asked the Advisory Group to recommend a consistent national approach to eligibility for physician-assisted dying and patient advocacy groups also sought an easily understandable criterion for accessing the service regardless of where in the country a patient lives. The federal government could facilitate this by affirming that the definition of “adult” in the context of physician-assisted dying relates to a patient’s ability to give consent rather than a particular age cut-off. That is, to allow access to patients who are competent, regardless of age.

Grievous and Irremediable Medical Condition

RECOMMENDATION 18: “Grievous and irremediable medical condition” should be defined as a very severe or serious illness, disease or disability that cannot be alleviated by any means acceptable to the patient. Specific medical conditions that qualify as “grievous and irremediable” should not be delineated in legislation or regulation.

RECOMMENDATION 19: Provinces and territories should request that medical regulatory authorities develop guidance/tools for physicians in order to ensure that criteria for access to physician-assisted dying have been met and procedural safeguards have been respected.

The second aspect of eligibility requires that the physician confirm that the patient is suffering from a grievous and irremediable medical condition. The Supreme Court does not offer a definition of “grievous” in the *Carter* decision. The Canadian Oxford Dictionary defines “grievous” as “very severe or serious.” This definition should be used in any changes proposed to the *Criminal Code*, provincial/territorial legislation or regulatory authority standards related to physician-assisted dying. Consistent with the *Carter* decision, we understand that “irremediable” is used to describe a condition that cannot be alleviated by any means acceptable to the patient. The determination of whether a condition is irremediable should be a two-step process. First, the physician must determine whether any treatments exist for the condition. Second, the patient must determine whether any of the available treatments are acceptable to him or her.

We heard consistently through the stakeholder engagement process that grievous and irremediable should not be defined in terms of specific health conditions. No list of specific conditions could capture the range of illnesses, diseases and disabilities that might meet the parameters established by the Supreme Court. Instead, we recommend that regulatory authorities develop tools to assist physicians in making this determination on a case by case basis.

Intolerable Suffering that is Enduring

The Supreme Court states that the medical condition must cause enduring suffering that is intolerable to the individual in the circumstances of his or her condition. This is a subjective test based on the patient’s response to his or her condition. In order to determine whether this eligibility criterion has been met, the physician must receive from the patient a very clear statement of what the patient considers or would consider to be suffering that is intolerable.

Competency and Consent

RECOMMENDATION 20: Physicians should use existing processes in the health care system to assess competency and consent.

During our consultations, we heard from some stakeholder groups who felt that a panel of doctors, a tribunal or judge, or a specially-trained professional should be required to conduct a vulnerability assessment for all persons with disabilities seeking physician-assisted dying. We also heard that a mental health assessment should be required for all persons seeking physician-assisted dying.

We share these group’s concerns about the protection of vulnerable populations and the need for safeguards to do so. However, our research and discussions lead us to believe that existing mechanisms

are sufficient to ensure that patients are making an informed choice and that physicians can effectively assess patient competence. In the text that follows, we describe the current systems in place to support informed consent and competency assessment and show how these systems can be applied to the implementation of physician-assisted dying.

Informed Consent

To be valid, consent must be free and informed. To be free, the person making the choice must not be subject to coercion or undue pressure. For consent to be informed in the context of physician-assisted dying, we follow the Federation of Medical Regulatory Authorities of Canada's advice in their June 6, 2015, guidance on physician-assisted dying:

The attending physician must disclose to the patient information regarding their health status, diagnosis, prognosis, the certainty of death upon taking the lethal medication, and alternatives, including comfort care, palliative and hospice care, pain and symptom control and other available resources to avoid the loss of personal dignity. The physician must advise the patient of any counselling resources that are available to assist the patient. The attending physician must inform the patient of his or her right to rescind the request at any time. The attending physician has an obligation to take reasonable steps to ensure that the patient has understood the information that has been provided.

Competency

To be competent to consent to treatment, the person must be able to understand information relevant to the decision and appreciate the nature and consequences of the specific decision being made or not made. Competence can fluctuate over time and a person may be competent for one decision (e.g., simple with minor consequences) but not another (e.g., complex with very serious consequences).

Assessment

In most cases where a person requests physician-assisted dying, there will be little doubt that his or her decision is free and informed and that the patient has the competence to make the decision to choose physician-assisted dying. In other cases, competency may be in question and there may be reason to doubt whether the decision is free and/or informed. Particular concerns that have been raised include those involving persons with psychiatric conditions, minors, and persons living with severe disabilities. For example, we heard concern from some stakeholders that individuals with psychiatric conditions or minors may not be capable of appreciating the consequences of the decision because of their mental condition or lack of life experience and not-yet-fully developed executive functions. There were those who felt individuals living with severe disabilities may be particularly vulnerable to coercion or make the choice because of a lack of social supports and few other options. As a consequence, some suggested that age, psychiatric illness, and disability should be exclusion criteria for access to physician-assisted dying (or should be subject to different regulatory requirements).

Governments undoubtedly have an obligation to protect individuals who might seek physician-assisted dying while they are not capable of making an autonomous choice. However, we do not feel those who fall into these categories should automatically be denied the right to access physician-assisted dying.

Instead, we acknowledge the need for heightened scrutiny during assessments of the eligibility criteria for physician-assisted dying in the face of any signals that might indicate compromised autonomy (including, but not limited to psychiatric illness, disability, or age). Just as they already do for other end-of-life decisions, where a health care provider has concerns, doubts, or uncertainty about whether an individual is competent and is making a free and informed choice, the provider should take whatever time and consult any additional experts as is necessary to reach the conclusion that the person does or does not meet the eligibility criteria. Health care providers must assess the components of a valid consent on a regular basis and often in circumstances in which the decision is complex and the consequences dire. The same skills (and time and additional expertise) that are used for assessing the elements of informed choice for other end-of-life decisions are transferable and adequate for making such assessments for the physician-assisted dying decision.

Although we do not recommend the use of age, psychiatric condition, or disability as exclusion criteria for access to physician-assisted dying (as described in Recommendation 18), we do recommend the development of better assessment tools for consent and competency (especially in relation to vulnerabilities associated with lack of social support for persons living with disabilities). We also recommend the development and implementation of educational materials designed to improve the capacity of health care providers to assess competency – particularly in the presence of potentially compromising conditions or social contexts. This approach will serve the objective of protecting individuals who might seek physician-assisted dying but are not capable of making an autonomous and informed choice. It will also have the added benefit of protecting individuals who might make other life-limiting decisions while not capable of making an autonomous choice (e.g., refusing life-sustaining treatment in the face of a traumatic injury).

Insured Persons

RECOMMENDATION 21: Access to physician-assisted dying should be available only to those who are eligible for publicly-funded health services.

In addition to the criteria set out in the Supreme Court’s decision in *Carter*, we believe that only patients who are eligible for publicly-funded health services should be considered eligible for physician-assisted dying. The *Carter* decision does not include citizenship, residency, or status as an insured person as an eligibility criterion for access to physician-assisted dying, but almost all jurisdictions where physician-assisted dying is legal limit access to the service in this manner. Although imposing a Canadian residency requirement would prevent residents of foreign countries from visiting Canada to receive physician-assisted dying, imposing limits based on citizenship or permanent residency status could also create a barrier to access for some in Canada. As a result, we recommend that all – and only – those eligible for publicly-funded health services also qualify for physician-assisted dying.

Review

Second Assessment

RECOMMENDATION 22: Two physicians must assess the patient to ensure that all criteria are met.

Patients who are enduring intolerable suffering and who meet all other eligibility criteria for physician-assisted dying should not have their suffering extended or compounded by an unnecessarily burdensome administrative process to access this service. We feel, however, that the approval of an attending and reviewing physician (or nurse practitioner acting within their scope of practice) is a reasonable safeguard to help ensure that a patient has indeed met the eligibility requirements for accessing physician-assisted dying and an appropriate step to help support the attending physician.

Following the request for physician-assisted dying and assessment of eligibility and competency by the attending physician, we recommend an additional safeguard be put into place for physician-assisted dying whereby a second physician assesses the patient for eligibility and provides a report to the attending physician. For this to be justifiable hurdle, and not an unjustifiable barrier, this recommendation is conditional upon our earlier recommendation that Criminal Code changes make it possible for other regulated health care professionals – in addition to physicians – be permitted to provide assistance in dying (see Recommendation 8).

RECOMMENDATION 23: Where there is limited physician supply, provinces and territories should enable virtual physician assessments and visits using telemedicine services (or other video-based consultations), or if necessary, transport reviewing physicians to the patient for the second assessment.

While we recommend that two physicians should be involved in ensuring that all criteria have been met, we recognize that some communities do not have access to local physicians at all. In these cases, provinces, territories or the regional health authorities should work to provide patients with access to physicians either through telemedicine, by bringing physicians into the community or, if the patient is willing, by transporting him or her to an area where physicians are available and willing to conduct the necessary evaluations.

Appeals and Dispute Resolution

RECOMMENDATION 24: For decisions related to competency, existing mechanisms in the health care/legal system by which patients can appeal competency decisions should be used.

Existing provincial/territorial mechanisms allow patients to appeal decisions related to competency and set out the circumstances in which a patient has a right to appeal. For example, in Ontario, if a physician

has determined that a patient is not competent to consent to treatment, the patient has the right to appeal to the Consent and Capacity Board. No new system to handle competency disputes is required for physician-assisted dying.

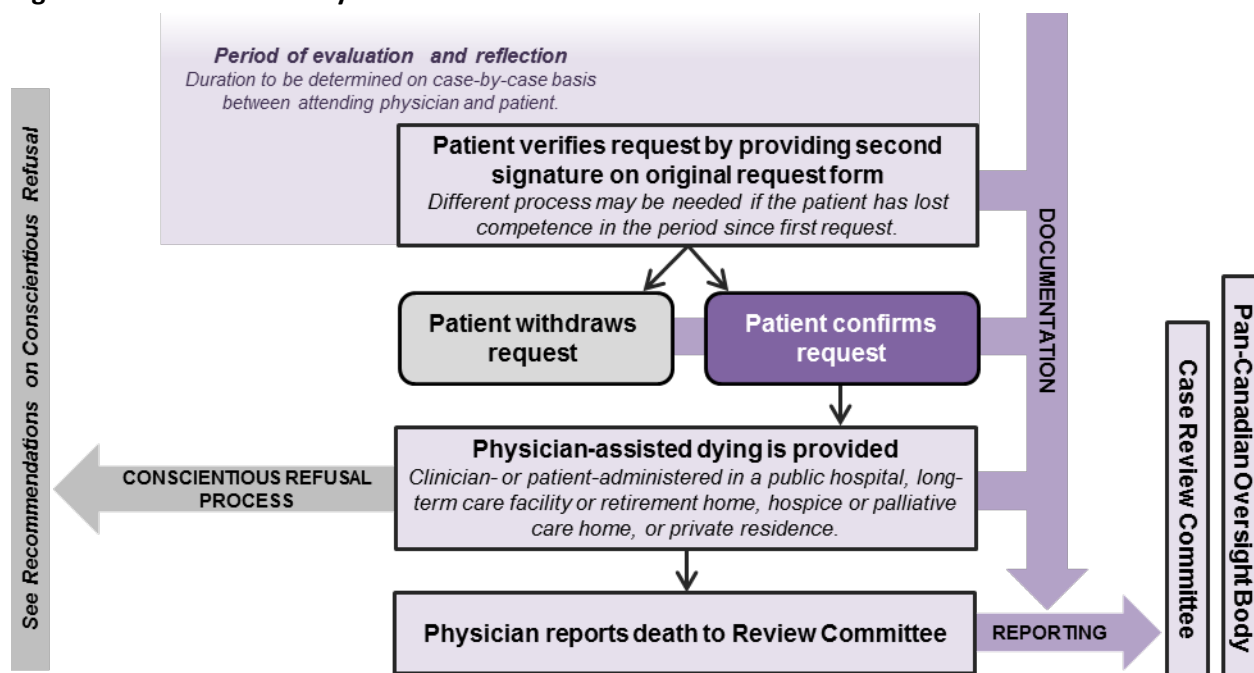
RECOMMENDATION 25: We do not recommend that an appeal process be established to respond to situations where the attending and/or reviewing physician conclude that the eligibility criteria (other than competency) have not been met. In this circumstance, patients should not be precluded from seeking assistance from other physicians.

We do not feel it necessary to set up an appeals process when the attending or reviewing physician concludes that the eligibility criteria (other than competency) have not been met. Instead we recommend the following:

- If the attending physician determines that the eligibility criteria (other than competency) have not been met, the attending physician shall inform the patient of the reasons for that determination. The patient should not be precluded from consulting another physician.
- If the reviewing physician determines that the criteria (other than competency) have not been met, the reviewing physician shall inform the patient and attending physician of the reasons for that determination. The attending physician or patient should not be precluded from seeking the opinion of another reviewing physician.

Provision

Figure 5. Provision Pathway



Once the reviewing physician has confirmed that the eligibility criteria have been met, the attending physician may request that the patient re-confirm his or her intention (if the patient is still competent) and the physician may provide physician-assisted dying to the patient.

RECOMMENDATION 26: *We do not recommend a prescribed waiting/reflection period. Rather, the time between initial request and declaration will vary according to the time it takes for the attending and reviewing physician to be confident that the declaration is free and informed and made by a competent individual.*

Several stakeholder organizations have requested that governments be prescriptive in setting out a specific waiting/reflection period as part of a clearly articulated physician-assisted dying process. Others have suggested this would not respect patient autonomy and physician judgement. While a mandated waiting/reflection period has been established in some jurisdictions, such as in the U.S. states that offer physician-assisted dying, we believe that such an approach would impose an arbitrary barrier to access that would negatively impact both patient decision-making and physician judgement.

Furthermore, a specific time period serves as a poor proxy for detecting decisions that are either not fully informed, not voluntary or made when a patient is not capable of fully appreciating the consequences of the decision being made. In some cases, a set time period may be too short for the physician to make a confident assessment of the elements of a valid consent. In other cases, it may be longer than is necessary.

As such, we do not recommend a particular prescribed time period. What is essential is that the patient has sufficient time to come to an informed and voluntary decision, to understand the information, and appreciate the consequences of his or her decision, and that the physician has had sufficient time to come to the conclusion that all of the eligibility criteria have been met. The time required to meet these conditions will vary depending on circumstances and so a set amount of time would be arbitrary. Furthermore, the passage of at least some time in every case is assured by the requirement that the attending and reviewing physicians both be confident that the consent is free and informed and made by a competent individual.

RECOMMENDATION 27: Physician-assisted dying should be available wherever patients live (including in hospitals, long-term care facilities and at home), except certain conscientiously objecting facilities.

Increasingly, Canadians express the desire to die in their own home and we believe both physician-assisted dying and palliative care should be delivered in the home if that is the patient's wish. In some cases, a patient's home may be a retirement facility, nursing home or hospice.

RECOMMENDATION 28: There should be no requirement that a physician be present at a self-administered assisted death.

Patients should have the right to choose who is present at their time of death. Therefore, there should be no requirement that a physician (or nurse practitioner acting within the scope of their practice) be present at a self-administered physician-assisted death. We recognize that self-administered physician-assisted dying may result in more complications than physician-administered physician-assisted dying. However, patients should be free to determine for themselves whether the benefits to them of allowing self-administration without a physician present outweigh the potential risks. Self-administration without a provider present may lead to more complications and adverse events, but research from other jurisdictions indicates that these events are extremely rare. Physicians should ensure that the potential risks are clearly explained to the patient and provide instructions on how to respond to them should they materialize.

Reporting

Case Review

RECOMMENDATION 29: Following the provision of physician-assisted dying, physicians should file a report with a Review Committee to support the review of each individual case. This review will ensure transparency and confirm compliance with existing policies and procedures.

Although we do not support case review before provision of physician-assisted dying (as outlined in Recommendation 20), we believe that a regular review of individual cases after provision is required to confirm that all procedural safeguards have been followed correctly and to identify any systemic problems as soon as possible. Within 14 days of the provision of the assistance (either through the writing of a prescription or direct provision by a health care provider), the attending physician must file a report with the Review Committee (for details on the makeup and mandate of the Review Committee, see Recommendation 39). The Review Committee should have access to all patient files including the patient declaration form, patient information form, attending and reviewing physician's reports and additional competency assessments (if undertaken). Provinces and Territories should undertake any legislative or regulatory changes required to ensure that such health information can be shared with the Review Committee.

Vital Statistics

RECOMMENDATION 30: Physician-assisted dying should be listed as the manner of death on medical certificates of death across all provinces and territories and the name of the medical condition that qualified the patient for physician-assisted dying should be listed as the cause of death.

Listing physician-assisted dying on medical certificates of death may require legislative changes in some jurisdictions, but we believe that it is an important step for tracking and data collection purposes to ensure full transparency. Physician-assisted dying should be listed as the manner of death. The name of the medical condition that qualified the person for physician-assisted dying should be reported as the underlying cause of death. The injection or ingestion of drugs should be recorded as an antecedent cause.

Provinces and territories should direct their Vital Statistics registrars to work together to ensure a common approach is used across Canada to ensure that system oversight can be efficient and effective (See Recommendations 39-40 regarding oversight).

Role of Conscientiously Objecting Health Care Provider

We have already outlined the process for the provision of physician-assisted dying when there are no conscientious objections being raised. We have also highlighted the duties and obligations of all health care providers, whether or not they object to the provision of physician-assisted dying. These duties include the duty to provide full information about all end-of-life options, including physician-assisted dying, the duty to care for the patient in a non-discriminatory manner and the duty of non-abandonment of the patient until such a time as care has been transferred to another provider.

These duties must be fulfilled by a conscientiously objecting health care provider. While we believe that there is a communal responsibility to provide access to physician-assisted dying, individual providers are not absolved of their personal/professional responsibilities, particularly in a publicly-funded system.

We believe that the positions set out below represent a respectful reconciliation of the many competing values at stake in the context of physician-assisted dying.

We believe that this reconciliation of competing values also harmonizes the approach taken across health professions (i.e., nurses' consciences are not given less weight than physicians'). We also believe that the burden of the risk of lack of access should not fall on patients. We believe that the burden of the risk of failure to ensure the design, implementation and maintenance of a system for arranging transfers of care from providers and institutions that object to providing physician-assisted dying should rest on those with the greatest power and voice to ensure that the government and other organizations design, implement, and maintain an effective and efficient transfer of care system (i.e., health care providers, professions, regulators and institutions rather than patients with grievous and irremediable conditions that cause enduring intolerable suffering).

Furthermore, we heard from health care provider organizations that, even without any legislation or regulation addressing the issue of conscientious objection, access to physician-assisted dying is likely not going to be a problem. We can draw a logical inference that a duty to inform and duty of non-abandonment (manifest as a duty to ensure an effective transfer of care either directly or through a third party) is, in their view, redundant.

We also heard repeatedly from groups representing individuals who want access to physician-assisted dying to be available that they believe that, without legislation establishing a duty to inform and a duty of non-abandonment (manifest as a duty to ensure an effective transfer of care either directly or through a third party), there may be problems with access. It is our hope that this approach will increase trust in the health care system among these individuals by setting out these duties in law. Health care providers will not be harmed by a redundant provision and members of the public who support access for physician-assisted dying will benefit. It therefore seems reasonable and prudent to enshrine the duties in legislation.

In developing the recommendations below, we have attempted to reconcile the patient's rights and freedoms (to conscience, autonomy, life, liberty and the security of the person) with the provider's (to conscience, religion/creed, and privacy). We have consulted extensively on these questions and have worked to create a system that ensures access without unnecessarily limiting the conscience rights of providers.

Duty to Inform

RECOMMENDATION 31: Conscientiously objecting health care providers should be required to inform patients of all end-of-life options, including physician-assisted dying, regardless of their personal beliefs.

All end-of-life options (including palliative care and physician-assisted dying) should be discussed with patients in a respectful way regardless of the provider's beliefs. Such requirements are often already included in professional codes of ethics. For example, the Canadian Medical Association's Code of Ethics requires that physicians provide patients with the information they need to make informed decisions about their medical care.

RECOMMENDATION 32: Conscientiously objecting health care providers should be required to appropriately inform their patients of the fact and implications of their conscientious objection to physician-assisted dying. Any ongoing treatment of the patient must be provided in a non-discriminatory manner.

Conscientiously objecting providers have a duty to inform new patients and, when appropriate, current patients of their position on physician-assisted dying. This allows patients to make an informed choice with respect to enrolling with or retaining that provider. Regulatory authorities and governments should produce educational materials for physicians and patients to help navigate these discussions. We also encourage all physicians to initiate and regularly revisit conversations with patients around advance care planning, the goals of care, and the patient's end-of-life wishes.

Duty to Care for the Patient

RECOMMENDATION 33: Conscientiously objecting health care providers should be required to either provide a referral or a direct transfer of care to another health care provider or to contact a third party and transfer the patient's records through the system described in Recommendation 4.

To facilitate access to physician-assisted dying, conscientiously objecting health care providers must refer, transfer care or contact a third party in a timely manner and transfer records to another health

care provider or third party, as required. There is no expectation that they will assess the patient's eligibility for physician-assisted dying.

We heard from some stakeholders who believed that a referral in the context of physician-assisted dying implied that the conscientiously objecting physician had assessed the patient, found them eligible for physician-assisted dying and was transferring care for the purposes of providing the service. While this is an option available to those who object to the provision of service, we did not want to imply that assessment is an obligation, or that this was the only option available to providers.

When we discuss a direct transfer of care, we envisage a situation where a patient has requested physician-assisted dying and has already discussed end-of-life options with their health care provider. We recognize that some providers view a transfer of care as morally preferable to referral because, unlike referral, it is taken to neither explicitly nor implicitly affirm the service sought by the patient. A health care provider could transfer the patient to another health care provider for the assessment and treatment of the patient's medical condition and, if the patient meets the eligibility criteria, provision of physician-assisted dying. The receiving health care provider must be someone who is willing and able to accept the person as a patient and does not conscientiously object to physician-assisted dying. Following the transfer of care, the receiving health care provider would follow the pathway outlined earlier in this report.

For those conscientiously objecting health care providers who are not willing to provide a direct transfer of care on conscience or religious grounds, we provide the option of contacting and transferring the patient's records through a publicly-funded system designed to ensure that patients are able to access a health care provider willing to accept them as a patient for assessment and, if the eligibility criteria are met, to provide physician-assisted dying. If this system is not in place, conscientiously objecting providers should be required to make a direct transfer of care to a health care provider who is willing and able to accept the person as a patient and does not conscientiously object to physician-assisted dying. It is imperative that the burden of the transfer to another physician, institution or third party not fall on the patient seeking the care.

As described in Recommendation 4, we recommend a system where regional health authorities develop a publicly-funded care coordination system to help facilitate access to physician-assisted dying. One of this system's key functions should be to receive requests from unwilling or unable health care providers and transfer patients to providers who are willing and able to receive new patients.

Role of Institutions

Duties of Institutions

All institutions have certain responsibilities in common, many of which align with our recommendations related to physicians.

RECOMMENDATION 34: All institutions should be required to inform patients/residents of any institutional position on physician-assisted dying, including any and all limits on its provision.

This recommendation will ensure that patients have clarity on what is permitted within the facility. They can then make informed decisions with respect to whether to enter or remain in the facility.

RECOMMENDATION 35: Provinces and territories should prohibit any requirement by institutions that patients give up the right to access physician-assisted dying as a condition of admission.

RECOMMENDATION 36: Provinces and territories should prohibit any requirement by institutions that physicians refrain from the provision of physician-assisted dying external to the non-participating institution. In addition, employment conditions or privileges should not be negatively impacted in any way.

Taken together, the two recommendations above limit the power of institutions to restrict the autonomy of patients who may wish to seek physician-assisted dying at a later date, and providers, who may wish to provide physician-assisted dying outside a faith-based institution that does not offer physician-assisted dying. They represent an appropriate balance between patient and physician autonomy, patient access, and institutional autonomy.

Duties of Non Faith-Based Institutions

RECOMMENDATION 37: Non faith-based institutions, whether publicly- or privately-funded, must not prevent physician-assisted dying from being provided at their facilities.

Governments have significantly more levers to influence the policies and practices of institutions that are funded in whole or in part by public funds. However, as a point of principle, we believe that physician-assisted dying should be available wherever people are living and dying. This includes privately-funded institutions. Recognizing that not all institutions will feel capable of providing physician-assisted dying for a variety of reasons, including size, geography and mandate, we concluded that institutions should be permitted to offer a patient transfer to another institution, as long as the receiving institution can and will provide a health care provider who is willing and able to accept the

person as a patient, to assess whether the criteria for access to physician-assisted dying have been met, and provide physician-assisted dying where the criteria for access have been met.

Duties of Faith-Based Institutions

RECOMMENDATION 38: Faith-based institutions must either allow physician-assisted dying within the institution or make arrangements for the safe and timely transfer of the patient to a non-objecting institution for assessment and, potentially, provision of physician-assisted dying. The duty of care must be continuous and non-discriminatory.

Faith-based institutions have a duty to care for and not abandon the patients within their institution. While they should not be required to provide access to physician-assisted dying, they must still ensure access for patients who wish to seek it.

When a patient makes a request for physician-assisted dying, faith-based institutions should be required to either allow for the assessment and provision of physician-assisted dying within the institution or make arrangements for an effective transfer of the patient to a non-objecting institution. This transfer must also include the transfer of all relevant records, and must be made to a non-objecting institution where the patient's medical condition can be assessed and treated by a health care provider who is willing and able to assess whether the patient meets the eligibility criteria for physician-assisted dying and, if so, can provide assistance. If a safe and timely transfer to a non-objecting institution is not possible, the objecting institution must allow an outside health care provider to assess the patient and, if the eligibility criteria for physician-assisted dying are met, to provide assistance. The receiving outside health care provider would follow the pathway for physician-assisted dying as outlined previously in this report.

Oversight

It is essential for a properly functioning regulatory framework that there is robust and independent oversight to: monitor compliance with relevant laws, policies and standards; to inform continuing development of policies and practices; and to ensure public confidence in the integrity of the system. To support the implementation of physician-assisted dying, we recommend two levels of oversight: one at the provincial/territorial level and one at the pan-Canadian level.

RECOMMENDATION 39: Provincial and territorial governments should establish Review Committee systems to review all cases of physician-assisted dying after the provision of the service to ensure compliance with relevant federal/provincial/territorial legislation and health professional regulatory standards, transparency and accountability.

An independent review committee system should be established in each province and territory, or with agreement amongst groups of provinces and territories, to monitor compliance with the legal and regulatory framework for physician-assisted dying and to facilitate public reporting on physician-assisted dying in Canada. The Review Committees should include a physician, a legal expert, an ethicist, and a public representative who can determine whether the relevant laws and professional standards have been followed. Where issues arise, the Review Committees should report any potential violations to the appropriate authorities.

Individual cases should be reviewed after provision of assistance (see Recommendation 29). For each case of physician-assisted dying, the Review Committee will review the documentation submitted by physicians. As a starting point, we recommend that all cases be reviewed by the Review Committee. However, it may be possible for only a sample to be reviewed once the system of providing physician-assisted dying has matured in Canada. Where the Committee determines that the physician acted in compliance with the relevant laws and professional standards, the physician will be informed and the file will be closed. Where a physician is thought to have potentially violated laws or standards, the Review Committee will report this to the relevant professional regulatory authority for investigation and response under its professional self-regulatory powers. Any subsequent reporting by a regulatory authority to the police will follow the regulatory authority's normal processes with respect to reporting suspected violations of provincial or federal legislation. Where the Review Committee determines that a health institution or any other person was non-compliant with provincial/territorial legislation, it will refer the case to the relevant regulatory authority in its jurisdiction (e.g., regional health authority, Ministry of Health).

The Review Committee will also compile de-identified population-level data on physician-assisted dying in its jurisdiction. This may include incidence of physician-assisted dying, the underlying causes of death, the settings where physician-assisted dying was provided (e.g., hospital, home), the regulated health professional who provided the service (e.g., physician, nurse practitioner), the modality of physician-

assisted dying (i.e., self-administered or provider-administered), and any complications arising in the provision of physician-assisted dying. To facilitate pan-Canadian comparisons, common metrics should be developed for application across Review Committees.

The Review Committee should be required to prepare an annual report of its findings for the purpose of public reporting on physician-assisted dying at a provincial or territorial level and for submission to the pan-Canadian Commission on End-of-life Care.

RECOMMENDATION 40: Provincial and territorial governments should (preferably in collaboration with the federal government) establish a pan-Canadian Commission on End-of-life Care to provide system oversight and to report to the public.

A pan-Canadian Commission on End-of-Life Care should be established to report to the public on the implementation of physician-assisted dying. The Commission could be developed as part of a pan-Canadian strategy on palliative and end-of-life care, including physician-assisted dying, or it could be a separate body if a pan-Canadian strategy cannot be developed in a timely manner. It should report annually on things such as: the number of cases of physician-assisted dying; the number of requests for physician-assisted dying including those that were refused or never acted upon; and demographic data about who is requesting physician-assisted dying and why. These reports will help to ensure that the system in place is – and is seen to be – legitimate, trustworthy and non-discriminatory.

The Commission should also be given additional functions associated with a robust regulatory framework for physician-assisted dying including to:

- conduct or commission research it deems necessary in accordance with relevant federal, provincial, and territorial law and policy;
- consult with the public, health providers, and other experts on issues related to physician-assisted dying;
- inform the development and delivery of resources on moral, legal, and clinical aspects of physician-assisted dying to health care providers, legal professionals, and the public; and
- make recommendations to federal, provincial and territorial governments about potential law and policy reform with respect to physician-assisted dying in Canada.

Research and Continuing Quality Improvement

RECOMMENDATION 41: There should be coordination across funders and federal/provincial/territorial governments on a research strategy to inform implementation and continuing development of end-of-life care, including physician-assisted dying, in Canada.

Physician-assisted dying is a new practice in Canada. We are entering a critical phase in which evidence-gathering should be undertaken systematically and rigorously to inform responses to these Canadian questions. Although other jurisdictions provide insight into its practice, physician-assisted dying in the Canadian context raises unique policy and practice questions. There are unanswered questions, for example, about organ donation in the context of physician-assisted dying and the role and regulation of palliative sedation. Answering these questions will require the research community and governments to work collaboratively to advance a coordinated research agenda in service of Canadians.

Health Professional Education and Training

RECOMMENDATION 42: Professional organizations, regulatory authorities and universities should collaborate with each other and with patient groups to develop appropriate curricula and continuing education programs and training for students, physicians and health professionals that are related to the provision of physician-assisted dying.

A recurrent theme throughout our consultation with stakeholders was the need for education and training of health professionals with respect to physician-assisted dying, including its clinical, legal, and ethical aspects. Health professional education and training should include both undergraduate and post-graduate education, as well as continuing professional education of licensed health professionals. Health professional education should not be limited to regulated health professionals, but should also address the learning needs of other health care workers involved in patient care. Although some clinical specialties may be more likely to participate in the provision of physician-assisted dying, end-of-life conversations including about physician-assisted dying may arise in any therapeutic relationship between patients and providers. This suggests that physician-assisted dying and related end-of-life issues should be a core component of all health professional education. The curriculum should ideally include training on: how to talk with patients about physician-assisted dying; what the legal, regulatory, and ethical obligations are; the extent and limits of conscientious objection; the psychosocial aspects of illness; awareness of and sensitivity to cultural, linguistic, and other forms of diversity; and assessment of social vulnerability. Notably, this curriculum would be broadly relevant to the delivery of high quality end-of-life care and other clinical care.

Public Education and Engagement

RECOMMENDATION 43: Provinces and territories should provide public education about physician-assisted dying and apply best practices for public engagement to inform the continued development of end-of-life care law, policies, and practices.

Public education and engagement are critical to a transparent system of end-of-life care, including physician-assisted dying. There is a need for public education on what physician-assisted dying is (and what it is not), how it fits within a continuum of end-of-life services, how it can be accessed and under what conditions, and how physician-assisted dying is governed, administered, and monitored, including what safeguards are in place. Patients and families also need information about what supports and services are available for patients and their families at the end-of-life. While some of this information may be provided by physicians and other health professionals in conversation with their patients, such information should also be readily publicly available for patients and members of the public. There is also a need for patient and public engagement to inform the continuing development of high-quality end-of-life care and supportive care, and the implementation of physician-assisted dying. Current best practices in patient and public engagement should be proactively incorporated into provincial and territorial planning and the implementation of physician-assisted dying.

APPENDICES

Appendix 1 – Member Biographies

DR. JENNIFER GIBSON (CO-CHAIR)

Ontario

Director of the University of Toronto Joint Centre for Bioethics

Jennifer Gibson is Sun Life Financial Chair in Bioethics and Director of the University of Toronto Joint Centre for Bioethics, and Associate Professor in the Institute of Health Policy, Management, and Evaluation at the University of Toronto. She holds a PhD in philosophy (bioethics and political theory). Her research focuses on ethical governance and performance of health organizations and systems. Gibson directs the World Health Organization Collaborating Centre for Bioethics at the University of Toronto and is also a member on the Executive Committee for the Global Institute for Psychosocial, Palliative, and End-of-Life Care, University of Toronto and Princess Margaret Cancer Centre. Jennifer has served on government and health sector advisory committees on public health emergencies, critical care triage, drug funding and supply, and the Ebola response in Ontario and internationally.

MAUREEN TAYLOR (CO-CHAIR)

Ontario

Physician Assistant in Infectious Diseases and Medical Journalist

Maureen Taylor is a Physician Assistant (PA) in Infectious Diseases at Toronto East General Hospital, and an Associate Clinical Professor in the Department of Family Medicine at McMaster University. Prior to her studies as a PA, Maureen was a broadcast journalist for 25 years, including seven years as the National Medical/Health Reporter for the Canadian Broadcasting Corporation. Maureen is a three time winner of the Canadian Medical Association/Canadian Nurses Association awards for excellence in health reporting.

Maureen was married to microbiologist and infectious disease expert Dr. Donald Low, who was diagnosed with an inoperable brain tumour in February 2013. He died seven months later. Since then, Maureen has publicly advocated for the right of terminally ill Canadians to choose an assisted death.

DR. DOUG COCHRANE

British Columbia

Patient Safety and Quality Officer for BC and Chair of the BC Patient Safety and Quality Council

Dr. Doug Cochrane is the Patient Safety and Quality Officer for BC and Chair of the BC Patient Safety and Quality Council. He is also a Professor at the University of British Columbia in Neurosurgery.

The BC Patient Safety & Quality Council has adopted a definition of quality that spans health care. Care at the end-of-life is one sector in which the Council advocates, supporting end-of-life planning, palliation where needed and primary care and home services.

Given the nature of Dr Cochrane's clinical practice as a neurosurgeon, meeting and care for and with families and patients facing end-of-life are common. Arising from this experience, Dr Cochrane recognizes the importance of how a disease process and treatments are affected by the context of the patient and family. Care is not only providing treatments of a disease process or the minimization disability, but when applicable, allaying suffering and respecting patient family autonomy. He has written on the Groningen Protocol.

DR. JOCELYN DOWNIE

Nova Scotia

Professor in the Faculties of Law and Medicine at Dalhousie University

Jocelyn Downie is a Professor in the Faculties of Law and Medicine at Dalhousie University. She is a Fellow of the Pierre Elliott Trudeau Foundation as well as a Fellow of the Royal Society of Canada and the Canadian Academy of Health Sciences. She received an honours BA and MA in Philosophy from Queen's University, an MLitt in Philosophy from the University of Cambridge, an LLB from the University of Toronto, and an LLM and Doctorate in Law from the University of Michigan. After graduation from law school, she clerked for (former) Chief Justice Antonio Lamer at the Supreme Court of Canada.

Specifically in the area of assisted death, Downie has published numerous books and articles including *Dying Justice: A Case for Decriminalizing Euthanasia and Assisted Suicide in Canada*, winner of the 2005 Abbyann Lynch Medal in Bioethics from the Royal Society of Canada. Downie was also a Special Advisor to the Senate of Canada Committee on Euthanasia and Assisted Suicide, a member on the Royal Society of Canada's Expert Panel on End-of-Life Decision Making, and a member of the pro bono legal team in *Carter*.

RUTH GOBA

Ontario

Human Rights Lawyer & Commissioner, Ontario Human Rights Commission

From February to October 2015, Ruth served as the Interim Chief Commissioner of the Ontario Human Rights Commission. She was first appointed as a Commissioner by the Government of Ontario in 2006 and continues in that capacity today.

Ruth received her B.A. (Honours) from the University of Toronto (1996) and her LLB from Osgoode Hall Law School (2000). She was called to the Bar in 2002.

After graduating from law school, Ruth worked in India for an international NGO on women's equality rights and with the United Nations Special Rapporteur on the Right to Adequate Housing. She has appeared before the UN Committee on Economic, Social and Cultural Rights in Geneva, Switzerland and has advocated at the UN Human Settlement Programme (UN HABITAT) in Nairobi, Kenya. In 2001, she completed her articles of clerkship at ARCH Disability Law Centre and then worked for the Centre for Equality Rights in Accommodation (CERA), a human rights organization that works domestically and internationally for equality in housing and for the realization of economic and social rights. From 2007 to 2009, she was the Executive Director of CERA. In private human rights law practice, Ruth's focus was on gender, disability and racial discrimination in employment and education.

Ruth has taught Disability Studies at Ryerson University, served on the Board of the National Association of Women in the Law and on LEAF's Legal Committee.

DR. NUALA KENNY

Nova Scotia

Professor Emeritus Dalhousie University Department of Bioethics

Dr. Nuala Patricia Kenny received her BA, Magna Cum Laude, from Mount Saint Vincent University in 1967, an MD from Dalhousie in 1972 and became a Fellow of the Royal College of Physician and Surgeons of Canada in Paediatrics in 1975. In 1993 she completed a Bioethics Fellowship at the Kennedy Institute of Ethics at Georgetown University.

After a distinguished career in pediatrics at the Hospital for Sick Children, Toronto and Queen's University, Kingston, she returned to Dalhousie as Professor and Head of the Department of Pediatrics and Chief of Pediatrics at the Izaak Walton Killam Hospital in 1988. In 1995, she became the founding Chair of the Department of Bioethics of the Dalhousie Faculty of Medicine.

From February to November 1999, Dr. Kenny was seconded as Deputy Minister of Health for the Province of Nova Scotia. From 2009-2014 she served as Ethics and Health Policy Advisor to the Catholic Health Alliance of Canada.

Past President of both the Canadian Pediatric Society and the Canadian Bioethics Society and author of over one hundred and eighty papers and three books, Dr. Kenny was appointed an Officer of the Order of Canada for her contributions to child health and medical education in 1999. She has received the Lifetime Achievement Award of the Canadian Bioethics Society, the Distinguished Service Award from the Canadian Health Association, the Catholic Health Association of Canada's Performance Citation Award, the Canadian Medical Association's Marsden Ethics Award and the Dalhousie University Alumni Achievement Award.

She has received six Honorary Doctorates for her work in child health, medical education and bioethics from Mount Saint Vincent University, Halifax, the Atlantic School of Theology, Halifax, Regis College,

Toronto, St. Francis Xavier University Antigonish, The College of New Rochelle, New York and Saint Paul's University, Ottawa.

PROFESSOR ARTHUR SCHAFER

Manitoba

Director of the Centre for Professional and Applied Ethics at the University of Manitoba

Arthur Schafer is Director of the Centre for Professional and Applied Ethics, at the University of Manitoba. He is also a Full Professor in the Department of Philosophy and an Ethics Consultant for the Department of Paediatrics and Child Health at the Health Sciences Centre in Winnipeg. For 10 years he was Head of the Section of Bio-Medical Ethics in the Faculty of Medicine of the University of Manitoba. He has also served as Visiting Scholar at Green College, Oxford.

Schafer has received a number of awards and honours. He is a Canadian Commonwealth Scholar, Honorary Woodrow Wilson Scholar, and a Canada Council Fellow. At the University of Manitoba he has received the Stanton Teaching Excellence Award, the Campbell Award for University Outreach, and the University Teaching Service Award for Teaching Excellence. He has published widely in the fields of moral, social, and political philosophy. He is author of *The Buck Stops Here: Reflections on moral responsibility, democratic accountability and military values*, and co-editor of *Ethics and Animal Experimentation*. He has published over 90 scholarly articles and book chapters, covering a wide range of topics, with a special focus on issues in professional and bio-medical ethics, business and environmental ethics. Schafer is National Research Associate of the Canadian Centre for Policy Alternatives, which has published two of his reports. He has made several hundred conference presentations in Canada and abroad, and has written dozens of newspaper articles for *The Globe and Mail*, *The Toronto Star*, *The Winnipeg Free Press*, *The Medical Post*, and *The Sunday Times (London)*.

DR. TREVOR THEMAN

Alberta

Registrar of the College of Physicians and Surgeons of Alberta

Dr. Trevor Theman is the Registrar of the College of Physicians and Surgeons of Alberta (CPSA), the regulatory body of the practice of medicine in Alberta. The CPSA provides direction to members on ethics and other issues such as physician-assisted dying. Dr. Theman is the former president of the Federation of Medical Regulatory Authorities of Canada (FMRAC). FMRAC is the national voice of the medical regulatory authorities in Canada.

DR. KARIMA VELJI

Ontario

President of the Canadian Nurses Association and Integrated Vice President, Mental Health Services, for London Health Science Centre and St. Joseph's Health Care London

Dr. Karima Velji is the 46th President of the Canadian Nurses Association. She is the integrated vice-president for mental health at London Health Sciences Centre and St. Joseph's Health Care. Most recently, Dr. Velji was the chief operating officer and chief nursing executive at Baycrest, a global leader in innovations on aging and brain health, and was vice-president of patient care and chief nursing executive at the Toronto Rehabilitation Institute, now a program in the University Health Network.

She has led the development of patient experience projects for the Ministry of Health and Long-Term Care and Local Health Integration Networks in Ontario. She has also led external reviews of several organizations including the Sunnybrook Health Sciences Centre, Bruyère Continuing Care and Schlegel Villages. In addition, she is board vice-chair with Accreditation Canada.

Dr. Velji has been a senior leader of palliative care services within her organizational leadership roles. She has clinical background as an oncology and palliative care nurse.

Appendix 2 – List of Stakeholders Consulted

Written Stakeholder Submissions Received

- ARCH Disability Law Centre
- Association for Reformed Political Action Canada
- Association of Registered Nurses of Newfoundland and Labrador
- BC Civil Liberties Association
- Canadian Association for Community Living
- Canadian Bar Association
- Canadian Civil Liberties Association
- Canadian Council of Registered Nurse Regulators
- Canadian Federation of Catholic Physicians' Societies
- Canadian HIV/AIDS Legal Network
- Canadian Hospice Palliative Care Association
- Canadian Medical Association
- Canadian Medical Protective Association (CMPA)
- Canadian Nurses Association
- Canadian Partnership Against Cancer
- Canadian Society of Hospital Pharmacists
- Canadian Society of Palliative Care Physicians
- Canadian Society of Respiratory Therapists
- Canadian Unitarian Council
- Canadian Working Group on HIV and Rehabilitation
- Catholic Civil Rights League
- Catholic Health Alliance of Canada
- Catholic Health Corporation of Manitoba
- Centre for Israel and Jewish Affairs
- Centres for Addiction and Mental Health
- Christian Legal Fellowship
- Citizens with Disabilities Ontario
- College of Family Physicians Canada
- College of Pharmacists of Manitoba
- College of Physicians and Surgeons of Manitoba
- College of Physicians and Surgeons of Ontario
- College of Registered Nurses of Manitoba
- College of Registered Nurses of Nova Scotia
- Council of Canadians with Disabilities
- Covenant Health
- Doctors NS
- Dying With Dignity
- Evangelical Fellowship of Canada
- Health Quality Council of Alberta
- HIV & AIDS Legal Clinic Ontario
- Hospice Palliative Care Ontario

- Human Rights Watch
- Manitoba Multi-faith Council
- Mental Health Commission of Canada
- National Association of Pharmacy Regulatory Authorities
- Northern Health Region
- NWT Medical Association
- Ontario Hospital Association
- Ontario Medical Association
- Palliative Manitoba
- Patients Canada
- PEI College of Physicians and Surgeons
- Physicians' Alliance against Euthanasia
- Protection of Conscience Project
- Public Prosecutions New Brunswick
- Qikiqtani Medical Association
- Saskatchewan Association of Social Workers (SASW)
- Winnipeg Regional Health Authority

In-Person/Teleconference Consultations

- Association of Faculties of Medicine of Canada
- BC Civil Liberties Association
- Canadian Association for Community Living
- Canadian Association of Retired Persons
- Canadian Cancer Society
- Canadian Civil Liberties Association
- Canadian Council of Registered Nurse Regulators
- Canadian Hospice Palliative Care Association
- Canadian Life and Health Insurance Association
- Canadian Medical Association
- Canadian Medical Protective Association
- Canadian Psychiatric Association
- Canadian Society of Palliative Care Physicians
- Council of Canadians with Disabilities
- Council of Pharmacy Registrars of Canada
- Covenant Health
- Dying With Dignity
- Ontario Hospital Association
- David Zussman, Jarislowsky Chair on Management in the Public Sector, University of Ottawa
- Dr. James Downar, palliative care physician
- Dr. Eric Wasylenko, palliative care physician
- Mr. David Wright, palliative care nurse
- Dr. Paul Henteleff, palliative care physician
- Dr. Gary Rodin, psychosocial oncology and palliative care physician

Appendix 3 – Recommendations That Should Be Implemented Through Provincial/Territorial Legislation

Recommendation 3: All provinces and territories should ensure access to physician-assisted dying, including both physician-administered and self-administered physician-assisted dying. The recommendations set out in Appendix 3 should be implemented through provincial/territorial legislation.

Recommendation 4: Provinces and territories should require all regional health authorities to have an effective publicly-funded care coordination system in place to ensure patient access to physician-assisted dying.

Recommendation 5: Provincial/territorial governments should publicly fund physician-assisted dying.

Recommendation 9: Provinces and territories should ensure that health professionals are protected from liability for acts or omissions done in good faith and without negligence in providing or intending to provide physician-assisted dying.

Recommendation 11: Provinces and territories should establish requirements to ensure a patient declaration form is completed and witnessed by an independent party.

Recommendation 14: Substitute decision makers should not be given the legal authority to consent to/authorize physician-assisted dying on behalf of an incompetent patient.

Recommendation 15: Provinces and territories should create a patient information form that gathers demographic data on those requesting physician-assisted dying and the reasons for the request.

Recommendation 16: To support case review and system oversight, data should be collected from the patient's initial request to the time of signing the death certificate and/or the completion of that patient's request (e.g., patient withdrawal of request, physician denial of requests).

Recommendation 18: "Grievous and irremediable medical condition" should be defined as a very severe or serious illness, disease or disability that cannot be alleviated by any means acceptable to the patient. Specific medical conditions that qualify as "grievous and irremediable" should not be delineated in legislation or regulation.

Recommendation 21: Access to physician-assisted dying should be available only to those who are eligible for publicly-funded health services.

Recommendation 22: Two physicians must assess the patient to ensure that all criteria are met.

Recommendation 29: Following the provision of physician-assisted dying, physicians should file a report with a Review Committee to support the review of each individual case. This review will ensure transparency and confirm compliance with existing policies and procedures.

Recommendation 30: Physician-assisted dying should be listed as the manner of death on medical certificates of death across all provinces and territories and the name of the medical condition that qualified the patient for physician-assisted dying should be listed as the cause of death.

Recommendation 31: Conscientiously objecting health care providers should be required to inform patients of all end-of-life options, including physician-assisted dying, regardless of their personal beliefs. (**See Note Below*)

Recommendation 32: Conscientiously objecting health care providers should be required to appropriately inform their patients of the fact and implications of their conscientious objection to physician-assisted dying. Any ongoing treatment of the patient must be provided in a non-discriminatory manner. (**See Note Below*)

Recommendation 33: Conscientiously objecting health care providers should be required to either provide a referral or a direct transfer of care to another health care provider or to contact a third party and transfer the patient's records through the system described in Recommendation 4. (**See Note Below*)

Recommendation 34: All institutions should be required to inform patients/residents of any institutional position on physician-assisted dying, including any and all limits on its provision.

Recommendation 35: Provinces and territories should prohibit any requirement by institutions that patients give up the right to access physician-assisted dying as a condition of admission.

Recommendation 36: Provinces and territories should prohibit any requirement by institutions that physicians refrain from the provision of physician-assisted dying external to the non-participating institution. In addition, employment conditions or privileges should not be negatively impacted in any way.

Recommendation 37: Non faith-based institutions, whether publicly- or privately-funded, must not prevent physician-assisted dying from being provided at their facilities.

Recommendation 38: Faith-based institutions must either allow physician-assisted dying within the institution or make arrangements for the safe and timely transfer of the patient to a non-objecting institution for assessment and potentially, provision of physician-assisted dying. The duty of care must be continuous and non-discriminatory.

Recommendation 39: Provincial and territorial governments should establish Review Committee systems to review all cases of physician-assisted dying after the provision of the service to ensure compliance with relevant federal/provincial/territorial legislation and health professional regulatory standards, transparency and accountability.

Note: All members of the Advisory Group agreed with the duties set out in these recommendations, but one member believes that they should be implemented through professional regulatory authority standards rather than legislation.

Appendix 4 – Patient Pathway

