

SELECT COMMITTEE

Dying With Dignity

Consultation document

May 2010



This year the Parliament of Québec will host a major societal debate. Join us!



A place for every citizen

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A Word from the Committee Chair



To die peacefully, surrounded by family and friends, or to simply slip away in one's sleep—such is the way many people would like their life to end. Unfortunately, the dying process can be slow or involve a lengthy decline. What is our society's answer to the suffering experienced by some people at the end of life or with a degenerative illness? How should we respond to demands for assisted death? In other words, how do we ensure that people die with dignity?

We posed this question to experts in a number of disciplines, particularly medicine, law, ethics, sociology, and psychology. They enlightened us on the various issues surrounding the question of dying with dignity. The quality of their briefs and presentations at the public hearings in February and March 2010 reflect a desire to lay a solid foundation for debate. We sincerely thank them. We also wish to stress the dedication of the people who accompany palliative care patients right up to their last breath, a reality we were able to glimpse during the hearings.

This document is the fruit of the reflections and questions that arose during our discussions with these experts. We hope it will serve as a guide and stimulate real debate. We now turn to you, the public, because beyond the legal and medical aspects, this is an issue that arises from the human condition and touches each person at the level of their most basic values. In order to hear from the greatest number of people possible, the MNAs will travel to a number of regions in Québec to hold hearings and meet with those who are interested in this issue.

We would like this to be a very open debate and are committed to allowing all points of view to be expressed. We believe that Québec can hold this debate in a serene atmosphere that allows each and everyone to express a point of view while respecting the opinions of others.

This year the Parliament of Québec will host a major societal debate. Join us!

A handwritten signature in black ink that reads "Geoffrey Kelley". The signature is written in a cursive, flowing style.

Geoffrey Kelley
MNA for Jacques-Cartier and Chair of the
Select Committee on Dying with Dignity

A Word from the Vice Chair



The debate on euthanasia and assisted suicide is something we can no longer avoid. Although it has been ongoing in Québec for some thirty years, it again came to the fore in Québec last fall. The discussion paper released by Québec Collège des médecins, polls conducted by Fédération des médecins spécialistes du Québec and Fédération des médecins omnipraticiens du Québec, as well as a poll of the Québec population have demonstrated a substantial level of support for medically assisted death under certain circumstances. This is in addition to the demands of a number of associations for a broad debate on the subject, as well as the periodic news reports on cases where members of the public have helped a loved one to die or people with a serious illness claim the right to assisted death.

It is also clear that the National Assembly must also turn its attention to this issue. MNAs have a responsibility to focus on major societal debates that are ongoing in the population. It is in fact one of their crucial functions as elected representatives. We must also ensure that these discussions are conducted responsibly and under ideal conditions in order to foster calm, respectful debate.

On December 4, 2009, the National Assembly of Québec unanimously adopted a motion to establish a select committee to study the issue of dying with dignity. We deliberately chose to avoid limiting the discussion to euthanasia, although this topic is central. We consider that the debate should be conducted on the broader context of end of life so that a number of issues can be discussed.

We believe that Quebecers are ready to hold this important societal debate and to join together in reflecting on this issue, one that is receiving more and more attention here at home as well as in many other countries. The various opinion polls that have been conducted in recent years, and that indicate a certain trend, are valuable. However, they cannot replace a broad general consultation that allows all those who wish to voice their opinion on this issue in detail.

We are aware of the difficulty of discussing this delicate subject, but we are happy to take up this challenge along with all Quebecers who decide to join us in reflecting on how we can ensure everyone may die with dignity. Our sole guide will at all times be the wellbeing of and respect for others in all their complexity in life, at the end of life, and in death.

A handwritten signature in black ink that reads "Véronique Hivon". The signature is fluid and cursive.

Véronique Hivon
MNA for Joliette and Vice Chair of the
Select Committee on Dying with Dignity

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Stéphanie Vallée (Gatineau)

Committee Clerk

Anik Laplante

Research and writing

Hélène Bergeron, Research Department,
Library of the National Assembly
David Boucher, Coordinator, Research Department,
Library of the National Assembly

Contributors

Marie-Claude Côté, Ethics Advisor, Commission
de l'éthique de la science et de la technologie
Dr. François Desbiens (writing of scenarios)
Robert Jolicoeur, Research Department,
Library of the National Assembly

Graphic Designer

Manon Paré, Communications Directorate

Writing assistant

Danielle Simard, Research Department,
Library of the National Assembly

Administrative Officer

Claire Vigneault, Committees Secretariat Directorate

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Québec (Québec) G1A 1A3

For more information on the work of the Select Committee
on Dying with Dignity, please contact Anik Laplante,
Committee Clerk, at the address above or at :

Telephone: 418-643-2722
Fax: 418-643-0248
Email: csmd@ssnat.qc.ca

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Dr. François Desbiens
Hubert Doucet
Jocelyn Downie
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Fédération des médecins spécialistes du Québec
Dr. Jana Havrankova
Bernard Keating
Dr. Bernard Lapointe
Dr. Michel L'Heureux and Louis-André Richard
Dr. Hubert Marcoux
Isabelle Marcoux
Joane Martel
Danielle Minguy
Brian L. Mishara
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To read the briefs or view
the expert testimony,
visit the National Assembly
of Québec website:

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INTRODUCTION

The debate on the issue of dying with dignity resurfaces periodically in the news. It took on even greater importance last fall following statements from members of the public and various experts, and the release of a number of opinion polls conducted by Fédération des médecins spécialistes du Québec, Fédération des médecins omnipraticiens du Québec, and Angus Reid-*La Presse* as well as the report by Québec Collège des médecins on the subject. A number of associations also took positions or raised questions. Québec MNAs seized the opportunity to launch a broad public consultation, judging that the time had come to invite you to think collectively about this issue.

A number of events have prepared us for such a debate. Nancy B's case received extensive media coverage in 1992. Suffering from a degenerative illness with no hope for a cure, this young woman requested that the respirator keeping her alive be unplugged. A Québec Superior Court judge granted her request. The reform of the Civil Code of Québec reaffirmed the need to obtain the patient's free and informed consent before administering any treatment and the patient's right to refuse care. It also enshrined the principles of autonomy, inviolability, and integrity of the individual. In 1993, Sue Rodriguez's struggle also touched us. She too had developed an incurable degenerative illness that prevented her from ending her life herself. Ms. Rodriguez made a public request for assisted suicide, but it was rejected by a close, five-four decision by judges of the Supreme Court of Canada.

Some believe that our attitudes toward death have changed in recent decades. Discoveries in the fields of medicine and pharmacology have led to a certain medicalization of death. Thanks to these advances, better living conditions, and longer life expectancy, we die at an older age. However, dying older can mean having illnesses that gradually lead to a loss of autonomy and poor quality of life. Aging can lead to profound solitude, both physical and emotional, which also is a major obstacle to quality of life. We should also remember that death, serious illnesses (cancer, degenerative illnesses), and certain physical disabilities also affect infants, children, young adults, and parents in the prime of life.

The subject of dying with dignity sparks intense debate, particularly concerning critical issues such as legalizing euthanasia and assisted suicide, but its scope is broader. Therapeutic obstinacy, the refusal or withdrawal of treatment, living wills, palliative care, and sedation: this short list gives an idea of the subject's breadth. The values of dignity, individual autonomy, compassion, and respect for the sacredness of life clash, and we sometimes must question our deepest convictions. The Select Committee on Dying with Dignity invites you to take part in this consultation so we can reflect together on actions that could be proposed.

WHAT THE WORDS MEAN

The Select Committee on Dying with Dignity will refer to the following definitions to make sure that everyone has a shared understanding of the terms related to the issue of dying with dignity¹.

Therapeutic obstinacy	Use of aggressive treatment to prolong the life of a patient in the terminal stages of an illness, with no real hope of improving his or her condition.
Capacity to consent to care	A person's capacity to understand the nature of the illness for which treatment is proposed, the nature and purpose of the treatment, and the risks and benefits of receiving or not receiving the treatment.
Cessation of treatment	Stopping of treatments that have the potential to prolong life.
Euthanasia²	An act that consists of deliberately causing the death of another person to put an end to that person's suffering.
Refusal of treatment	Refusal to receive treatment that has the potential to sustain a person's life.
Palliative sedation	Administration of medication to relieve pain by rendering a person unconscious.
Terminal sedation	Continuous administration of medication to relieve suffering by rendering a person unconscious until he or she dies.

¹ The definitions are largely based on the following works: École du Barreau, "Les droits de la personnalité", in *Personnes, famille et successions*, Chap. IV, Éditions Yvon Blais, p. 63. Collection de droit 2009–2010; Ghislaine Cleret de Langavant, *Bioéthique : méthode et complexité*, Sainte-Foy, Presses de l'Université du Québec, 2001, pp. 194–195; The Special Senate Committee on Euthanasia and Assisted Suicide, *Of Life and Death – Final Report*, Canada, June 1995, Chap. II; Yvon Kenis, "Acharnement thérapeutique", in *Nouvelle encyclopédie de bioéthique*, Gilbert Hottois and Jean-Noël Missa (eds.), Brussels, De Boeck University, 2001, p. 35; Health Canada, *Suicide in Canada: Update of the Report of the Task Force on Suicide in Canada*, Canada, 1994.

² The qualifiers "voluntary", "involuntary", "nonvoluntary", "active", "passive", "direct", and "indirect" are not defined because they tend to lead to confusion rather than greater clarity, and their use is out of date.

Palliative care	Multidisciplinary care designed to relieve suffering (whether physical or psychological ³) rather than cure, and whose objective is the patient's comfort.
Assisted suicide ⁴	The act of helping someone commit suicide by providing the means or the information on how to proceed, or both.
Living will ⁵	Instructions that a capable person gives, in writing or otherwise, concerning the decisions to be made regarding care in the event that the person is no longer able to make these decisions him or herself.

WHAT THE LAW SAYS⁶

The Criminal Code of Canada stipulates that euthanasia and assisted suicide are crimes⁷. However, it is up to the provinces to enforce criminal law. The Attorney General of each province is therefore responsible for deciding whether to lay charges and undertake criminal and penal prosecution. It should be noted that, for some twenty years, the sentences handed down by Canadian courts in cases of euthanasia and assisted suicide have been light if not symbolic.

The Canadian and Québec charters affirm certain values, including respect for the right to human dignity and integrity. Dignity refers to one's value as a person and the respect one is due, while integrity applies to one's physical and psychological protection.

The health sector is under Québec's jurisdiction. The Act respecting health services and social services and especially the Québec Code of ethics of physicians and Code of ethics of nurses guide the administration of healthcare. Moreover, the Civil Code of Québec provides a framework for, among other things, the issue of consent to care. It deals with adults who are capable⁸ of giving consent for themselves, those who are not, and minors.

³ By psychological suffering, the Committee also means moral, spiritual, and existential suffering. This latter adjective refers here to the meaning an individual gives to his or her existence at the end of life.

⁴ The term "suicide assistance" is also used.

⁵ Other terms are used, including "advance directive", "mandate given in anticipation of incapacity", and "biological will".

⁶ Appendix I provides more details on this subject.

⁷ On April 21, 2010, Bill C-384 proposing to amend the Criminal Code to legalize euthanasia and assisted suicide under certain conditions was rejected in the House of Commons by a vote of 228 to 59.

⁸ A capable person is someone with the ability to understand the nature of his or her illness and the proposed treatment, the nature and objective of the treatment, and the risks and benefits of the treatment whether he or she receives it or not.

The basic principle is that no person can undergo care without his or her consent, except in emergency situations. This consent must be free and informed, which means that the person must not feel any pressure in making his or her decision. In addition, the person must obtain all necessary information relating to the care he or she will be given, including the nature and objective of the care, the associated risks and their effects, and the consequences of refusing or ceasing treatment.

Accordingly, the will of an adult with the capacity to consent must be respected, principally by virtue of his or her right to autonomy. Indeed, the Civil Code recognizes that all people have the right to make decisions that affect them. This rule applies even if refusal or cessation of treatment leads to death.

Ms. Pigeon's Decision

Ms. Pigeon is 56 years old. She has just learned she has advanced ovarian cancer, which has metastasized to the stomach. Her doctor tells her she must undergo chemotherapy, then major abdominal surgery, and, possibly, a second course of chemotherapy. These treatments will be lengthy and will cause significant side effects. If Ms. Pigeon agrees to these treatments, she is estimated to have a 30% chance of surviving five more years. After careful consideration, she decides to refuse the treatments. She dies six months later.

The law allows a person to *refuse* treatment even if the decision may lead to his or her death.



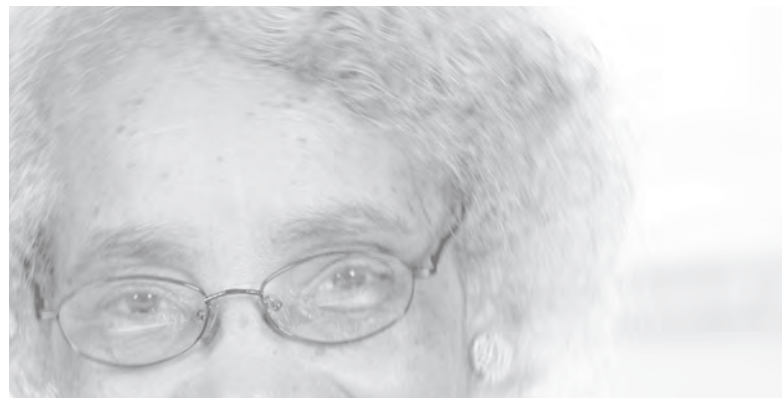
Ms. Dieudonné's Family's Decision

Ms. Dieudonné is 80 years old. She suffers from diabetes, which has led to the amputation of her right leg and a chronic obstructive pulmonary disease that makes her dependent on home oxygen treatment. Ms. Dieudonné is found unconscious and brought to the emergency room. She is resuscitated and intubated. It becomes clear that she has just suffered a major stroke and that she has an intracerebral hemorrhage. The doctor explains to her family that she is in a deep coma and that it is highly unlikely she will recover. After reflection, and in agreement with the doctor, Ms. Dieudonné's respirator is removed. She dies surrounded by loved ones 48 hours later.

The law allows a person to cease treatment even if it leads to his or her death. The law also allows such a decision to be made by the family of a person who is not capable of deciding for him or herself.

When individuals are not capable of giving consent or when minors are not recognized as being fully capable of making decisions about the care they receive, their representative (parent or guardian, for example) can act in their place.

The Civil Code provides the means (mandate given in anticipation of incapacity and living will) for adults to express their wishes regarding end-of-life care they would or would not want to receive in the event they become unable to make these wishes clear or are no longer able to make decisions for themselves. However, making such wishes known to one's doctor remains a challenge. Living wills, unlike mandates given in anticipation of incapacity, are not expressly mentioned in the Civil Code. Yet they do follow the letter of Section 12.



END-OF-LIFE CARE

Palliative Care

In the final stages of disease, suffering is often intense. In response, palliative care emerged some forty years ago as an approach to ensuring patient relief and comfort.

Palliative care is intended for people of all ages suffering from incurable disease, as well as for their loved ones. Ten or so years ago, palliative care resources in Québec were less developed than in the rest of Canada and were not widely available in the province. Today, the situation has improved, but palliative care is still available almost exclusively to those with terminal cancer.

A number of health and social service centers provide in-home palliative care to adults and, to a much lesser extent, children. This care is free, but the sick and their loved ones must pay for medication and equipment. When they cannot afford the expense, people must sometimes leave their home despite their wishes to end their days there.

Although an increasing number of hospital beds are designated for palliative care, a shortage remains—even though most people die in a hospital. Four university hospitals provide specialized pediatric palliative care.

In residential and long term care centers, the number of palliative care beds is insufficient. Palliative care hospices that receive sick people in terminal phase, particularly those suffering from cancer, are few in number and are unable to meet the population's needs.

Administering palliative care is complex. It is difficult to support a sick person and their loved ones, provide care to maintain the person's physical and psychological comfort, and administer medication to improve quality of life as much as possible. For this reason, palliative caregivers working with these patients require relevant knowledge and ongoing professional development. There is a notable lack of training in the field, and this applies to healthcare workers as a whole.

Palliative and Terminal Sedation

Palliative care is given within a holistic approach. It aims to alleviate not only physical pain but also psychological suffering. However, even with high quality palliative care, some intolerable pain and suffering cannot be relieved. In certain cases, palliative or terminal sedation may be an option.

Relieving Suffering at the Risk of Shortening Life

Mr. Labonté is a 58-year-old man who was diagnosed with very advanced lung cancer one year ago. He is in the terminal phase and is expected to live around one week. Even with morphine, he is agitated and suffering. He refuses to eat and hardly drinks. He repeatedly asks for help to end his suffering. As a last resort, Mr. Labonté is offered a general anesthetic similar to that used during surgery. This anesthetic, called "terminal sedation", will be administered until the time of death. Mr. Labonté understands that this will deprive him of his final moments of lucidity, but not wanting to suffer any longer, he decides that it is the only possible option. He says goodbye to his loved ones and is put to sleep. He dies four days later.

Sedation is used to alleviate suffering that is impossible to relieve otherwise, even if it may shorten the person's life.

Palliative sedation is a treatment that consists of giving medication to sick people to alleviate difficult-to-control pain by rendering them unconscious. It is possible to interrupt this sedation and reevaluate the situation with the person. Sometimes, administration of the pain relieving drug may hasten the time of death.

Terminal sedation is the continuous delivery of medication to sick people to render them unconscious until death, after all comfort care has failed. In certain cases, with family consent, terminal sedation may be administered to a person who is not capable.



EUTHANASIA AND ASSISTED SUICIDE

Euthanasia is a deliberate intervention to cause another person’s death in order to end suffering. In countries where it is legal, a doctor administers a lethal dose of medication.

Assisted suicide consists of helping someone to voluntarily commit suicide by providing the means or the information on how to proceed, or both. In countries where it is legal, a doctor prescribes a lethal dose of medication. The person is then free to take it, at the time he or she chooses. Assisted suicide is different than euthanasia because the person brings about his or her own death.

International Experiences

In Canada, as in most countries, euthanasia and assisted suicide are considered crimes. However, certain States have legalized one or both of these practices. The following table shows the States that have passed legislation in this regard.

States That Have Legalized Euthanasia or Assisted Suicide⁹

STATES	YEAR (Effective date)	EUTHANASIA	ASSISTED SUICIDE
Belgium	2002	X	
U.S.			
Oregon	1997		X
Washington	2009		X
Luxembourg	2009	X	X
Netherlands	2002	X	X

Switzerland’s penal code includes a provision that prohibits suicide assistance unless it is provided without selfish reasons. Assisted suicide is thus decriminalized if it is shown that the person assisting does not directly or indirectly benefit. In 1993, in the wake of the Sue Rodriguez affair, the Attorney General of **British Columbia** issued guidelines with respect to the charges brought against those who, out of compassion, help a sick person die. Under these guidelines, the Crown prosecutor approves the proceedings only when conviction is likely and it is in the public interest. In a similar vein, the Attorney General for **England and Wales** issued new guidelines in February 2010 to help determine which cases of assisted suicide should be taken to court.

⁹ Appendix II presents more details on legislative provisions and certain conditions that apply to patients and physicians.

Although each of the laws adopted by these States has its particularities, requests for euthanasia or assisted suicide must meet certain criteria, the most common being the following:

- The person is an adult and capable (with the exception of the Netherlands).
- The person is suffering from a serious and incurable disease.
- The person's pain and suffering are acute and, in his or her opinion, cannot be relieved.
- The person is informed and makes his or her request freely.
- The person verbally repeats his or her requests.
- The person makes a request in writing.
- Physicians have a role to play, from prescribing lethal medication to administering it.
- Two medical evaluations are required: one by the attending physician, the other by a physician who is independent of the sick person and the attending physician and competent with respect to the disease in question.
- Unless the person is opposed, the attending physician consults the other professionals on the regular care team.
- Unless the person is opposed, the attending physician must inform loved ones of the request.
- A wait time exists between the written request and the act committed by the physician.

Arguments Against and For the Legalization of Euthanasia and Assisted Suicide

For a number of years, the debate surrounding the legalization of euthanasia and assisted suicide has elicited arguments against and for both practices:

Arguments against legalization

Opponents of the legalization of assisted suicide are concerned about misapplication of the law. For example, they fear that the criteria to be met for euthanasia or assisted suicide requests would not always be respected or would be expanded with time. This argument is often presented in terms of a "slippery slope". Moreover, some believe that legalizing these practices would deny the sanctity of life and risk trivializing the act of ending life. They believe that although individual will may be an important value to respect at the end of life, societal values must also be reaffirmed. They point out that all human beings possess unique and inalienable dignity, regardless of their condition.

Those who reject euthanasia and assisted suicide legislation are also concerned about the vulnerability of people at the end of life. They believe that sick people might ask for help in dying because they fear becoming a burden to their loved ones or society, which opponents find unacceptable. They question whether it is really possible to make free and informed decisions in an end-of-life context.

Opponents believe that the ties of trust between patient and physician could be shaken. They fear that if a physician can carry out euthanasia, he or she will not do everything possible to keep the patient alive.

In countries where assisted suicide is legal, it is seldom requested. Those against legislation question why it is worth changing laws and running the risk of misapplication to satisfy the wishes of a minority.

Opponents believe there are other means of helping people at end of life, notably through improvement of the resources at residential and long term care centers and through palliative care services. Furthermore, they think that the legalization of euthanasia and assisted suicide could lead to a decrease in palliative care services and research investment in the field.

Arguments for legalization

Those who call for the legalization of euthanasia and assisted suicide generally do so in the name of human autonomy and dignity. They believe evaluating quality of life is ultimately a personal matter and that individuals have the right to decide when and how they will die if they consider their life conditions unbearable. They find it acceptable to end the suffering of a person whose agony persists, upon the person's request, as an act of compassion and human solidarity.

According to those who advocate legalization, a legal framework for euthanasia and assisted suicide would prevent illegal practices and the risk of abuse. Moreover, given that the court sentences handed down in cases of euthanasia and assisted suicide are often light if not symbolic, amending the legislation would align laws more closely with the reality of legal practice.

Many believe that legalizing assisted suicide could reassure those who fear they would be kept alive when they are tired of suffering. They ask why euthanasia and assisted suicide should be criminalized while cessation and refusal of treatment is accepted even though it could lead to death. For similar reasons, health professionals are far from consensus on terminal sedation. Some equate it with euthanasia, since the result—death—is known. Others consider it acceptable to end the physical and psychological suffering of a dying person when all comfort care has failed, since the intent is to provide relief and not to cause death. Still others recommend it only in the presence of physical pain and when all treatments have failed.

A common argument is that access to palliative care is limited. Another consideration is that those who are dying are not always completely relieved. Some believe that the issue needs to be examined from a broader perspective: for example, regulated euthanasia would be part of appropriate end-of-life care for the same reasons as palliative care.

Proponents of the legalization of euthanasia and assisted suicide do not believe that palliative care and aid in dying contradict one another. Far from it, since access to palliative care and the training of health professionals in this area has improved in countries where euthanasia or assisted suicide is legal.

It should be noted that advocates of aid in dying are not necessarily in favor of the parallel adoption of euthanasia and assisted suicide legislation, due to their distinct nature. Healthcare workers show a degree of openness to euthanasia, but are much more reserved with regard to assisted suicide. For many, each of these practices merits its own debate, as they are fundamentally different. This is why the Committee chose to first pose questions on euthanasia, then on assisted suicide, and subsequently deal with the two issues together.

This document is a guide on the issue of dying with dignity. It does not claim to exhaustively cover all aspects of the issue. Accordingly, the Committee invites you to reflect on all of the following elements or on specific ones. You may also pursue other lines of thought and share them with the MNAs and other citizens.

WHAT DO YOU THINK ABOUT EUTHANASIA?

When death is imminent

Ms. Johnson is 57 years old. Suffering from breast cancer, she has undergone surgery, radiotherapy, and chemotherapy. Three years after her diagnosis, doctors believe she is in the final stages of a terminal illness and has only a few weeks to live. Ms. Johnson is still conscious and lucid. Her condition is deteriorating rapidly. The medication to relieve her pain causes side effects: weakness, drowsiness, and constipation. Morphine, in increasingly stronger doses, makes her feel as if she is losing control. Ms. Johnson has difficulty eating and no longer has the strength to get up. She says she "hurts everywhere", experiences generalized discomfort, and is overcome by weariness. She sees no reason for living the final days ahead, knowing that her death is imminent and that her condition will only worsen. She tells her family that she would like to go. She asks the doctor to inject her with a substance that will lead to her death.

When disease results in incapacity

Mr. Leclerc is 79 years old. He is a widower with four children. He has suffered from Alzheimer's disease for a number of years. His condition has worsened and he has been admitted to a residential and long term care center (CHSLD). He has lost most of his short term memory and is disoriented: he doesn't know where he is or what day or season it is, and he no longer recognizes his family or the care team. He is incontinent, can no longer feed himself, and rarely moves. His children no longer recognize the man they love and have a hard time seeing him in such a state. When Mr. Leclerc learned of his diagnosis and the likely evolution of his disease, he confided to his children on several occasions that he did not want to end his days in such a condition. He also wrote down his wishes. For all these reasons, Mr. Leclerc's children ask the doctor to intervene in order to put an end to their father's life

The physicians attending Ms. Johnson and Mr. Leclerc cannot, by law, grant these requests.

1. Are there situations where the practice of euthanasia is justified? Do you have any experiences to share on this subject?
2. In certain situations, could euthanasia be considered part of appropriate end-of-life care?
3. Are you for or against the legalization of euthanasia, and why?
4. In the States where euthanasia has been legalized, requests for aid in dying must meet certain criteria. If euthanasia were legalized here, what criteria would be essential with regard to the following?

Who could request euthanasia?

Person's age

- Would only adults be allowed to make a request for themselves?
- Could minors also be allowed to do so in certain cases?
- Do you have any comments on this subject?

Person's capacity

- Would only capable persons be allowed to make a request?
- Would an incapable person's family be allowed to do so in certain cases?
- Would the parents of a sick child be allowed to do so in certain cases?
- Would a capable person be allowed to make an advance request in a living will, in anticipation of incapacity, to have his or her life ended in certain situations (for example, in the case of a person suffering from Alzheimer's disease)?
- Do you have any comments on this subject?

Health condition

- In what cases would euthanasia requests be taken into consideration?
- For those whose death is imminent and inevitable?
- For those in the final stages of a terminal illness?
- For those suffering from a degenerative and incapacitating disease?
- For those suffering from an incurable disease?
- For those severely disabled after an accident?
- For those with unbearable psychological suffering but whose physical pain is controlled?
- Do you have any comments on this subject?

Do you have any other criteria to propose?

Who would be allowed to practice euthanasia and where?

Who?

- Would only a doctor be allowed to practice euthanasia?
- Would other health professionals also be allowed to do so? If so, which ones?
- Do you have any comments on this subject?

Where?

- Should euthanasia be available only in hospitals?
- Could it also be practiced in residential and long term care centers?
- In palliative care hospices?
- In homes?
- Do you have any comments on this subject?

Do you have any other criteria to propose?

What procedure should be followed?

Request

- Would a verbal request be sufficient? Should a written request be required?
- In your opinion, how many written or verbal requests should be made?
- What should the wait time be between the initial request and euthanasia?
- Do you have any comments on this subject?

Doctors' opinion

- Should the doctor be required to request the opinion of one or more other doctors before practicing euthanasia?
- Do you have any comments on this subject?

Oversight and control of practice

- Who should these responsibilities be entrusted to?
- How should activities be controlled?
- Do you have any comments on this subject?

Do you have any other criteria to propose?

5. Do you think there are risks of misapplication? If so, what are these risks and how could they be avoided?
6. Some believe that legalizing euthanasia could compromise the ties of trust a patient has built with his or her doctor. How do you feel about this?

7. Some believe that prohibiting euthanasia encourages the artificial prolongation of life. What do you think?
8. Some claim that if euthanasia were legalized, there would be fewer suicides among the elderly. What do you think?
9. In your opinion, is there a significant difference between terminal sedation and euthanasia? If so, what is this difference?

WHAT DO YOU THINK ABOUT ASSISTED SUICIDE?

When a person's health condition deteriorates

Mr. Harvey is 70 years old. At age 60, he was diagnosed with multiple sclerosis that led to a progressive loss of autonomy. He had to stop driving at age 63 and needed a walker to move around at age 65. Since age 67 he has been confined to a wheelchair. He has been incontinent for one year. Mr. Harvey's suffering is increasing and he dreads the next stages of his loss of autonomy. He is lucid and has had several conversations with his family. He feels that his life is too difficult to bear any longer and asks his doctor to prescribe a drug that once ingested will lead to his death.

When an accident changes a life

Mr. Labranche is 40 years old. At age 30, he suffered a major car accident that severed his spinal cord very high up the neck. He became a paraplegic, meaning he lost the use of his arms and legs. He lives in a residential and long term care center (CHSLD). Although Mr. Labranche is dependent for all his everyday activities, he remains perfectly lucid. His partner left him in recent years. He has no children, but stays in touch with a few friends and family members. His doctor believes he could live another 20 years. After much reflection, Mr. Labranche confides in his doctor. He feels life is no longer worth living and requests aid in ending his life with a liquid medication he can suck through a straw.

The physicians attending Mr. Harvey and Mr. Labranche cannot, by law, grant these requests.

10. In your opinion, are there situations where the practice of assisted suicide is justified? Do you have any experiences to share on this subject?
11. Are you for or against the legalization of assisted suicide, and why?
12. Some believe that legalizing assisted suicide and not euthanasia could send a contradictory message with regard to efforts in the area of suicide prevention. What do you think?
13. In countries where assisted suicide has been legalized, requests for aid in dying must meet certain criteria. If assisted suicide were legalized here, what criteria would be essential with regard to the following?

Who would be allowed to request assisted suicide?

Person's age

- Would only adults be allowed to make a request for themselves?
- Could minors also be allowed to do so in certain cases?
- Do you have any comments on this subject?

Health condition

- In what cases would euthanasia requests be taken into consideration?
- For those whose death is imminent and inevitable?
- For those in the final stages of a terminal illness?
- For those suffering from a degenerative and incapacitating disease?
- For those suffering from an incurable disease?
- For those severely disabled after an accident?
- For those with unbearable psychological suffering but whose physical pain is controlled?
- Do you have any comments on this subject?

Do you have any other criteria to propose?

Who would be able to practice assisted suicide and where?

Who?

- Should the presence of a doctor be required?
- Would the presence of a different health professional be sufficient? If so, which one?
- Do you have any comments on this subject?

Where?

- Should assisted suicide be possible only in hospitals?
- In residential and long term care centers?
- In homes?
- Do you have any comments on this subject?

Do you have any other criteria to propose?

What procedure should be followed?

Request

- Would a verbal request be sufficient? Should a written request be required?
- In your opinion, how many written or verbal requests should be made?
- What should the wait time be between the initial request and the prescription for lethal medication?
- Do you have any comments on this subject?

Doctors' opinion

- Should the doctor be required to request the opinion of one or more other doctors before prescribing the medication?
- Do you have any comments on this subject?

Oversight and control of practice

- Who should these responsibilities be entrusted to?
- How should activities be controlled?
- Do you have any comments on this subject?

Do you have any other criteria to propose?

14. Do you think there are risks of misapplication? If so, what are these risks and how could they be avoided?

WHAT DO YOU THINK ABOUT AID IN DYING?

15. In Canada, aid in dying is a crime. However, the Attorney General of each province decides whether or not to undertake criminal prosecution. In the assisted suicide case of Sue Rodriguez, for example, no prosecution was undertaken. After her death, the Attorney General of British Columbia published guidelines for Crown prosecutors with respect to the charges brought against those who, out of compassion, help another person to commit suicide. Should this approach be considered by the Québec legislature?

16. For a number of years, the sentences handed down by Canadian courts with regard to aid in dying have often been light. Do you think this reflects a change in society's mindset? Should this be considered with regard to the issue of legalizing aid in dying?
17. If only euthanasia or only assisted suicide were legalized, which of these practices should be the one?
18. If aid in dying were permitted, would the possible concerns you might have about your end of life be dispelled?
19. Are people at the end of life capable of making free and informed decisions?
20. Some claim that legalizing aid in dying would help reduce anxiety among sick people. What do you think?
21. Some believe that if aid in dying were legalized, only a very small minority of sick people at end of life would request it, as is the case in the countries where legislation has been adopted. They therefore ask why legislation should be passed for this minority. What do you think?
22. Some believe that the current legislative framework does not reflect clinical reality, which leads to confusion among both healthcare workers and the population. For them, the status quo cannot continue; they believe that legislative changes are needed. What is your opinion on this subject?
23. Some believe that if palliative care services were better, fewer people would request euthanasia or assisted suicide. What do you think?

CONCLUSION

By undertaking a broad public consultation, the Select Committee on Dying with Dignity wishes to launch a key societal debate that concerns everyone. For this reason the Committee hopes that as many people as possible will contribute to its deliberations.

At the end of the consultation, the Committee hopes to formulate recommendations and submit them to the competent authorities. Is it necessary to legalize euthanasia? Is it necessary to legalize assisted suicide? Is it necessary to be concerned about misapplication? Can misapplication be prevented? How can we decide between autonomy and what some call respect for the sanctity of life? How individual wishes be reconciled with the common good? How far can we go in the name of compassion? What does dying with dignity mean? MNAs have many difficult questions to deal with.

The Committee notes that the various items submitted for reflection obviously do not cover all aspects of this topic. For this reason, you are invited to examine not only the questions raised by the Committee but also any other aspects that may help define the issues in question.

In a spirit of openness, the Committee invites you to share your experiences, knowledge, and opinions. As it seeks to determine the conduct that should be followed, the Committee needs to know the perspectives of Quebecers.

For more information,
consult the National Assembly website
for a bibliography on the subject:

assnat.qc.ca

APPENDIX 1

WHAT THE LAW SAYS: LEGISLATIVE PROVISIONS

CANADIAN AND QUÉBEC CHARTERS

The values of respect for individual autonomy, the right to integrity, and respect for human dignity are enshrined in Section 7 of the Canadian Charter of Rights and Freedoms.

Everyone has the right to life, liberty, and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

These values are also enshrined in Sections 1 and 4 of the Québec Charter of Human Rights and Freedoms.

Every human being has a right to life, and to personal security, inviolability, and freedom. He also possesses juridical personality.

Every person has a right to the safeguard of his dignity, honour, and reputation.

THE CIVIL CODE OF QUÉBEC AND CONSENT TO CARE ¹⁰

The Québec Civil Code is geared toward individual autonomy and respect for every individual's integrity and privacy. The two principles that serve as the basis of Civil Code provisions on care are set out in Sections 10 and 11.

Section 10:

Every person is inviolable and is entitled to the integrity of his person.

Except in cases provided for by law, no one may interfere with his person without his free and enlightened consent.

Section 11:

No person may be made to undergo care of any nature, whether for examination, specimen taking, removal of tissue, treatment, or any other act, except with his consent.

specimen taking, removal of tissue, treatment, or any other act, except with his consent.

¹⁰ École du Barreau, "Les droits de la personnalité", in *Personnes, famille et successions*, Chap. IV, Éditions Yvon Blais, pp. 59–66. Collection de droit 2009–2010. *Barreau du Québec Brief on Chapter VI entitled "Les directives préalables du Rapport de la vie et de la mort présenté au sous-comité du Comité sénatorial spécial sur l'euthanasie et l'aide au suicide"*, Barreau du Québec, March 2000, 18 pp.
<http://www.barreau.qc.ca/pdf/medias/positions/2000/200003-vieetmort.pdf>

If the person concerned is incapable of giving or refusing his consent to care, a person authorized by law or by mandate given in anticipation of his incapacity may do so in his place.

The rule of consent applies only to persons of full age who are actually capable of giving consent. If the person is incapable of giving consent or if, in the case of a minor, the person is not deemed to have full rights regarding care, the person's legal representative may act on his or her behalf.

Section 12:

A person who gives his consent to or refuses care for another person is bound to act in the sole interest of that person, taking into account, as far as possible, any wishes the latter may have expressed. If he gives his consent, he shall ensure that the care is beneficial notwithstanding the gravity and permanence of certain of its effects, that it is advisable in the circumstances, and that the risks incurred are not disproportionate to the anticipated benefit.

Certain rules are added based on the person's age.

- Minors under 14 years of age cannot give consent alone to care required by their state of health. In all cases, the consent of the person having parental authority or their tutor is required (Sect. 14, Par. 1). If the latter is unable or refuses to do so, without justification, the authorization of the court may be obtained (Sect. 16).
- Minors 14 years of age or older who are capable of giving consent may give their consent alone to care required by their state of health (Sect. 14, Par. 2). If they refuse this care, their refusal may be overruled by obtaining authorization of the court (Sect. 16).
- Where it is ascertained that a person of full age is incapable of giving consent to care required by his or her state of health, the power to give consent is assigned to the tutor, curator, or mandatary as designated by virtue of the homologated mandate in anticipation of incapacity. If the person of full age is not so represented, consent is given by his or her spouse or, if the person has no spouse or his or her spouse is prevented from giving consent, by a close relative or a person who shows special interest in the person of full age (Sect. 15). If the representative refuses to give consent to care without justification, the authorization of the court may be obtained (Sect. 16).

The Civil Code gives people two ways to express their wishes regarding consent to care in the event that they become incapable of doing so themselves.

- The mandate given in anticipation of the mandator's incapacity (Sect. 2166 to 2174) allows a person to express how he or she wants to be treated and cared for at the end of life and designate a third party to take responsibility for this. The mandate may extend to protecting the person and administering his or her property.

This is the most common way to give consent to anticipated future care. However, it does have limits. For example, the healthcare team may not be aware of the existence of the mandate, as the mandator or mandatary do not always have this document readily available; since this is a written

document, it is less flexible than verbal consent of the person's wishes; before the mandate is enforceable, it must be homologated by the court, which then witnesses and certifies the mandator's incapacity.

- There are various names for the other way people can express their consent to care wishes, including the "living will", "advance directive", "healthcare directive", or "directive to physicians". Although it is not expressly mentioned in the Civil Code, it is in line with the letter of Section 12. It allows a person to leave directives, either written or otherwise, that respect his or her wishes in the event that the person becomes incapable of expressing them.

It does not designate someone to make sure the declarant's wishes are carried out and is addressed to anyone in a position to provide the declarant with necessary end-of-life care. It has a narrower legal scope than the mandate in anticipation of incapacity. The healthcare team merely takes note of the directives; it is not unconditionally bound to uphold them.

THE CODE OF ETHICS OF PHYSICIANS

Section 7:

A physician must disregard any interference which does not respect his professional independence.

Section 28:

A physician must, except in an emergency, obtain voluntary and informed consent from the patient or his legal representative before undertaking an examination, investigation, treatment, or research.

Section 29:

A physician must ensure that the patient or his legal representative receives explanations pertinent to his understanding of the nature, purpose, and possible consequences of the examination, investigation, treatment, or research which he plans to carry out. He must facilitate the patient's decision making and respect it.

Section 58:

A physician must, when the death of a patient appears to him to be inevitable, act so that the death occurs with dignity. He must also ensure that the patient obtains the appropriate support and relief.

THE CODE OF ETHICS OF NURSES

Section 28:

A nurse shall seek to establish and maintain a relationship of trust with her or his client.

Section 30:

A nurse shall respect, within the limits of what is generally admissible in the practice of the profession, the client's values and personal convictions.

THE CRIMINAL CODE AND EUTHANASIA

Euthanasia is not specifically addressed in the provisions of the Criminal Code, but a few of its sections may apply depending on the circumstances. The following are examples of some such sections:

Section 14:

No person is entitled to consent to have death inflicted on him, and such consent does not affect the criminal responsibility of any person by whom death may be inflicted on the person by whom consent is given.

Section 222:

(1) A person commits homicide when, directly or indirectly, by any means, he causes the death of a human being.

Section 229:

Culpable homicide is murder

- a) where the person who causes the death of a human being
 - (i) means to cause his death [...].

Section 231:

- (1) Murder is first degree murder or second degree murder.
- (2) Murder is first degree murder when it is planned and deliberate.

Section 245:

Everyone who administers or causes to be administered to any person or causes any person to take poison or any other destructive or noxious thing is guilty of an indictable offence and liable

- a) to imprisonment for a term not exceeding fourteen years, if he intends thereby to endanger the life of or to cause bodily harm to that person [...]

THE CRIMINAL CODE AND ASSISTED SUICIDE

Section 241:

Every one who

- a) counsels a person to commit suicide, or
- b) aids or abets a person to commit suicide,

whether suicide ensues or not, is guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years.

APPENDIX II

STATES THAT LEGALIZED EUTHANASIA OR ASSISTED SUICIDE : SURVEY

STATES	YEAR (effective date)	EUTHANASIA	ASSISTED SUICIDE	LAW, REGULATION, OR COURT DECISION	CONDITIONS
BELGIUM	2002	X		Loi relative à l'euthanasie (Euthanasia Act)	<ul style="list-style-type: none"> The patient is of age of majority (or an emancipated minor) and capable and conscious at the time the request is made. The illness is serious and incurable. The patient is in a medically futile condition of constant and unbearable physical or mental suffering that cannot be alleviated. The request is voluntary, well-considered, and repeated, and is not the result of any external pressure. The patient's request must be in writing. The attending physician must consult another physician. The physician consulted must be independent of the attending physician and the patient, and must be competent to give an opinion about the disorder in question. The physician consulted must examine the patient and report on his or her findings. If there is a healthcare team that has regular contact with the patient, the physician must discuss the patient's request with the team or its members. When death does not come in the near future, the physician must consult a second physician (either a psychiatrist or a specialist in the disorder in question); the physician consulted examines the patient and reports on his or her findings. When death does not come in the near future, the physician must allow at least one month between the patient's written request and the act of euthanasia. An advance directive is only valid if it is drafted or confirmed no more than five years prior to the patient's loss of the ability to express his or her wishes.
UNITED STATES State of Oregon	1997		X	Oregon Death with Dignity Act	<ul style="list-style-type: none"> The patient must be a capable adult who is suffering from a terminal disease. The patient's life expectancy is less than six months. The patient is a resident of the State of Oregon. If the physician has any doubts as to the patient's judgment, he or she cannot write the prescription and must refer the patient for counseling. The patient must make an oral request and a written request, and reiterate the oral request. No less than 15 days shall elapse between the patient's initial oral request and second oral request. The medical opinion of a second physician is required. The patient must self-administer the medication (without assistance), but a physician may be present.

STATES	YEAR (effective date)	EUTHANASIA	ASSISTED SUICIDE	LAW, REGULATION, OR COURT DECISION	CONDITIONS
UNITED STATES State of Washington	2009		X	Washington Death with Dignity Act	<p>The conditions are similar to those set out in the Oregon Death with Dignity Act.</p> <ul style="list-style-type: none"> • Differences: <ul style="list-style-type: none"> • The patient must make both an oral request and a written request. The patient must reiterate the oral request at least fifteen days after making the initial oral request. • There are two waiting periods: At least 15 days shall elapse between the patient's initial oral request and the writing of a prescription, and at least 48 hours shall elapse between the date the patient signs the written request and the writing of a prescription.
LUXEMBOURG	2009	X	X	March 16, 2009 bill on euthanasia and assisted suicide	<ul style="list-style-type: none"> • The patient is of legal age of majority and capable and conscious at the time the request is made. • The request is voluntary, considered carefully, and repeated, as warranted; it is not the result of any external pressure. • The patient is in a medically futile condition of constant and unbearable physical or mental suffering that cannot be alleviated, resulting from a disorder caused by illness or accident. • The request to resort to euthanasia or assisted suicide is made in writing. • The attending physician must consult another physician. The physician consulted must be independent of the attending physician and the patient, and must be competent to give an opinion about the disorder in question. The physician consulted must examine the patient and report on his or her findings. • Unless the patient objects, the physician must discuss the patient's request with the healthcare team that has regular contact with the patient or with the members of the patient's family. • The advance decision is taken into account; it may be upheld, reiterated, cancelled, or adapted at any time. It is recorded in an official system, and the government authority must ask the person to confirm it every five years.
NETHERLANDS	2002	X	X	1984–1986: Two Supreme Court decisions	<p>1980s: Euthanasia is still illegal, but court decisions where physicians who performed euthanasia are found not criminally liable for their actions sets a legal precedent in this regard.</p>

STATES	YEAR (effective date)	EUTHANASIA	ASSISTED SUICIDE	LAW, REGULATION, OR COURT DECISION	CONDITIONS
NETHERLANDS (continued)	2002	X	X	<p>1994: Notification Procedure for the Medical Termination of Life on Request and Without Order in Council</p> <p>1994–1995: Supreme Court decisions on the issue of medically assisted suicide</p> <p>1998: New procedure specifically regarding termination of life performed at the patient's request</p> <p>2002: Termination of Life on Request and Assisted Suicide (Review Procedures) Act</p>	<p>1994: Does not legalize euthanasia, but guarantees the immunity of physicians who perform it according to the criteria set out by the regulation, including the following:</p> <ul style="list-style-type: none"> • The patient must repeatedly and explicitly express the desire to die. • The patient's decision must be well informed, free, and considered carefully • The patient must be suffering from severe physical or mental pain with no prospect of relief. • The patient does not have to be terminally ill. • The physician must consult at least one other physician and may consult other healthcare professionals if he or she so desires. • The physician must inform the coroner that the euthanasia has been carried out. <p>2002: Euthanasia and assisted suicide are legalized under certain circumstances.</p> <ul style="list-style-type: none"> • The patient must be at least 12 years of age: <ul style="list-style-type: none"> • For sick children age 12 to 16, parental consent is mandatory. • Young people age 16 and 17 may make the decision for themselves, but parents must always participate in discussions with physicians about this topic. • Clarifies the criteria already adopted: <ul style="list-style-type: none"> • The request must be made in writing. • The physician must hold the conviction that the request by the patient is voluntary and considered carefully. • The physician must hold the conviction that the patient's suffering is lasting and unbearable and that there is no possible hope for improvement. • The physician must consult at least one other independent physician, who examines the patient and confirms in writing that the attending physician has met the criteria with due care. • The attending physician terminates the patient's life or assists the patient in ending his or her life (physician must be present), by providing the patient with all the medical care and attention needed. • The physician must report the death to the coroner. • The law explicitly recognizes the validity of an end-of-life declaration written by the patient.

- In 2010 in **England and Wales**, the Director of the Public Prosecutions issued guidelines citing 22 factors for determining whether to bring charges in assisted suicide cases. The law has not changed (assisted suicide remains illegal), but prosecutors now have new guidelines to help them determine which cases should be taken to court.
- In 1993 the Attorney General of **British Columbia** introduced guidelines with respect to charging individuals who, out of compassion for the deceased, participate in causing a death. Under the guidelines, Crown Counsel will approve prosecution only where there is substantial likelihood of conviction and the public interest so dictates.
- In **Switzerland**, euthanasia is prohibited, but the penalty for performing it (killing a person out of compassion at this person's express request) is less severe than for other types of homicide (Sect. 114). As for assisted suicide, the Penal Code includes a provision that prohibits assisted suicide, unless this assistance is provided without any selfish motives (Sect. 115).

The overview above is drawn essentially from the following legislative provisions and documents:

Belgium, *Loi relative à l'euthanasie*, effective as of May 28, 2002. http://www.ulb.ac.be/cal/Documents/Documentsdereferences/loiethanasie_28052002.pdf.

Luxembourg, *Loi du 16 mars 2009 sur l'euthanasie et l'assistance au suicide*, effective as of March 16, 2009. http://www.unifr.ch/ddp1/derechopenal/legislacion/l_20090402_01.pdf.

Netherlands, *Termination of Life on Request and Assisted Suicide (Review Procedures) Act*, s. p. [Official translation of the Dutch Act, effective as of April 1, 2002]. <http://www.kuleuven.be/ep/viewpic.php?LAN=E&TABLE=EP&ID=58>

State of Oregon, *Oregon Death with Dignity Act*, effective as of October 27, 1997. <http://www.oregon.gov/DHS/ph/pas/ors.shtml>.

State of Washington, *Washington Death with Dignity Act*, effective as of November 4, 2009. <http://wei.secstate.wa.gov/osos/en/Documents/I1000-Text%20for%20web.pdf>.

Switzerland, *Swiss Penal Code*, Sect. 114, "compassionate murder" and Sect. 115, "assisted suicide." <http://www.admin.ch/ch/f/rs/3/311.0.fr.pdf>.

United Kingdom, *Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide*, February 2010. http://www.cps.gov.uk/publications/prosecution/assisted_suicide_policy.html.

Valiquet, Dominique and Marlisa Tiedemann, *Euthanasia and Assisted Suicide in Canada*, rev. July 17, 2008, [Ottawa], Library of Parliament, Parliamentary Information and Research Service, 2008. 27 pp. (Current Issue Review No. 91-9F). [Notably for the Netherlands]. <http://www2.parl.gc.ca/Content/LOP/ResearchPublications/919-f.pdf>

APPENDIX III

EXCERPTS FROM THE MOTION CARRIED UNANIMOUSLY BY THE NATIONAL ASSEMBLY

Motion to set up an *ad hoc* committee to consider the issue of the right to die with dignity and the terms for enforcing it, as the case may be [...].

Regarding the two consultations held by the committees,

Resolutions regarding first consultation

That the Committee on Health and Social Services may begin its work, no later than 60 days after the present motion is adopted, by proceeding with special consultations and holding public hearings with a view to considering the issue of the right to die with dignity; that, to this end, it may hear experts who will be selected in the working session; and that these experts notably discuss the following issues in their statements:

- End-of-life conditions and care
- The law and terms and conditions that may eventually lay the framework for the right to euthanasia
- Any other considerations that may enlighten committee members [...].

That within 45 days of the end of the hearings, the committee produce a consultation paper designed to facilitate public participation in the general consultation that will be initiated by the *ad hoc* committee; that said document immediately be submitted to the *ad hoc* committee without being made public.

Resolutions regarding the second consultation

That the *ad hoc* committee examine the consultation document and that it be able to make any additions to it, as it sees fit;

That said document be submitted to the National Assembly within 30 days of its receipt;

That the general consultation may begin on approximately August 17, at the earliest, or within a reasonable amount of time in order to allow individuals and organizations to produce a brief;

That the committee be able to devote periods of time to the public hearing, where the public will have expressed its interest to be heard by the committee despite not having submitted a brief;

That the committee be able to meet outside the buildings of the National Assembly and Québec City;

That the committee be able use videoconferencing as part of the hearings;

That the committee carry out an online consultation in order to foster the broadest possible public participation [...].

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Dying With Dignity

Committees Secretarias Directorate

Édifice Pamphile-Le May
1035, rue des Parlementaires
3^e étage, Bureau 3.15
Québec (Québec) G1A1A3
Telephone : 418 643-2722
Fax : 418 643-0248
sec.commissions@assnat.qc.ca