CANADIAN PROVINCIAL/TERRITORIAL EXPERT ADVISORY GROUP ON PHYSICIAN-ASSISTED DYING WRITTEN STAKEHOLDER SUBMISSION FORM

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BACKGROUND

In February 2015, the Supreme Court of Canada struck down the federal law prohibiting physician- assisted dying (PAD). The ruling applies to a competent adult who:

- Clearly consents to the termination of life; and
- 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 gave governments one year to consider the development of new laws and practices for physician-assisted dying.

In July 2015, the federal government established an external panel to inform its legislative response to the Supreme Court of Canada's decision. The primary focus of the Federal Expert Panel's work is to provide advice to the federal government on possible amendments to the Criminal Code. In August 2015, eleven provinces and territories established the Provincial/Territorial Expert Advisory Group on Physician-Assisted Dying (the "Advisory Group").

As provinces and territories have the primary responsibility for health care, including regulating physicians and health care institutions, provincial and territorial governments must consider whether regulatory or other changes are needed over the coming months in response to the Supreme Court's decision. The Advisory Group will provide advice on the development of laws, policies, practices and safeguards for provinces and territories to consider in advance of physician-assisted dying becoming legal in Canada.

Your organization's input and feedback will be considered as part of the Advisory Group's deliberations.

INSTRUCTIONS

The Advisory Group is seeking input on the following questions. Your organization's responses will be used by the Advisory Group to inform its advice to the provincial and territorial governments on physician-assisted dying, with a focus on the needs of patients and their families as well as health institutions and regulatory bodies.

Please answer all questions relevant to your organization's interests. **If your organization does not have a position or opinion on a particular issue, please feel free to leave that section blank.** Please limit your response to each question to 1000 characters (or approximately 200 words). If your organization has developed specific guidance (e.g., policy, guidelines) for its staff or members related to the implementation of PAD, you may attach it to your reply email. Please send the completed template and attachment to PADadvisorygroup@ontario.ca by **September 24, 2015**.

Please note that all information collected by the Advisory Group is governed by Ontario's *Freedom of Information and Protection of Privacy Act* and may be subject to disclosure in accordance with that Act. In addition, comments or documents provided to the Advisory Group may be shared with provinces and territories participating in the work of the Advisory Group and will be treated as public information that may be used and disclosed by the Advisory Group without the consent of the author, or the organization on whose behalf the submission is made. As such, please ensure that you do not include any personal information about identifiable individuals in your responses to this template.

The information collected will be considered by the Advisory Group in developing recommendations for provinces and territories to consider as they develop their responses to the Supreme Court's decision on physician-assisted dying. If you have any questions about how the Advisory Group will collect, use and disclose the information that you are providing, please contact Alicia Neufeld at Alicia.Neufeld@ontario.ca.

QUESTIONS	FEEDBACK
GENERAL	
What are your organization's thoughts on the Supreme Court of Canada's decision in *Carter v. Canada (Attorney General)*?	We appreciate the opportunity to participate in this process. We were disappointed with the decision of the Supreme Court (Court) and remain opposed to the legalization of assisted suicide and euthanasia. There were two basic legislative objectives for the prohibition of assisted suicide and euthanasia: the promotion of life and the protection of the vulnerable. The Court only addressed the first. For many reasons, including the protection of the integrity of the health care system and medical professionals, and to affirm the respect for life of all persons, we believe the prohibition on intentional killing should remain and our laws be unequivocal that killing or assisting in the killing of another is wrong and should not be condoned in Canadian society. We believe the government of Canada should re-enact or re-assert s. 14 and 241(b), making it clear that the blanket prohibition is necessary to not only protect vulnerable persons, but also for the promotion of life and the integrity of our heath care system and *Criminal Code*. We note also that the Court found that a patient who fits the circumstances has a "right" to be free of the state prohibition against assisted suicide, as does a willing physician who freely assists them in their suicide. The Court did *not* rule that the patient has a right to access state assistance or compel anyone to assist them in their suicide. In this regard, there is no "right" to assistance, and no one, neither persons nor institutions, are required to participate. This survey is premised on the understanding that assisted suicide will be permitted and should be facilitated by medical professionals and the health care system. We are opposed to assisted suicide. Our recommendations on how assisted suicide may be facilitated if the federal government proceeds with enabling legislation are intended to minimize the harm of a practice we wholly reject and oppose. Based on evidence from other jurisdictions, safeguards will never fully eliminate the risk of abuse. The practice will put vulnerable people at risk, will seriously compromise the integrity of the medical profession and the health care system, and undermine our society's commitment to the sanctity of human life and our commitment to care for one another.

In general, should provinces and territories develop new legislation or regulations to govern the provision of physician-assisted dying (PAD) or should the regulation of PAD be left to regulatory bodies (e.g., professional colleges) and/or individual physicians and patients?	If the Federal Government does not re-assert s. 14 and s. 241(b) as stated above, the regulation of assisted suicide should remain solely in federal jurisdiction as any exemptions to the prohibition would be exceptions to the *Criminal Code*.

ELIGIBILITY CRITERIA	
In the Supreme Court of Canada's decision, it was determined that, in certain circumstances, a "competent adult" must not be prohibited from accessing PAD. • **What should the definition of "adult" be?** • **Should the competency requirement apply at the time of request for PAD or at the time of provision of the assistance, or both?** *See Appendix 1 for additional information.*	In Canada, the age of majority is the age at which a person is considered by law to be an adult. This age is either 18 or 19, depending on the province or territory. If the federal government legislates to allow assisted suicide, the definition of "adult" should be set at 19 years of age, to ensure both consistency with existing legal ages of majority, and to ensure the definition is the same across provinces and territories. The competency requirement should apply both at the time of request for assisted suicide and at the time of its' provision.

The Supreme Court of Canada's decision limits PAD to those who have a "grievous and irremediable medical condition". • **What does "grievous and irremediable medical condition" mean to your organization?** • **Should the term "grievous and irremediable medical condition" be defined in the provincial/territorial legislation or regulation?** • **Should specific medical conditions be defined in law or should it be determined in each case by the patient and their physician? If the medical conditions should be defined in law, what medical conditions should be included?** *See Appendix 2 for additional information.*	The term "grievous and irremediable medical condition" must be defined in law by the federal government to ensure strict national standards. Without this, the term itself leaves far too much room for subjectivity, and, we suggest, abuse. As noted by the Christian Medical and Dental Society of Canada (CMDS) in their submission to this advisory group, often patients come to their physicians and ask to die as a cry for help. They need to be cared for and supported, not abandoned and killed. The criteria should be strict to protect those who might request it out of loneliness, desperation, depression or discouragement. We suggest "grievous" be restricted to mean persons with terminal illnesses and who are near death (life expectancy of three months or less), and where it is beyond the capacity of high quality palliative care to manage pain. Decisions should not be tied to the medical condition *per se*, but whether it has progressed to the point of meeting the criteria above. Psychological suffering should be expressly excluded from any definition of "grievous and irremediable medical condition." Any provincial/territorial laws or regulations developed, following the response of the federal government, should conform to the definition established in federal law.

PROCEDURAL SAFEGUARDS TO ENSURE ELIGIBILITY CRITERIA ARE MET

The Supreme Court of Canada's decision limits PAD to a competent adult person who "clearly consents to the termination of life".

- **What processes should be put in place to ensure that the consent to PAD is informed? (e.g., what information should have to be provided to the patient? Who should provide the information?)**

See Appendix 3 for additional information.

As stated above, we are opposed to assisted suicide. Our recommendations on how assisted suicide may be facilitated if the federal government proceeds with enabling legislation are intended to minimize the harm of a practice we wholly reject and oppose.

A patient's consent to termination of life must include the following elements:

1. The patient must be a competent adult, as defined in federal law.
2. The patient must have the capacity to consent legally.
3. Consent must be fully informed, meaning the patient has been adequately informed by the attending physician regarding:

- his/her medical diagnosis
- health status
- prognosis
- alternative treatments including comfort care, palliative and hospice care, and pain and symptom control
- the certainty of death upon taking the lethal medication

4. Consent must be voluntary, made in the absence of coercion or influence from family members, health care providers or others
5. The patient must, him or herself, make the request. As recommended by the Canadian Medical Association (CMA), substitute decision-makers carrying out advance directives or the wishes of currently incompetent patients are not acceptable proxies.
6. The patient must make, him or herself, repeated requests for assistance in suicide.
7. Consistent with Canadian consent laws, consent should be an ongoing process, and the individual should be able to withdraw consent at any time. If consent is withdrawn at any time, the request process should begin again, including waiting periods between requests.

The processes to ensure consent must be set by the federal government in statute.

What processes should be put in place to ensure that the consent to PAD is voluntary?	Again, we are opposed to assisted suicide. Our recommendations on how assisted suicide may be facilitated if the federal government proceeds with enabling legislation are intended to minimize the harm of a practice we wholly reject and oppose. Federal laws and regulations (this may require the establishment of a federally appointed regulatory body) should clearly address issues of vulnerability, voluntariness and potential coercion. The CMA recommends that the attending physician must be fully satisfied that: - the patient's decision to request assistance in suicide has been made freely, without coercion or undue influence from family members, health care providers or others; - the patient has a clear and settled intention to end his/her life after due consideration; and - the patient has requested assistance in suicide him/herself, thoughtfully and repeatedly, in a free and informed manner. As recommended by the CMDS, the attending physician should have to consult with other health professionals who have seen the patient, as well as with the family or caregivers. If the attending physician is satisfied that the patient is a competent adult who has the capacity to consent in a fully free and informed manner, then the request should be assessed by a minimum of two independent physicians, one of whom is trained in palliative care, as well as a psychologist or psychiatrist. The requests should be confirmed in writing and the consent video-recorded. As the procedure would be undertaken as an exception of a *Criminal Code* offense, we also recommend that a lawyer affirm the process was strictly adhered to and confirm the determination of the medical team.

What processes should be put in place to ensure that the person requesting PAD is competent? For example: • **Who should conduct the competency assessment(s)?** • **Should an assessment by a psychiatrist or psychologist be required in any or all cases? If some, which ones?)**	As stated above, we are opposed to assisted suicide. Our recommendations on how assisted suicide may be facilitated if the federal government proceeds with enabling legislation are intended to minimize the harm of a practice we wholly reject and oppose. Federal laws and regulations (this may require the establishment of a federally appointed regulatory body) should clearly address issues of competency. We recommend a process to ensure competency and consent that is rigorous. One reason we opposed any exceptions to the blanket prohibition was the possibility of abuse and/or coercion, or someone contemplating death due to loneliness or psychological distress. The attending physician should conduct the initial competency assessment. He/she must be satisfied that the patient is mentally capable of making a fully informed decision at the time of the request(s). The assessment should include a full discussion of the patient's diagnosis and prognosis, all treatment options, including pain management and palliative or hospice care, and full consideration of the patient's concerns, fears and personal and family values. The physician must be satisfied that the patient is capable of giving fully informed consent, and that this consent is given freely, without undue influence or possible coercion from health care providers, family members or others. If the attending physician is satisfied the above conditions are met, the request should then be assessed by a minimum of two independent physicians, one of whom is a palliative care expert, as well as a psychologist or psychiatrist. As the procedure would be undertaken as an exception of a *Criminal Code* offense, we also recommend that a lawyer affirm the process was strictly adhered to and confirm the determination of the medical team.

How many physicians should be required to confirm that the eligibility criteria have been met? Must they be from any particular specialties? Must they be independent of one another? If so, what should be the definition of independent for these purposes?	The process for determining whether eligibility criteria have been met must be defined in federal law and clearly outlined in regulations (perhaps developed by a federally-appointed national regulatory body). As indicated in the pervious answer, in addition to the attending physician, a minimum of two independent physicians, one of whom is an expert in palliative care, as well as a psychiatrist or psychologist should be required to confirm the eligibility criteria have been met. The physicians assessing eligibility should be independent in that they are not, apart from the attending physician, directly involved in the care of the patient. As the procedure would be undertaken as an exception of a *Criminal Code* offense, we also recommend that a lawyer confirm the determination of the medical team.

Should a waiting period (sometimes called a "cooling off period") be established between the request and the provision of PAD? If so, how long should the waiting period be? Should the waiting period vary based on the medical condition?	The process for making a request should be defined in federal law and clearly outlined in regulations (perhaps developed by a federally-appointed national regulatory body). Requests for assistance in suicide should be made repeatedly, with cooling off periods between requests. We suggest that there should be a cooling off period of at least 21 days between a first and second request, and an additional 14 days between the second and third request. There should be a final cooling off period of 7 days between the final request and the provision of assistance in suicide.

What should be the formal requirements for a patient's request for PAD? (e.g., should requests be written or can they be oral? Should witnesses be required?)	As stated above, we are opposed to assisted suicide. Our recommendations on how assisted suicide may be facilitated if the federal government proceeds with enabling legislation are intended to minimize the harm of a practice we wholly reject and oppose. The process for making a request for assistance in suicide should be defined in federal law and clearly outlined in regulations. We suggest that patients should be required to make at least three written requests. All requests should be documented by the attending physician and video-recorded. The final request must be signed by two independent witnesses who have reviewed the documentation and video recordings of the previous requests, and who have no pecuniary or other interest in the death of the patient. In addition, the requests must be accompanied by an affirmation from the two additional doctors consulted, the psychologist or psychiatrist, and the lawyer-confirming competency and consent at each stage of the request process.

ROLE OF PHYSICIANS	
What is the appropriate role of physicians in physician-assisted dying? For example: • **Should a physician's role be to actively administer the medication that causes death if requested to do so by a patient who meets the eligibility criteria?** • **If an eligible patient prefers, and has the ability, should a physician's role be to prescribe the lethal medication which the patient would then administer themselves?** • **Should physicians always remain with the patient until the time of death?**	While the Supreme Court used the term physician, we are concerned this would do harm to the integrity of the medical profession and the health care system. If permitted, we suggest that physicians or other persons participating in assisted suicide should be licensed under a federally regulated authority. Only those who are licensed should participate directly in assisted suicide. Such a requirement would allow for careful controls and monitoring of these practices, protect the integrity of the medical system and protect the conscience of the many physicians and health professionals who believe that to assist in a patient's death is contrary to the oath they have taken to do no harm. Such a system would allow a federal authority to ensure careful controls and monitoring of assisted suicide, to review every case and to perform audits to ensure compliance with all regulations. As stated above, we are opposed to assisted suicide. Our recommendations on how assisted suicide may be facilitated if the federal government proceeds with enabling legislation are intended to minimize the harm of a practice we wholly reject and oppose. If permitted, assisted death should involve only the provision of lethal medication by a licensed physician or health care professional, and not its' administration. The lethal medication must be administered by a positive act of the patient. No one should be permitted to kill another. If an eligible patient prefers and has the ability, a properly licensed and trained physician could prescribe the lethal medication which the patient would administer themselves. The licensed physician or professional should always remain with the patient until the time of death.

ROLE OF OTHER HEALTH CARE PROVIDERS	
What is the appropriate role of non-physician regulated health care professionals in the provision of PAD?	Again, we are opposed to assisted suicide. Our recommendations on how assisted suicide may be facilitated if the federal government proceeds with enabling legislation are intended to minimize the harm of a practice we wholly reject and oppose. Only those who are trained and licensed should participate in assisted suicide. Such a requirement will protect the conscience of the many physicians and health professionals who believe that to assist in a patient's death is contrary to the oath they have taken to do no harm. The role of unlicensed physicians and health care professionals should be restricted to patient care, pain and symptom management, treatment and support.
Should non-physician regulated health care professionals (e.g., Registered Nurse, Nurse Practitioner) acting under directives from a physician be allowed to fulfill a request for PAD?	No. Only persons licensed under the federal authority regulating the practice can fulfill the request.

What is the appropriate role of non-regulated health workers in the provision of PAD?	None. Only persons licensed under the federal authority regulating the practice can fulfill the request.

CONSCIENTIOUS REFUSALS BY HEALTHCARE PROVIDERS	
Should physicians have the right to refuse to provide PAD for reasons of conscience? If yes: • **What continuing obligations, if any, do they have to the patient?** • **Does the right to refuse include the right to refuse to provide an effective referral for PAD?** *See Appendix 4 for additional information.*	Yes, physicians must have the right to refuse to participate in physician-assisted suicide for reasons of conscience, including the right not to provide an effective referral. This is critical even if it is determined in law that there is a positive right to assisted suicide. As noted above, the Court did not rule that the patient has a right to access state assistance or compel anyone to assist them in their suicide. In this regard, there is no "right" to assistance, and no one, neither persons nor institutions, are required to participate. The requirement that a person be licensed to participate in assisted suicide has the added value of being an opt-in approach, which would serve to protect those who are compelled not to participate by reason of religious belief or conscience and maintain that to assist in a patient's death is contrary to the oath they have taken to do no harm. A patient may refuse a given treatment, but until and unless the patient does so, the physician is obligated to continue to care for the patient, including treatment, pain and symptom management.

Should non-physician regulated health care professionals (e.g., Registered Nurse, Nurse Practitioner, Pharmacist, etc.) have the right to refuse to participate in the provision of PAD for reasons of conscience? • **If so, under what circumstances?**	Yes. In every circumstance.

ROLE OF INSTITUTIONS	
What is the appropriate role of health care institutions (e.g., hospitals, hospices, long-term care facilities, etc.) in making PAD services available to patients?	The provision of assisted suicide is incompatible with the role and responsibility of the health care system. If the federal government determines that assisted suicide is to be allowed under certain circumstances, then in order to maintain the protection of life and prevent the undermining of the health care system, we suggest that this practice should take place outside of health care institutions. It is worth noting that in response to legislative initiatives regarding euthanasia and assisted suicide in Quebec, hospices in the province have indicated their refusal to participate in these procedures. It is unreasonable and incongruous to expect institutions committed to the protection, restoration and preservation of life to participate in the intentional taking of life. We also note, as stated above, that the Court's decision did not find a right to access, but only an exemption from the force of the *Criminal Code* prohibition. We object to both the participation of health care institutions and the use of public funds in the provision of assisted suicide.

On what issues in particular does your organization feel that health institutions need specific guidance – through legislation, regulation, or guidelines – for the implementation of PAD services?	Health institutions will require clarity on any change in the law, the circumstances under which physician assisted suicide can be offered, and the processes required for assistance in suicide.
Should health care institutions be required to provide PAD at their facility? If yes, please explain why. If no, under what circumstances and what responsibility should the institution have to ensure patients have access to PAD?	No. Health care institutions should not be required to provide assisted suicide at their facility. If the federal government determines that assisted suicide is to be allowed under certain circumstances, then in order to maintain the protection of life and prevent the undermining of the medical profession and the health care system, we urge that this practice should take place outside of health care institutions. It is unreasonable and incongruous to expect institutions committed to the protection, restoration and preservation of life to participate in the intentional taking of life.

What should be the responsibility of the health care institution to the patient when a physician within the facility refuses to provide PAD for reasons of conscience and/or provide an effective referral for PAD in a case where the requesting patient meets the eligibility criteria?	None. As stated above, health care institutions should not provide assisted suicide.
ACCESS	
What barriers to access do you foresee that will need to be addressed in implementing PAD? In what ways do you think these barriers could or should be reduced? **Where access to PAD is limited by these barriers, what steps should be taken to facilitate access for patients seeking the service?**	It is important to note that in the Carter case, the Supreme Court found that a patient who meets the criteria as laid out in the decision has a *negative* right to be free of the state prohibiting (by criminal law) a willing physician from providing physician assisted death. But the Court did not grant a *positive* right to demand State assistance in death. The State is not required to provide a physician who will assist in a patient's death. The federal government is not required to turn that into a positive right of access to physician assisted death. It is the purview of the federal government, in responding to the Carter decision, to determine the circumstances under which patients should be allowed to seek assisted death, and how those requests are to be accommodated.

What unique implementation issues, if any, do you foresee for PAD in rural or remote settings? How should they be addressed?	As stated previously, in the Carter case, the Supreme Court found that a patient who meets the criteria as laid out in the decision has a *negative* right to be free of the state prohibiting (by criminal law) a willing physician from providing physician assisted death. But the Court did not grant a *positive* right to demand State assistance in death. The State is not required to provide a physician who will assist in a patient's death. The federal government is not required to turn that into a positive right of access to physician assisted death. It is the purview of the federal government, in responding to the Carter decision, to determine the circumstances under which patients should be allowed to seek assisted death, and how those requests are to be accommodated.

How could and should provincial/territorial governments ensure equitable access to PAD?	As stated previously, in the Carter case, the Supreme Court found that a patient who meets the criteria as laid out in the decision has a *negative* right to be free of the state prohibiting (by criminal law) a willing physician from providing physician assisted death. But the Court did not grant a *positive* right to demand State assistance in death. The State is not required to provide a physician who will assist in a patient's death. The federal government is not required to turn that into a positive right of access to physician assisted death. It is the purview of the federal government, in responding to the Carter decision, to determine the circumstances under which patients should be allowed to seek assisted death, and how those requests are to be accommodated.

If it is determined that a patient is ineligible for PAD, should the patient have a right to appeal that decision? If so, what process should be used and to whom should the appeal be directed?	If assisted suicide is legalized, the process for determining eligibility of a patient should be clearly laid out in federal law and regulations to ensure uniformity across the country. A patient deemed ineligible after such an assessment process could have the right to appeal the decision, after a waiting period and as set out in the regulations. The appeal could be made directly to the federal authority.

SETTINGS	
In what health care settings should PAD be provided? *See Appendix 5 for additional information.*	If, in responding to the Court's decision in *Carter*, the federal government decides to allow assisted suicide in certain circumstances, it will also be the purview of the federal government to determine what those circumstances are, and how those requests are to be accommodated. This will include who can legally carry out those requests, and in what settings physician assisted suicide can legally be provided. It is our belief that the provision of assisted suicide is incompatible with the role and responsibility of the health care system. If the federal government determines that assisted suicide is to be allowed under certain circumstances, then in order to maintain the protection of life and prevent the undermining of the medical system, we suggest that this practice should take place outside of health care institutions.

If PAD were provided at home, what implementation issues would this raise? How should they be addressed?	The idea of providing assistance in suicide at home is an example of why it will be imperative that only those who have been specially trained, licensed by and are accountable to the federal authority (such as a national regulatory body) should be legally permitted to participate in assisting in a suicide. If legalized, it will need to be strictly regulated and monitored. A system would need to be put in place to ensure close monitoring, control and reporting.
Are there other implementation issues related to the settings in which PAD might be provided that need to be addressed?	As noted above, it is our belief that the provision of assisted suicide is incompatible with the role and responsibility of the health care system. If the federal government determines that assisted suicide is to be allowed under certain circumstances, then in order to maintain the protection of life and prevent the undermining of the medical system, we suggest that this practice should take place outside of health care institutions.

CASE REVIEW AND OVERSIGHT	
What reporting (including documentation) should be required of the physician following the provision of PAD? How should this reporting be done? Who should receive the reports? *See Appendix 6 for additional information.*	If, in responding to the Court's decision in *Carter*, the federal government decides to allow assisted suicide in certain circumstances, then a federal authority, perhaps a national regulatory body, will develop the regulations governing assisting in a person's suicide, within the parameters of the law. The federal authority will need to develop processes for determining patient eligibility, and for training and licensing of professionals who will be legally allowed to participate in assisted suicide. There will also need to be a mechanism for collecting information (data collection) about every instance of assisted death, the performance of regular audits of licensed providers and facilities in order to ensure compliance with the laws and regulations, and regular reporting to the federal government. The regulatory body should develop standardized documentation for the request process as outlined previously, including confirmation of consent and competence. All of this documentation must be completed and submitted to the regulatory body following the assisted death of the patient.

Should there be a review of each case of PAD? If yes: • **Should it be undertaken before or after the assistance is provided?** • **Who should undertake the review?** • **What standards (e.g., clinical, professional, legal) should be used in the review?** • **To whom should the reviewer(s) report any findings of non-compliance with the standards?** **If there should be no review, why not?**	Yes. The federal authority should review each instance of assisted suicide to ensure compliance.

Should an oversight body be established? If yes: • **Should it be national or provincial/territorial?** • **Should it be administered by government or by regulatory bodies?** • **What role and responsibilities should it have?** • **What should its composition be, in terms of the number of members and their backgrounds?** • **What should be its obligations for public reporting and quality improvement?** • **What other considerations are relevant to an oversight system, process, or body?**	If assisting the suicide of a person is permitted, the federal authority is responsible for regulations, licensing and oversight. One option would be the establishment of a federally appointed, national regulatory body. Such a body should be national, with representation from across the country. The federal government should administer the regulatory/oversight body. The regulatory body's responsibilities should include: - Development of regulations, including definitions and eligibility criteria, assessment process, etc. - Training and licensing of professionals who will participate in assisting of suicides. - Development of standardized forms and data collection (reports from attending and consulting physicians, medical records of patients, written requests of patients, reports from the licensed person who assisted in death, etc.) - Review of all instances of assisted suicide for compliance with the regulations - Annual report addressing compliance with the laws and regulations, the numbers of assisted suicide requests made, and the number granted/denied The regulatory body should be interdisciplinary, from fields including but not limited to law, medicine, ethics, palliative care, psychology.

ADDITIONAL SUPPORTS	
What, if any, educational materials should be developed for and provided to physicians and other health care providers? Who should be responsible for developing these materials (e.g., provincial/territorial governments, professional bodies, provincial Colleges of Physicians and Surgeons)?	Medical professionals must be given more training and education in palliative care, pain management and counseling. The training in this area is wholly inadequate. We recommend a national strategy for the provision of palliative and end of life care. Physicians and other health care providers will require clarity on any change in the law, the circumstances under which physician assisted suicide can be offered, and the processes required for assistance in suicide. This should be provided by the federal authority.

Should an independent organization be established to support physician practice (e.g., information, training) and/or facilitate patient access to PAD services? • **If so, who should establish it? What should it be tasked to do?** • **If not, what organization(s) should assume this responsibility?**	No.
What other resources should be developed to support physicians and other health care providers in relation to PAD?	None.

What resources should be developed to support patients and their families/caregivers in relation to PAD?	We recommend a national strategy for the provision of palliative and end of life care, which would include the development of resources and supports for families and caregivers of those facing terminal illness.
ADDITIONAL INPUT	
Is there anything else, not covered above, that your organization considers relevant to the implementation of PAD? Please use this space or attach additional comments to your e-mail response.	This survey is premised on the understanding that assisted suicide will be permitted and should be facilitated by medical professionals and the health care system. We are opposed to assisted suicide. Our recommendations on how assisted suicide might be facilitated if the federal government proceeds with enabling legislation are intended to minimize the harm of a practice we wholly reject and oppose. Based on evidence from other jurisdictions, safeguards will never fully eliminate the risk of abuse and involuntary euthanasia. We reiterate that we believe exceptions to the blanket prohibition on assisted suicide and euthanasia will put vulnerable people at risk, will seriously compromise the integrity of the medical profession and the health care system, and will undermine our society's commitment to the sanctity of human life and our commitment to caring for one another.