Endgame: Philosophical, Clinical and Legal Distinctions between Palliative Care and Termination of Life

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Endgame: Philosophical, Clinical and Legal Distinctions between Palliative Care and Termination of Life

Mary J. Shariff* and Mark Gingerich**

The end is in the beginning and yet you go on.
— Samuel Beckett

Medical Assistance in Dying, Medical Aid in Dying, Physician-Assisted Death, Physician-Assisted Dying, Physician-Assisted Suicide all refer to the same thing: the intentional administration or provision of a lethal substance to a patient at the patient’s request to cause the patient’s death – in other words, the practice of termination of life by health care professionals.

Recent Canadian dialogue surrounding legislative reform to permit physicians or other health care providers to provide termination of life frequently links termination of life practice to the practice of palliative care. For example, palliative care and termination of life have been described as activities falling on an end-of-life “spectrum” or “continuum of care”. The usage of such expressions, as well as aspects of the advocacy scoping and advancing termination of life practice in Canada, are contributing to a lack of clarity with respect to the substance of these two activities.

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The purpose of this discussion is to explore philosophical, clinical and legal distinctions between the practices of palliative care and termination of life in order to gain a better understanding of their substance, significance and relevance to end of life care, and in turn, ascertain reasons as to why it is critical to retain and promote such distinctions not only within the health care regulatory environment but also for the benefit of the public interest.

I. DEFINITIONS

Palliative care: “Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. … Palliative care... intends neither to hasten nor postpone death.”¹

Termination of life (medical aid in dying; medical assistance in dying; MAiD; assisted death; assisted dying; EAS): providing or administering medication to “intentionally bring about the patient’s death, at the request of the patient.”²

• Physician Assisted Suicide; Assisted Suicide; Physician Assisted Death; Physician Assisted Dying; PAS; PAD: at the request of the patient, prescribing or providing a substance to a patient for the patient to self-administer and cause their own death.

• Euthanasia: at the request of the patient, administering a substance to a patient to cause the patient’s death.

¹ World Health Organization, WHO Definition of Palliative Care, online: World Health Organization <http://www.who.int/cancer/palliative/definition/en/> [hereinafter “WHO Definition”].
² Carter v. Canada (Attorney General), [2015] S.C.J. No. 5, 2015 SCC 5, [2015] 1 S.C.R. 331, at para. 40 (S.C.C.) [hereinafter “Carter”]. The Authors have chosen to use the term termination of life throughout this discussion as it was specifically used by the Supreme Court of Canada in Carter to describe the activity requiring the consent of the patient in its “declaration of invalidity” of the Criminal Code provisions. For further discussion of the “Declaration of Invalidity” in Carter see infra, note 20 et seq. and accompanying text. Other terms, such as medical aid to die, medical assistance in dying, MAiD, physician assisted suicide, PAS, physician assisted dying, PAD, euthanasia, EAS, etc., will also occasionally be used to reflect the specific usage of a term(s) in a particular legal context.
II. INTRODUCTION

Recent Canadian dialogue surrounding legislative reform to permit physicians and other health care providers (HCPs) to practice “termination of life” frequently links termination of life to the practice of palliative care. For example, termination of life and palliative care have been described as activities falling on an end-of-life “spectrum” or “continuum of care.” The usage of terms such as “spectrum” and “continuum” as well as other dialogue and aspects of the advocacy surrounding termination of life practice in Canada are arguably provoking a trajectory towards a regulatory structure that aligns or equates termination of life with palliative care.

The purpose of this discussion is to explore philosophical, clinical and legal distinctions between the practices of palliative care and termination of life in order to gain a better understanding of their substance, significance and relevance to end of life, and in turn, ascertain why it is critical to retain and promote these distinctions within the Canadian health care regulatory environment as well as why it is patient-centred and in the public interest to maintain them.

Part III begins with an examination of the ways in which key Canadian politico-legal inputs (i.e., the Carter case, Quebec’s An Act respecting end-of-life care, the 2015 Provincial-Territorial Report on Physician Assisted Dying and the 2016 Report of the Special Joint Committee on Physician-Assisted Dying) describe termination of life practice and how they have contributed to an emerging conceptual collapse between palliative care and termination of life, the latter a practice which, until very recently in Canada, was entirely prohibited under the criminal law. After describing the Federal nod to palliative care

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3 See, for example, Quebec legislation, An Act respecting end-of-life care, CQLR, c. S-32.0001, s. 1 [hereinafter “Quebec Act”]:

The purpose of this Act is to ensure that end-of-life patients are provided care that is respectful of their dignity and their autonomy. The Act establishes the rights of such patients as well as the organization of and a framework for end-of-life care so that everyone may have access, throughout the continuum of care, to quality care that is appropriate to their needs, including prevention and relief of suffering.

4 Carter, supra, note 2.

5 Quebec Act, supra, note 3.


7 Special Joint Committee on Physician-Assisted Dying, Medical Assistance In Dying: A Patient-Centred Approach, (February 2016, 42nd Parliament, 1st Session) [hereinafter “Joint Committee Report”].
in the recent Canadian termination of life law, An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying), or “Bill C-14”. Part III concludes with the observation that the use of expressions such as “spectrum” and “continuum” signal the arrival of one of the most acute questions for contemporary social and health care policy in the face of the legalization of termination of life, namely, “what ought to be the regulatory interface between the respective practices of palliative care and termination of life?”.

Part IV turns to a broader health care evidentiary context to demonstrate that palliative care and termination of life have been and continue to be (even with termination of life legalization in certain jurisdictions) understood as substantively distinct practices, philosophically and clinically. Part IV provides an account of philosophies, definitions, and objectives of palliative care and termination of life through a variety of statements and guidelines from various health and palliative care organizations, medical associations and colleges (domestic and international). As will be discussed, the raison d’être of palliative care is to address the experience of suffering through the development and provision of meticulous whole-person care aimed at “affirming life” — enhancing its quality and improving its experience. On the other hand, termination of life seeks to end the experience of suffering by ending an individual’s life. Given the contradictory philosophies and clinical objectives, many of these organizations, though not all, expressly exclude termination of life from palliative care practice. Part IV describes that a patient-centred approach points to increasing, rather than decreasing, vigilance in terms of respecting the distinctions between palliative care and termination of life. Part IV concludes with a summary of some of the tensions at issue and offers a preliminary list of procedural/relational considerations that may be relevant to future development of a regulatory interface between these two practices.

Part V turns to legal precedent to examine the palliative care-termination of life interface as currently reflected in the termination of life laws of: the European jurisdictions of The Netherlands, Belgium and Luxembourg;
DISTINCTIONS

Colombia;\textsuperscript{10} the United States jurisdictions of Oregon, Washington, Vermont, California, Colorado and the District of Columbia;\textsuperscript{11} and Canada, which includes both the Federal \textit{medical assistance in dying} law, Bill C-14\textsuperscript{12} and Quebec’s \textit{Act respecting end-of-life care}.\textsuperscript{13} This section demonstrates how the laws consistently maintain substantive distinctions between \textit{palliative care} practice and \textit{termination of life} with some jurisdictions going so far as to recognize a right to \textit{palliative care}. The section also describes that legalization of \textit{termination of life} involves creating an exemption to the criminal law,\textsuperscript{14} with continued recourse to, and oversight by, the criminal law being a key feature of \textit{termination of life} practice. If any legal relationship

\textsuperscript{10} Constitutional Claim Decision by Chief Magistrate Carlos Gaviria Diaz C-239/97 (May 20, 1997) [hereinafter “C-239/97”]; Sentencia T-970/14 of Constitutional Court of Colombia [hereinafter “T-970/14”; Republic of Colombia, Minister of Health and Social Protection Resolution 1216 (April 20, 2015) [“Resolution 1216”].


\textsuperscript{12} Bill C-14, supra, note 8.

\textsuperscript{13} Quebec Act, supra, note 3.

\textsuperscript{14} In Switzerland, assisted suicide is not prohibited by the Swiss Penal Code. The Penal Code only prohibits assistance with suicide if done for selfish reasons. Accordingly, in Switzerland, the development of assisted suicide practice has largely evolved through the activities of right to die organizations and not through end of life discussions that resulted in amendment to the criminal law. For the same reasons, legal assisted suicide in Switzerland is not technically restricted to persons with particular medical conditions. Because of Switzerland’s unique circumstances, it is omitted from the remainder of this discussion. For further discussion see Mary J. Shariff, “Assisted death and the slippery slope—finding clarity amid advocacy, convergence, and complexity” (2012) 19(3) Current Oncology 143. Note that at the time of submission of this article, the Victoria Parliament, Australia passed the \textit{Voluntary Assisted Dying Act 2017}, No. 61 of 2017 on November 22, 2017 which received Royal Assent on December 5, 2017. Accordingly, the \textit{Victoria Act} is not included in this discussion. The \textit{Victoria Act} is anticipated to be implemented the earlier day of the day of Proclamation or June 19, 2019.
between palliative care and termination of life can be gleaned to date, it is one of legal antagonism with palliative care leveraged as a procedural safeguard for the practice of termination of life in the preponderance of termination of life laws.

The article concludes with the observation that notwithstanding the usage of terms like “spectrum” and “continuum”, philosophical, clinical and legal precedents unequivocally distinguish the practice of palliative care from the practice of termination of life — particularly in terms of their respective “endgames”. In the world of palliative care, palliative care and termination of life are by basic definition, mutually exclusive and ought to remain that way. Ensuring persons requesting termination of life have access to palliative care does not require equating termination of life practice with palliative care. Indeed, patient-centred care points to upholding these distinctions rather than collapsing them.

In Canada, despite its recent legalization, termination of life law continues to be in a state of flux and the subject of ongoing intense reform debate. While it is incontrovertibly clear that palliative care is exclusively aimed at enhancing the quality of life of all persons suffering from life-limiting illness, given its grounding in the principle of autonomy, the eventual scope and purpose of Canadian termination of life law remains unclear. The paper argues that if we are genuine in our desire to better understand suffering and to continue to improve our responses to it, it is incumbent on Canadian lawmakers to ensure that the distinction(s) between palliative care and termination of life is not only maintained but strongly promoted, especially in any future laws related to end-of-life care. Given the instability and uncertainty surrounding the

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15 The goals of palliative care are discussed in Part IV below.
regulation, scope and practice of termination of life services in Canada, lawmakers should, at minimum, provide a regulatory environment that allows for the continued clear and unfettered development of palliative care.

III. BLURRING OF DISTINCTIONS BETWEEN PALLIATIVE CARE AND TERMINATION OF LIFE

1. The Carter Case

In Carter, the Supreme Court of Canada concluded that the prohibition against aiding and abetting suicide was “void” insofar as, it deprives a competent adult of such assistance where the person affected

(1) clearly consents to the termination of life; and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition.

In arriving at this “Declaration of Invalidity”, the Court held that the prohibition on “physician-assisted dying” (whereby the “physician provides or administers medication that intentionally brings about the patient’s death, at the request of the patient”) was an infringement of the rights to life, liberty and security under section 7 of the Canadian Charter of Rights and Freedoms (the Charter) in a manner not in

17 *Supra*, note 2. The plaintiffs in the Carter case included: Gloria Taylor who was suffering from Amyotrophic Lateral Sclerosis or ALS; Lee Carter and her husband Hollis Johnson who helped Ms. Carter’s mother, Kay Carter (who was suffering from spinal stenosis) to travel to Switzerland to receive assisted dying through the organization Dignitas; and Dr. William Shoichet, a physician who would be willing to participate in physician-assisted dying if it were not prohibited. The plaintiffs brought a civil claim before the British Columbia Supreme Court challenging the constitutionality of the Criminal Code provisions against physician-assisted dying, specifically ss. 14, 21, 22, 222 and 241.

18 The Court describes s. 241(b) of the Criminal Code of Canada (aiding suicide) and s. 14 (cannot consent to one’s own death) as the provisions at the core of the challenge. *Id.*, at para. 20.

19 *Id.* at paras. 4, 127 (emphasis added).

20 *Id.*, at para. 40.

accordance with the principles of fundamental justice. The Supreme Court further found that the infringement was not saved by section 1 as the prohibition’s objectives could be achieved by implementing safeguards to protect vulnerable persons from abuse and error while allowing certain other persons to access physician-assisted dying.

The Supreme Court’s contribution — whether intentional or unintentional — to a conceptual breakdown between palliative care practice and termination of life is substantively reflected in the content of paragraph 23 which states:

The trial judge began by reviewing the current state of the law and practice in Canada regarding end-of-life care. She found that current unregulated end-of-life practices in Canada — such as the administration of palliative sedation and the withholding or withdrawal of lifesaving or life-sustaining medical treatment — can have the effect of hastening death and that there is a strong societal consensus that these practices are ethically acceptable (para. 357). After considering the evidence of physicians and ethicists, she found that the ‘preponderance of the evidence from ethicists is that there is no ethical distinction between physician-assisted death and other end-of-life practices whose outcome is highly likely to be death’ (para. 335). Finally, she found that there are qualified Canadian physicians who would find it ethical to assist a patient in dying if that act were not prohibited by law (para. 319).

22 Id., at para. 126. According to the Court, the right to life was engaged because, “the prohibition on physician-assisted dying had the effect of forcing some individuals to take their own lives prematurely, for fear that they would be incapable of doing so when they reached the point where suffering was intolerable.” Id., at paras. 57-58. Further, denying certain individuals the right to request a physician’s assistance in dying interferes with their ability to make decisions concerning their bodily integrity and medical care and thus trenches on liberty. And, by leaving people like Ms. Taylor to endure intolerable suffering, it impinges on their security of the person.

23 Id., at para. 66.

24 Id.

25 Id., at paras. 121-122.

26 Carter, supra, note 2, at para. 23 (emphasis added); see also Carter, id., at para. 66.
Unless one has the context of the full trial judgment, the synopsis of the trial judge’s conclusion concerning the ethical acceptance and foreseeability of hastened death with respect to different end-of-life practices is problematic. First, when Smith J., the trial judge, came to her conclusion with respect to hastening death (as referenced in the Supreme Court quote above), it was situated within the specific context of the withholding or withdrawal of life-saving or life-sustaining treatment.\(^\text{27}\)

It is well understood that the legal foundation for withholding or withdrawing treatment however (and as described by the trial judge),\(^\text{28}\) relates to the right of persons to be free from unwanted physical interference, whereby without consent, medical care is wrongful.\(^\text{29}\)

Second, with respect to the use of opioids in palliative care, the trial judge acknowledged that the weight of evidence was that the “proper use of opioids in palliative care does not cause death” but could “have that effect if used inappropriately.”\(^\text{30}\)

Similarly, the trial judge did not conclude that palliative sedation hastened death. Accordingly, it is misleading for the Supreme Court in \textit{Carter} to imply — or, perhaps more accurately, to be interpreted as implying — that there was societal consensus on hastening death beyond withholding/withdrawing of life saving or life sustaining treatment circumstances and the “no treatment without consent” principle. As stated by the trial judge (and as recognized by the Supreme Court), “As to physician-assisted death, weighing all the evidence, \textit{I do not find there is societal consensus either way}....”\(^\text{31}\)


\(^{28}\) \textit{Id.}, at paras. 207-224.

\(^{29}\) The Court discussed this in context of informed consent, \textit{id.}, but see also tort of battery (treatment without consent) in Philip H. Osborne, \textit{The Law of Torts}, 4d ed. (Carswell, 2011), at 282-85, 286-87, 299.

\(^{30}\) \textit{Carter BCSC}, supra, note 27, at paras. 199, 195. Note that the \textit{Carter} case appeared to ground the “no ethical distinction” conclusion on foreseeability of hastened death. For a description of the foundational ethical principles with respect to palliative care practices such as palliative sedation see Liliana De Lima \textit{et al.}, “International Association for Hospice and Palliative Care Position Statement: Euthanasia and Physician-Assisted Suicide” (2017) 20(1) Journal of Palliative Medicine 8, at 11, online: NCBI <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5177996/pdf/jpm.2016.0290.pdf> [hereinafter “\textit{De Lima et al.}”]; Distinguishing palliative sedation from euthanasia and PAS is based on the ethical principles of beneficence (duty to alleviate suffering) and nonmaleficence (duty to prevent or avoid harm). It should never be used with the intention to shorten life. \textit{Id.}

Leaving this aside for the moment, for the purposes of this discussion, the point is that the trial judge did not make any judicial finding, clinically or legally, equating physician-assisted dying with palliative care (care which may or may not include withholding or withdrawing treatment or palliative sedation). Rather, the trial judge’s observations were made to support a conclusion that, given the existence of other clinical practices where there was a possibility of risk of hastened death, there was a “strong consensus” that the practice of physician-assisted dying: “would only be ethical with respect to voluntary adults who are competent, informed, grievously and irremediably ill, and where the assistance is ‘clearly consistent with the patient’s wishes and best interests, and [provided] in order to relieve suffering’ (para. 358).”

Unfortunately, the blurring of the clinical and legal distinctions between palliative care practices and termination of life is further exacerbated by commentary that relies on abstractions or non-contextual excerpts from the Carter case. It is therefore very important to keep in mind that the Canadian Supreme Court in Carter is entirely silent as to the precise nature of the relationship between palliative care and termination of life. Moreover, given certain other statements made by the Supreme Court, one might reasonably take the view that the Court implicitly acknowledged certain distinctions between these activities. For example, the Supreme Court observed that those in favour of reform of physician-assisted dying laws have highlighted “the limits of palliative care in addressing suffering”, that is, have highlighted the suggestion that termination of life might somehow begin where palliative care ends. The Supreme Court also noted that the trial judge “rejected the argument that the legalization of physician-assisted dying would impede the development of palliative care in the country, finding that the effects of a permissive regime, while speculative, ‘would not necessarily be negative’ (para. 736)”, an implicit suggestion that the trajectory of palliative care practice is distinct from physician-assisted dying.

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32 Carter, supra, note 2, at para. 24 (emphasis added).
33 See, for example, Dan Lett, “The torturous ethics of assisted death”, Winnipeg Free Press (June 24, 2017) online: <https://www.winnipegfreepress.com/opinion/analysis/the-torturous-ethics-of-assisted-death-430492323.html>.
34 Carter, supra, note 2, at para. 6. Note that limits of palliative care frequently relate to patient rejection of palliative care intervention and not to the futility of the palliative care approach. See also discussion in Carter BCSC, supra, note 27, at paras. 188-202.
35 Carter, supra, note 2, at para. 26; see also id, at paras. 27, 106 and 107.
2. Quebec: An Act Respecting End-of-life Care

On December 10, 2015, Quebec’s Act respecting end-of-life care came into force. The Quebec Act establishes a right to receive “end-of-life care” which is defined by the Quebec Act as “palliative care provided to end-of-life patients and medical aid in dying”. The Quebec Act introduced medical aid in dying for individuals “of full age” and at the “end of life”, notwithstanding that at the time, the Criminal Code provisions that prohibited medical aid in dying were still in effect.

The Quebec Act describes its purpose as follows:

The purpose of this Act is to ensure that end-of-life patients are provided care that is respectful of their dignity and their autonomy. The Act establishes the rights of such patients as well as the organization of and a framework for end-of-life care so that everyone may have access, throughout the continuum of care, to quality care that is appropriate to their needs, including prevention and relief of suffering.

Accordingly, the Quebec Act advances the concept of an end-of-life continuum of care which includes both palliative care and medical aid in dying and therefore the Act, conceptually and practically, links these two activities. But a closer look at the Quebec Act reveals that the legislation

36 Quebec Act, supra, note 3.
37 Quebec Act, id., Title II, Chapter I, s. 3(3) (emphasis added). Note the Quebec Act also establishes an advance directives medical regime. Id., Title 1, s. 1 and Title III.
38 To qualify for medical aid in dying an individual must be: insured; of full age and capable of giving consent to care; at the end of life; suffering from a serious and incurable illness; in an advanced state of irreversible decline in capability; and experiencing constant and unbearable suffering (physical or psychological). Quebec Act, id., Title II, Chapter IV, Division II, s. 26.
40 In addition to suspending the Declaration of Invalidity for one year (to February 6, 2016), in January 2016, the Supreme Court unanimously granted the Attorney General Canada a four-month extension of the suspension to June 6, 2016. Carter 2016, supra, note 25. At the request of the Attorney General of Quebec, however, the Supreme Court (in a 5-4 split decision) granted Quebec an exemption from the four-month extension, thereby allowing the Quebec Act to continue to operate without constitutional challenge. Carter 2016, id., at paras. 4, 7. Note that none of the Attorneys General opposed the Quebec Attorney General’s request to be exempt from the extension of the suspension. The matter of whether the Quebec Act (advanced inter alia under provincial jurisdiction related to health) was constitutionally sound (given the Federal Government’s jurisdiction over criminal law) was not ultimately challenged or tested in a court of law. For further discussion, see in context of the Appellant’s claim for inter-jurisdictional immunity in Carter, supra, note 2, at paras. 49-53.
41 Quebec Act, supra, note 3, Title I, s. 1 (emphasis added); see also earlier discussion of palliative care and medical aid in dying as both being part of a “continuum of care” in Quebec in Quebec National Assembly, Select Committee on Dying with Dignity, Dying with Dignity Report (March 2012), online: RICU <http://www.ricu.qc.ca/pdf/documents/rapports/index.pdf> [hereinafter “Quebec Report”].
actually treats the activities as entirely distinct. For example, the Quebec Act defines palliative care and medical aid in dying, respectively, as follows:

“palliative care” means the total and active care delivered by an interdisciplinary team to patients suffering from a disease with reserved prognosis, in order to relieve their suffering, without delaying or hastening death, maintain the best quality of life possible and provide them and their close relations the support they need;42

“medical aid in dying” means care consisting in the administration by a physician of medications or substances to an end-of-life patient, at the patient's request, in order to relieve their suffering by hastening death.43

The Quebec Act further defines “continuous palliative sedation” as “part of palliative care” (and therefore legally an act that does not delay or hasten death) and consists of:

administering medications or substances to an end-of-life patient to relieve their suffering by rendering them unconscious without interruption until death ensues.44

It should be noted that the Quebec Act restricts medical aid in dying to the act of euthanasia (physician administration of medications or substances to hasten death) and therefore further conveys a key substantive distinction between medical aid in dying and palliative care: the former is clearly intended to cause the death of the patient, whereas the latter is not.

In addition to treating palliative care as substantively distinct from medical aid in dying, the Quebec Act imposes different procedural protocols and safeguards depending on which category of “care” is at issue. For medical aid in dying in Quebec, for example, the patient must request it “themselves”.45 Because the Quebec Act further establishes a “right” to receive “end of life care”,46 in addition to establishing a right to medical aid in dying, the Quebec Act also establishes a separate and distinct right to palliative care.

42 Quebec Act, id., at Title II, Chapter 1, s. 3(4) (emphasis added).
43 Id., at Title II, Chapter 1, s. 3(6) (emphasis added).
44 Id., at Title II, Chapter 1, s. 3(5) (emphasis added).
45 Id., at Division 2, s. 26. Whereas Medical Aid in Dying is addressed in Chapter IV, Division 2, refusal of life-sustaining care or withdrawal of care is addressed in Chapter II, Continuous Palliative Sedation is addressed in Chapter IV, Division 1.
46 Id., Title II, Chapter 2, s. 4. Note that the right is not an unfettered right, as it is to be applied “within the limits of the human, material and financial resources...”; Id.
Because Quebec’s legislation restricts medical aid in dying to those at end of life, the usage of the term “continuum” might have a certain logic to it, given that the legislation is described as reflecting a motivation of the human desire for a “good death”. On the other hand, the substance of the two responses to dying remains entirely distinct, and thereby challenges the appropriateness of “continuum” language. Furthermore, from a patient-centred perspective, the patient determines what constitutes a “good death”, and thus regulatory structures need to support this autonomous decision by keeping the distinctions clear.


On August 14, 2015, “eleven participating provinces and territories” appointed a nine-member “Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying” to provide non-binding advice to Provincial and Territorial Ministers of Health and Justice on “issues related to physician-assisted dying”. Following consultations with different interest groups and stakeholders, the Provincial-Territorial Report was issued a little less than three months later on November 30, 2015, just before the Quebec Act came into effect. According to the Report, the advice provided was to “assist provinces and territories in deciding what policies and procedures should be implemented within their jurisdictions in response to the Supreme Court’s decision in Carter”.

The principal theme emerging from the Provincial-Territorial Report’s recommendations was the development and implementation of a
“pan-Canadian strategy for palliative and end-of-life care, including physician assisted dying” through collaboration with the provinces, territories and federal governments as well as with relevant institutions and organizations. In addition to recommending collaboration and coordination, the Report made recommendations related to physician-assisted dying access, processes and documentation, eligibility assessment, conscientious objection, institutional obligations, oversight and review, and education and training.

Throughout the Report, an equivalence between termination of life (or “physician-assisted dying” as it is referred to in the report) and palliative care is advanced, directly and indirectly.

For example, the Report’s Foreword states:

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

The foregoing statement of belief links termination of life to palliative care. It frames “physician-assisted dying” as end-of-life care and advocates for its inclusion on a “continuum” of end-of-life services. This endorsement of termination of life as part of an end-of-life care continuum and/or its commonality with palliative care is echoed throughout the Report.

The Provincial-Territorial Report, however, provides no express justification for placing physician-assisted dying on an “end-of-life” continuum alongside palliative care and indeed, the Report makes

50 Recommendations 1 and 2, id., at 5.
51 Recommendations 1-43, id., at 5-11.
52 “Physician-assisted dying is one option in the end-of-life care continuum”. Id., at 18.
Finally, we believe that physician-assisted dying should be integrated into existing end-of-life processes and mechanisms as much as possible. ... Physician assisted dying should be treated as one appropriate medical practice within a continuum of services available at the end-of-life.
Id., at 19;
Public education and engagement are critical to a transparent system of end-of-life care, including physician-assisted dying. There is a need for public education on what physician-assisted dying is (and what it is not), how it fits within a continuum of end-of-life services, how it can be accessed and under what conditions, and how physician-assisted dying is governed, administered, and monitored, including what safeguards are in place.
Id., at 51; see also, for example, id., at 24, 28, 29, 36, 41, 44, 49 and 50.
no mention of the definition or substance of palliative care. Rather, it appears that the principal purpose for creating a conceptual linkage between palliative care and physician-assisted dying is to promote access to physician-assisted dying services across Canada and then to dismiss access to palliative care as a necessary pre-condition to physician-assisted dying access.53

Additionally, the Report encourages a broad interpretation of the Carter case in terms of the individuals who would qualify for physician-assisted dying services. For example, the Report makes the following observation:

It is notable that the Supreme Court did not limit the ruling to those unable to take their own lives, to cases of terminal illness, or to people near death. The Court’s declaration is also not restricted to physical illnesses, diseases or disabilities, and includes mental illness.54

The Report goes on to recommend that the Carter qualifying criteria of “grievous and irremediable medical condition” should not be specifically delineated in legislation or regulation but rather defined “as a very severe or serious illness, disease or disability that cannot be alleviated by any means acceptable to the patient”55 and determined on a case by case basis.56 Furthermore, the Report recommends that physician-assisted dying should be available to patients through an advance declaration “when certain conditions that the patient believes would constitute enduring intolerable suffering are met, even if the patient will no longer be competent when those conditions are met”.57 This would potentially include physician-assisted dying for conditions such as dementia, non-terminal illness and various forms of disability. In other words, the Report recommends that physician-assisted dying access

53 See, for example, discussion, id., at 20, 23-24. For instance, while it is conceded that a lack of access to palliative care “might, in some specific cases, threaten various elements of a valid consent”, withholding access to physician-assisted dying is not the correct response: “Better palliative care should not be seen as a pre-condition for the development of a system that permits physician-assisted dying, but rather as a complement to improved end-of-life care.” Id., at 20. It might be useful to note here that the provision of palliative care information (though not necessarily palliative care itself) subsequently became a required element for achieving informed consent for termination of life under the Canadian law, Bill C-14. Bill C-14, supra, note 8, s. 3.
54 Provincial-Territorial Report, supra, note 6, at 15 (emphasis added).
55 Recommendation 18, id., at 7, 18-19.
56 Id., at 35.
57 Id., at 31; see also id., at 34-37.
should not be restricted to individuals actually at the end of life but should be available to respond to a range of illnesses, disease, and disabilities. Thus, the Report’s connecting of physician-assisted dying, “a new practice in Canada”, to the language of “end of life” not only obfuscates the difference between the objects of termination of life and palliative care practice, it is also inconsistent with the substance of the Report’s own recommendations — unless the phrase “end of life” is meant to be taken as mutable, fluctuating between consequential and causal meanings. Without some explanatory precision in this regard, however, the Report’s use of the term “end of life”/“end-of-life” creates a false equivalency.

A similar muddying within the Report is evident in the usage of the word “continuum” in the first place. The Report seems to imply (like Quebec) that both palliative care and physician-assisted dying ought to be included on an end-of-life continuum of services (see excerpt from the Foreword above). However, unlike Quebec, the Report is unequivocal in its position that palliative care services do not have to be made available in order to proceed with physician-assisted dying, thereby repudiating the basic concept of continuum, at least as it concerns the process or interface between palliative care and physician-assisted dying. For example, as stated by the Report:

…withholding physician-assisted dying from everyone until palliative care is available and offered to all is not the appropriate response, as it denies those who are eligible the right to die in the manner they choose. Instead, society should work tirelessly to improve access to quality palliative care

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58 Id., at 50.
and health care providers should ensure that, in each individual case, any consent to physician-assisted dying is free and informed and made by a competent individual within the constraints of the system.59

Granted, the above statement is made within a discussion of informed consent, but it is nonetheless important to observe that the Report actually only expressly describes the inclusion of *physician-assisted dying* as a required option within a “continuum of end-of-life services”.60

In any event, the following question is ultimately raised by review of the Provincial-Territorial Report: if *physician-assisted dying* is not to be limited to end-of-life circumstances clinically speaking, and if *palliative care* does not actually have to be made available (for whatever reason) in order to proceed with *physician-assisted dying*, then what does the phrase “end-of-life continuum of services” substantively convey?

### 4. Report of the Special Joint Committee on Physician-Assisted Dying

In December 2015, the House of Commons and Senate established a Special Joint Committee on Physician-Assisted Dying [the “Joint Committee”] to: “…make recommendations on the framework of a federal response on physician-assisted dying that respects the Constitution, the Charter of Rights and Freedoms, and the priorities of Canadians.”61

In February 2016, the Joint Committee issued its report, “Medical Assistance in Dying: A Patient-Centred Approach”62 and made recommendations regarding who should be eligible for “medical assistance in dying” or “MAiD” as well as the processes to ensure that only those eligible for MAiD could avail themselves of it. “Guided by” the *Carter* case and following a number of hearings, the majority of the Joint Committee made 21 recommendations including recommendations concerning eligibility criteria, advance directives, processes, safeguards, conscientious objection, referrals, reporting, public awareness, and improvements to health supports and services including for mental health and dementia.63

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59 Id., at 20.
60 Id., at 3, 18, 19 and 51.
62 Id.
Similar — though not identical — to the Provincial-Territorial Report, the Joint Committee Majority Report recommended that the term “grievous and irremediable medical condition” not be specifically defined and that access to MAiD be made available to individuals with both terminal and non-terminal conditions, which would include mental illness as a qualifying condition and consent achieved through the use of advance directives.64

In terms of palliative care, the Joint Committee Majority Report explicitly acknowledged that many Canadians “do not have access to high quality palliative care when they need it.”65 The Report recommended that culturally and spiritually appropriate end-of-life care services, including palliative care, be made available to Indigenous patients; and that a Secretariat on Palliative and End-of-Life care be established along with the development and implementation of a pan-Canadian palliative and end-of-life strategy.66

Unlike the Provincial-Territorial Report, the Joint Committee Majority Report does not directly conflate palliative care with termination of life; the use of “end of life” language in the Report is predominantly in reference to the specific machinations of the Quebec Act. Furthermore, the Joint Committee Majority Report offers some additional insight as to why Quebec describes medical aid in dying on a “continuum of end-of-life care”. According to the Report, by situating medical aid in dying within a continuum of end-of-life care, medical aid in dying is brought under provincial jurisdiction over health care delivery. This in turn provided Quebec, a provincial government, the jurisdictional wiggle room to offer and regulate medical aid in dying, notwithstanding the federal criminal law to the contrary (at that time).67

Note, again, that situating medical aid in dying in “end-of-life” care logically limits medical aid in dying access to dying patients which is indeed the case under the current Quebec Act.68

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64 Recommendations 2-4 and 6, id., at 12-15, 21-24.
65 Id., at 33.
66 Recommendations 18 and 19, id., at 32-33.
67 Id., at 7; see also general discussion in Quebec Report, supra, note 41, at Part II; see also discussion in J. Nicol & M. Tiedemann, Euthanasia and Assisted Suicide in Canada, Publication No. 2015-139-E (December 15, 2015), at 8. For the matter of Quebec’s non-compliance with Criminal Code provisions, see supra, note 40.
68 See qualifying criteria in Quebec Act, supra, note 3; see also discussion in Quebec Report, id., at 60.
For these reasons, the Joint Committee Majority Report appears more coherent than the Provincial-Territorial Report. Even so, the Joint Committee Majority Report contributes to a certain amount of blurring between palliative care and termination of life as the Report makes recommendations for the development of a “palliative and end-of-life strategy” without either defining “palliative” or “end-of-life” or providing clarification as to whether MAiD should be included in the envisioned “end-of-life strategy”.

5. “Bill C-14” — the Canadian Medical Assistance in Dying Law

The termination of life debate in Canada eventually distilled down to the Canadian Medical Assistance in Dying law commonly known as Bill C-14, which came into effect on June 17, 2016. Bill C-14, among other things, creates “exemptions from the offences of culpable homicide, aiding suicide and administering a noxious thing” in order to permit certain health care providers to administer, prescribe or provide a substance to cause death (MAiD) to requesting patients whose medical conditions cause them enduring and intolerable suffering and whose natural deaths are “reasonably foreseeable”.

Bill C-14 doesn’t expressly describe the relationship between palliative care and MAiD, nor does it provide a definition of palliative care. It does, however, describe palliative care as a “means” to relieve suffering and positions it as a key element for achieving informed consent for MAiD. That is, a patient can give informed consent to receive MAiD only “after having been informed of the means that are available to relieve their suffering, including palliative care” (what palliative care options are actually available is another question entirely). As will be demonstrated in Part V, Bill C-14’s leveraging of palliative care to satisfy consent to MAiD is common to the termination of life laws in the other termination of life permissive jurisdictions. That palliative care has been intentionally positioned to sit in legal tension with requests for MAiD challenges the notion of continuum qua continuous sequence.

Bill C-14 also makes reference to the importance of palliative care, describing a commitment to helping facilitate access to palliative and

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69 Bill C-14, supra, note 8, at Summary and s. 3; see also Criminal Code, supra, note 39, s. 241.2.

70 Id.
end-of-life care\textsuperscript{71} and calling for parliamentary review of the provisions of the Bill and of the state of palliative care in Canada five years after the Bill is in effect.\textsuperscript{72}

6. Preliminary Observations

The relationship between \textit{palliative care} and \textit{termination of life} is much more complex than what has thus far been revealed through the MAiD legalization debate in Canada.\textsuperscript{73} During the course of Canadian \textit{termination of life} law reform, however, certain politico-legal inputs have expressly or impliedly equated or conflated \textit{palliative care} with \textit{termination of life} practice, including through language such as “continuum” and “spectrum”. This raises the question as to what ought to be the regulatory interface between these two practices.

Three additional key questions that arise out of this Canadian dialogue include:

1. What is the purpose, scope and trajectory of MAiD practice in Canada?

2. What is the current understanding of health care providers and the public regarding the substance of the respective practices of \textit{palliative care} and MAiD?

3. What legal considerations arise out of the jurisdictional aspects of MAiD, \textit{i.e.}, criminal law and health law.

The discussion now turns to a description of how the practice of palliative and health care is presently understood from the perspective of health care associations, organizations and medical colleges. As will be discussed, the preponderance of \textit{palliative care} definitions, objectives and perspectives arising from palliative care, medical associations, societies and colleges expressly exclude the practice of \textit{termination of life}.

\textsuperscript{71} Bill C-14, \textit{id.}, at Preamble.

\textsuperscript{72} \textit{Id.}, at Summary and s. 10.

IV. ASSOCIATIONS, SOCIETIES AND COLLEGE PERSPECTIVES ON PALLIATIVE CARE AND TERMINATION OF LIFE

1. Palliative Care Associations and Societies

Within Canada alone there are no less than 13 palliative care associations and hospice societies. There are dozens more internationally. The central objective of these associations and societies is to develop and promote end-of-life care strategies so that suffering can be relieved and care aimed at quality of life can be provided to patients, their families and carers. By promoting research and implementing initiatives to improve the quality of the death experience, palliative care associations can properly be described as seeking to help patients achieve “a good life to the very end”.

The critical perspective imparted by national and international palliative care associations is that dying is a natural or normal process of living and that dying well is part of living well. This perspective

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74 Palliative care associations reviewed include those in the jurisdictions of Canada, Netherlands, Belgium, Luxembourg, Switzerland, the states of Oregon, Washington, Vermont, California and Montana in the United States, as well as other international palliative care associations.

75 For a list of provincial palliative care associations, see Canadian Hospice Palliative Care Association, “Provincial Associations,” (2016) online: CHPCA <http://www.chpca.net/about-us/provincial-associations.aspx>.

76 For a list of international palliative care associations, see International Association for Hospice and Palliative Care, “Global Directory of Palliative Care Services, Hospices, and Organizations,” (2016) online: Hospice Care <http://hospicecare.com/global-directory-of-providers-organizations/>.


accordingly informs and illuminates two central pillars of palliative care: (1) the philosophy: palliative care seeks to affirm life; \(^{80}\) and (2) the intent: palliative care intends neither to hasten nor postpone death. \(^{81}\)

(a) Philosophy: Palliative Care is Life-affirming

Palliative care organizations describe a “life-affirming” response to suffering at end of life, one that is comprehensive, responds to all threats to life and aims to relieve suffering in all its dimensions. As “whole person” care, palliative care is aimed at addressing the patient’s symptoms as well as their “needs, hopes and fears”, \(^{82}\) including physical,
psychological, social, cultural, spiritual, and existential threats or needs, so that the patient can live life “fully to the very end with dignity and respect.”

Accordingly, palliative care is about achieving the best quality of life, which includes achieving “quality in dying” and can involve meaningful and valuable experiences during the dying process. Palliative care can involve, for example, meeting with a multi-disciplinary team, talking openly about illness and prognosis, psychosocial and spiritual support, goal setting, opportunities to visit and revisit the care plan, pain and symptom management and educational seminars for patients, family members and other carers. The process of dying “often leads to enhanced meaning and purpose and can be a sacred experience for the patient and family.”

High-quality palliative care can provide significant opportunities for personal, social and spiritual growth and for reconciliation within families, despite the very real presence of physical decline.
Many palliative care associations also articulate the belief of an inverse relationship between palliative care and termination of life, i.e., that access to high-quality palliative care may alter requests for termination of life. This belief is grounded in clinical experience and therefore conveys one practical relational consideration. It also reflects a more expansive procedural protocol, i.e., that patients experiencing suffering from life-limiting illness be met with life-affirming responses — in essence, a means of exploratory truth-seeking that can help uncover patient-centred factors that may, among other things, lead individuals to request termination of life. Indeed, a wish for hastened death is not necessarily synonymous with a genuine desire to die.

In addition to vertical (care-team/patient) and horizontal (care-team/patient/family/carers) truth-seeking, the provision of palliative care also incorporates contemplation of capacities to respond. This in turn nudges into view macro perspectives on vulnerability. Thus, as reflected upon by the European Association of Palliative Care (EAPC), “[g]ood provision of palliative care is paramount in order to ensure that people don’t ask for euthanasia through lack of optimal symptom control or private or social marginalization.”

88 For Canadian palliative care associations that make this claim, see Canadian Society of Palliative Care Physicians, Brief to the Standing Committee on Justice and Human Rights, (2016), online: CSPCP <http://www.cspcp.ca/wp-content/uploads/2016/05/Submission-from-Canadian-Society-of-Palliative-Care-Physicians.pdf>; Canadian Hospice Palliative Care Association, CHPCA Issues Paper on Euthanasia, Assisted Suicide and Quality End-of-Life Care (2010), at 6, online CHPCA: <http://www.chpca.net/media/7835/PHD_Issues_Paper_-_April_24_2010_-_Final.pdf> [hereinafter “CHPCA Issues”]; For international associations, see Materstvedt et al., Euthanasia, supra, note 81, at 99; CHAPCA, supra, note 80; See also generally discussion in De Lima et al., supra, note 30.


90 See, for example, CHPCA Issues, supra, note 88, at 4; Radbruch et al., id., at 7.


92 Radbruch et al., supra, note 81, at 11 and discussion, id., at 9-10; see also Materstvedt et al., Euthanasia, supra, note 81, at 99; see also discussion in R. Cohen-Almagor, “First do no harm: intentionally shortening lives of patients without their explicit request in Belgium” (2015) 41 J. Med. Ethics 625.
The “life-affirming” pillar of palliative care thus functions as both (a) “message” — pain and suffering can be addressed by means other than hastened death and (b) “medium” — an approach that can tease out the reasons behind a request for hastened death and hopefully begin to respond to help support that life. For example, the Canadian Society of Palliative Care Physicians (CSPCP) advocates for universal access to palliative care so that no Canadian feels that “hastened death is the only option by means of which to minimize suffering.”

The life-affirming philosophy of palliative care also undergirds and stimulates medical innovation as well as the proactive and preventative focus of palliative care practice, research and development. Palliative care research explores the origins of physical pain and suffering “at an earlier time in the trajectory of disease” so that palliative care can be introduced early and integrated into the management of serious illness. Thus, even though palliative care offers much to patients specifically requesting termination of life, palliative care associations and practitioners consistently emphasize that palliative care should not be reduced to a mere gatekeeping role for termination of life.

At minimum, the “life-affirming” pillar of palliative care can therefore be seen to point to a dialogue and vision that translates inter alia into critical familial/social messaging, care processes, and research and development aimed at the prevention and relief of suffering by

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94 There “is wide recognition that the principles of palliative care should be applied as early as possible in the course of any chronic, ultimately fatal illness.” Cecilia Sepúlveda et al., “Palliative Care: The World Health Organization’s Global Perspective” (2002) 24:2 Journal of Pain and Symptom Management 91, at 92; see also discussion in Romayne Gallagher et al., “Palliative Care: Therapy for the living” (2016) 58:5 B.C. Medical Journal, at 257-58; Anthony J. Caprio, “Palliative care: renaming as supportive care and integration into comprehensive cancer care” (2016) 188:10 Canadian Medical Association Journal 711, at 711.

95 De Lima et al., supra, note 30, at 12; Materstvedt et al., Euthanasia, supra, note 81, at 99; Canadian Society of Palliative Care Physicians, “Important Message for all MPs in Canada re Bill C-14 and Bill C-277” (June 16, 2016) online: CSPCP <http://www.cspcp.ca/wp-content/uploads/2016/06/Letter-from-the-Canadian-Society-of-Palliative-Care-Physicians-16-June-2016.pdf> [hereinafter “CSPCP Message”].
facilitating quality of life, endowing meaningful choice and protecting against/addressing vulnerability. Taken together, these factors have prompted calls to establish universal access to *palliative care* as a human right, nationally and internationally.96

(b) Intention: Neither to Hasten nor Postpone Death

Consistent with the “life-affirming” philosophy, the second principal pillar of *palliative care* is that it seeks neither to hasten nor postpone death.97 This is in stark contrast to the intention and sole goal of *termination of life* which is to cause immediate death.98

On this basis, many palliative care associations expressly distinguish *palliative care* practice from *termination of life*. The Canadian Society of Palliative Care Physicians for example, unequivocally states that medical aid in dying is “NOT part of the practice of palliative care”,99 a position


97 Materstvedt et al., Euthanasia, supra, note 81, at 98; Radbruch et al., supra, note 81, at 5; CHPCA Model Guide, supra, note 79, at 6.

98 “In euthanasia the intention is to kill the patient ... and the successful outcome is immediate death” (emphasis in the original). Materstvedt et al., Euthanasia, id., at 99; see also Bill C-14, supra, note 5, at Preamble and s. 3 and Criminal Code, supra, note 39, s. 241.1.

99 CSCP Submission, supra, note 93; see also CSPCP Message, supra, note 95.
also taken by the EAPC and the International Association for Hospice and Palliative Care.\textsuperscript{100}

Advocates who have argued that there is no distinction between \textit{palliative care} and \textit{termination of life} often focus on this aspect of \textit{palliative care} practice seeking to equate \textit{termination of life} with \textit{palliative care} by trying to demonstrate that certain \textit{palliative care} practices either hasten death or have the same outcome as \textit{termination of life}.\textsuperscript{101} This reductionist view of \textit{palliative care} however disregards the legal significance of intention and overlooks the concomitant life-affirming philosophy upon which the entire practice is premised.\textsuperscript{102}

(c) Complementarity or Choice?

In jurisdictions where \textit{termination of life} has been legalized, there are a few palliative care associations that describe \textit{termination of life} and \textit{palliative care} as complementary and embed, to some extent, \textit{termination of life} practice within \textit{palliative care}.

For example, in the Netherlands, Palliatieve Zorg (PZ) states that all of the legal options in the Netherlands — euthanasia, terminal sedation, withholding of food or treatment — can be offered to the patient as a part of \textit{palliative care}.\textsuperscript{103} Intriguingly, however, and consistent with other palliative care associations, PZ still affirms the WHO Definition\textsuperscript{104} and

\textsuperscript{100} De Lima \textit{et al.}, \textit{supra}, note 30, at 12 and Materstvedt \textit{et al.}, \textit{Euthanasia, supra}, note 81, at 99; Radbruch \textit{et al.}, \textit{supra}, note 81, at 2, 8; see also discussion in Louis C. Charland \textit{et al.}, “Decision-Making Capacity to Consent to Medical Assistance in Dying for Persons with Medical Disorders” (2016) 1 Journal of Ethics in Mental Health 1, at 8.


\textsuperscript{102} For brief discussion see Ontario Medical Association, “Palliative Care Backgrounder: OMA’s End of Life Care Strategy” (April 2014), at 1.


\textsuperscript{104} WHO Definition, \textit{supra}, note 1, and associated text.
philosophy of palliative care which clearly distinguishes palliative care from the intentional hastening of death.\textsuperscript{105}

With respect to Flanders region of Belgium, the European Institute of Bioethics (IEB) describes this development as follows:

> euthanasia has entered the field of ‘good medical practice.’ This idea of complementarity [between palliative care and euthanasia] seems to have been quickly adopted by the three federations of palliative care in Flanders … [and] since 2003 the FPCF has endorsed the vision of ‘integrated palliative care.’\textsuperscript{106}

For the Federation Palliative Care Flanders (FPCF), palliative care includes full and proper consideration of a patient’s request for euthanasia\textsuperscript{107} or “euthanasia accompaniment”.\textsuperscript{108} Thus, the FPCF sees euthanasia as an option that serves the goals of palliative care.\textsuperscript{109} Yet, like PZ in the Netherlands (and for that matter the majority of palliative care associations worldwide), the FPCF affirms the WHO Definition of palliative care,\textsuperscript{110} describing that while it may occasionally be acceptable to consider both “together when caring for one and the same patient,” the WHO Definition excludes euthanasia from the practice of palliative care.\textsuperscript{111}

Given that these associations expressly recognize that palliative care is distinct from termination of life, the notion of “complementarity” makes little sense unless it is viewed from the perspective of advocating patient “choice” rather than from the perspective of the medical practitioner/activity. The movement to embrace termination of life as part of patient choice within palliative care can be observed in Oregon, the

\begin{footnotesize}
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    \item \textsuperscript{106} European Institute of Bioethics, Does the Belgian Model of Integrated Palliative Care Distort Palliative Care Practice? (European Institute of Bioethics, 2015), at 3, online: IEB <http://www.ieb-eib.org/en/pdf/20151126-euthanasie-et-soins-palliatifs-english.pdf> [hereinafter “IEB”].
    \item \textsuperscript{107} Id., citing Federatie Palliatieve Zorg Vlaanderen, “Over palliatieve zorg en euthanasie” (September 22, 2011) [hereinafter “Federation Palliative Care Flanders”].
    \item \textsuperscript{108} Paul Vanden Berghe et al., “Assisted Dying--The Current Situation in Flanders: Euthanasia embedded in palliative care” (2013) 20:6 European Journal of Palliative Care 266, at 266 [hereinafter “Vanden Berghe et al.”].
    \item \textsuperscript{110} Vanden Berghe et al., supra, note 108, at 268.
    \item \textsuperscript{111} Id.
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American state with the longest history of PAS.\textsuperscript{112} For example, the Oregon Hospice and Palliative Care Association states as follows:

Oregon’s Death With Dignity Act went into effect in 1997. It no longer matters whether physician-assisted dying should or should not be permitted. It is a legal option in Oregon. Oregonians need not choose between hospice and physician-aid in dying. Dying Oregonians can choose both from among the options on the end-of-life continuum of care.\textsuperscript{113}

Because the mandate of palliative care is to help identify and address suffering by providing patients with options and choice (a “good death”), and because euthanasia requests more often relate to a desire to be in control, fear of dependency and existential despair (rather than a failure of palliative care),\textsuperscript{114} it perhaps seems logical to endorse termination of life as just another item on a list of options available to a patient within palliative care. After all, palliative care “is no panacea” and there will be some whose suffering or symptoms will not be relieved by palliative care.\textsuperscript{115}

Two additional key considerations put forward to argue in support of a “euthanasia-embedded” approach are health care professional obligations of “continuity of care” and patient “non-abandonment”.\textsuperscript{116} As described by the FPCF, if a palliative care professional declines a patient’s request for euthanasia, leaving them to an external medical practitioner outside the context of the regular and familiar care team, this is not “optimal care” but rather a form of patient abandonment.\textsuperscript{117}

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\textsuperscript{112} Oregon Act, supra, note 11.


\textsuperscript{114} Vanden Berghe \textit{et al.}, supra, note 91.

\textsuperscript{115} Bernheim & Mullie, supra, note 91; In \textit{Carter}, the Supreme Court noted that those in favour of PAD law reform highlighted “the limits of palliative care in addressing suffering.” \textit{Carter}, supra, note 2, at para. 6; Dr. Donald Low also commented on the limits of palliative care: “palliative care is a major role, and a valuable role, but [it] cannot take away the symptoms that I’m going to have, [it] can help make it a little bit better, but I’m still going to suffer from loss of strength, loss of ability to either eat or swallow … these are things that palliative care is going to hopefully make it a little bit easier to face, but they’re not going to take them away.” See Youtube, “In Memory of Dr. Donald Low”, (September 24, 2013), at 00h:02m:10s, online: <https://www.youtube.com/watch?v=q3jgSkxV1rw>; see also College of Physicians and Surgeons Canada, CFPC Task Force on End-of-Life Care: Summary Report, (2015), at 3.

\textsuperscript{116} Vanden Berghe \textit{et al.}, supra, note 108, at 267.

\textsuperscript{117} \textit{Id.}
the “crucial domains” (e.g., physical suffering that is difficult to relieve, unrecognized depression, guilt issues, pressure from family, loss of meaning etc.) and thus brings “important added value”. But note how “euthanasia-embedded” palliative care — premised on concepts of patient choice, continuity of care, patient non-abandonment and the added-value of palliative care for individuals requesting termination of life — does not provide any insights for resolving the conflicting philosophies/intentions/objectives at a macro level. Moreover, as participation in termination of life is voluntary, this approach reduces these conflicts to one that bears primarily on the personal choice or conscience on the part of the health care professional who may or may not, as the FPCF puts it, be able to “go the full way”. This begs the question whether the substance of the conflicting philosophies/intentions/objectives between palliative care and termination of life is appropriately resolved, structurally-speaking, by the internal exercise of conscience on the part of individual physicians. Asking this question is not to dismiss the importance and protection of the exercise of HCP conscience with respect to termination of life, but is rather aimed at prompting consideration of the macro-dimensions (e.g., cultural, economic, social, legal etc.) of palliative care and termination of life that could be overlooked if the substantive conflict is not transparently scrutinized and fully appreciated. For example, a physician who does not personally perceive any conflict between the practices and views termination of life as simply one health care option among many, may overlook legal safeguards specific to termination of life practice such as the safeguard that termination of life must be expressly requested by an individual themselves and not introduced by the HCP. Arguably, promoting patient choice through HCP declarations of “complementarity” between palliative care and termination of life paradoxically undermines


119. Vanden Berghe et al., supra, note 108, at 269.

120. Exercise of conscience and professional judgment by HCPs in matters related to termination of life is an important and standard aspect of all legislated termination of life schemes globally. Comparison between termination of life schemes is discussed in more detail in Part V, below.

patient choice and increases risk of coercive influences by provoking a shift in the locus of control away from the patient and towards the physician.

2. Medical Associations

Medical Associations provide guidance to physicians and promote the art and science of medicine, as well as the betterment of public health. Consistent with palliative care associations, most medical associations distinguish palliative care from termination of life as life-affirming, whole-person care with no intention to hasten or prolong death versus intention to cause death. In terms of termination of life, medical associations can be seen to have at least four perspectives: in conflict with palliative care/medicine; neutral towards legalization; tolerance, last resort or marginal choice; and/or silence, pragmatism.

(a) In Conflict with Palliative Care/Medicine

According to the World Medical Association (WMA), termination of life is both distinct from and in conflict with the principles of medical practice that underlie palliative care. For the WMA, while certain treatments intended to alleviate suffering “may have the additional effect of accelerating the dying process,” these treatments remain distinct from euthanasia and physician-assisted suicide, which intend death. Furthermore, the WMA, like the WHO, does not view palliative care as a mere privilege, but as a right, and “fundamental to improving people’s

122 Medical associations reviewed include those in the jurisdictions of Canada, United Kingdom, Netherlands, Belgium, Luxembourg, Switzerland, the states of Oregon, Washington, Vermont, California and Montana in the United States, Australia and the World Medical Association.


125 Id.; see also World Medical Association, “WMA Declaration on End-of-Life Medical Care” (adopted October 2011), online: WMA <https://www.wma.net/policies-post/wma-declaration-on-end-of-life-medical-care/>.
quality of life and well-being”. The WMA does not view termination of life as a right and maintains the position that a physician who intentionally or deliberately hastens a patient’s death has acted unethically and further “condemns as unethical both euthanasia and physician-assisted suicide.”

Similarly, the British Medical Association (BMA) distinguishes between palliative/“end-of-life” care (care to live as well as possible until death) and “physician-assisted dying” (measures intentionally designed to terminate a person’s life) and opposes the latter, describing it as being in conflict with “the ethics of clinical practice”, as the principal purpose of medicine is to improve patients’ quality of life, not foreshorten it. The BMA supports the “establishment of a comprehensive, high quality palliative care service available to all.”

The Australian Medical Association and the American Medical Association also hold analogous perspectives and affirm not only the distinctions but also the conflict between termination of life and palliative care, and that medical practitioners should never intentionally end a patient’s life.

It is important to note that the appreciation of conflict is not limited to the practice of palliative care specifically. Rather, it extends to the practice of medicine generally (of which palliative care is a part) — that
is to say, *termination of life* is incompatible with the practice of medicine. Thus as described by the Medical Society of the State of New York (MSSNY),

Despite shifts in favor of physician-assisted suicide as evidenced by its legality in an increasing number of states, physician-assisted suicide and euthanasia have not been part of the normative practice of modern medicine. Compelling arguments have not been made for medicine to change its footing and to incorporate the active shortening of life into the norms of medical practice. Although relief of suffering has always been a fundamental duty in medical practice, relief of suffering through shortening of life has not. Moreover, the social and societal implications of such a fundamental change cannot be fully contemplated. MSSNY supports all appropriate efforts to promote patient autonomy, promote patient dignity, and to relieve suffering associated with severe and advanced diseases. Physicians should not perform euthanasia or participate in assisted suicide.

It is also important to observe that this position — that *palliative care* and *termination of life* are distinct, conflicting practices — exists not only in jurisdictions where *termination of life* continues to be illegal such as in Britain and New York, but also in permissive jurisdictions where it has been legalized. For example, in the United States in 2009, the Supreme Court of Montana recognized patient consent as a physician defence in the event of a charge of homicide for assisting a terminally

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133 AMA Code of Medical Ethics, *id.*, at Chapter 5, 5.7 and 5.8; see also reflection in Radbruch *et al.*, *supra* note 81, at 10, regarding role conflicts and impact of *termination of life* on physicians’ professional identity and medical institutions; see also Kenneth R. Stevens, “Emotional, Psychological Effects of Physician-Assisted Suicide and Euthanasia on Participating Physicians” (2006) 21:3 Issues in Law and Medicine 187; Dr. Jeff Blackmer, CMA Vice-President of Medical Professionalism: “I can’t tell you how many, but I can tell you that it’s enough that it’s been noted at a systemic level…. For some doctors, the act is simply too distressing…. We’re seeing individuals, or groups of physicians who are participating and really feel like they’re alleviating pain, alleviating suffering…. And then we’re seeing doctors who go through one experience and it’s just overwhelming, it’s too difficult, and those are the ones who say, ‘take my name off the list. I can’t do any more.’” Sharon Kirkey, “‘Take my name off the list, I can’t do any more’: Some doctors backing out of assisted death”, *National Post* (February 26, 2017) online: <http://nationalpost.com/news/0227-na-euthanasia/wcm/f066440c-b343-46c0-9fa3-91c5b3925d>. For a Canadian narrative see, Nicholas Hune-Brown, “How to End a Life”, *Toronto Life* (May 23, 2017), online: <http://torontolife.com/city/life/doctors-assist-suicide-like-end-life/>.


136 *Myers*, *supra*, note 101.
patient to die.\textsuperscript{137} The Montana Medical Association, however, maintains a position against the “deliberate act of precipitating the death of a patient” and instead supports competent \textit{palliative care}.\textsuperscript{138}

\textbf{(b) Neutral Towards Legalization}

Physician assisted suicide has been legalized through statutory instrument in Oregon (1994),\textsuperscript{139} Washington (2008),\textsuperscript{140} Vermont (2013),\textsuperscript{141} California (2015),\textsuperscript{142} Colorado (2016),\textsuperscript{143} and Washington, D.C. (2016).\textsuperscript{144}

Despite legalization of PAS in Vermont, the Vermont Medical Society (VMS) retains the view that laws for or against assisted suicide are not advisable and instead endorses \textit{palliative care}.\textsuperscript{145} Similarly, the Medical Society of the District of Columbia (MSDC) did not take a position on the Death with Dignity Bill during its recent debate, but “instead recognized the AMA position on physician-assisted suicide”,\textsuperscript{146} namely that PAS is “fundamentally incompatible with the physician’s role as healer”.\textsuperscript{147} Accordingly, both the VMS and the MSDC can be seen to have taken a neutral position with respect to legalization of \textit{termination}

\textsuperscript{139} Oregon Act, \textit{supra}, note 11. The Oregon Act took effect in 1997.
\textsuperscript{141} Vermont Act, \textit{supra}, note 11. The Vermont Act took effect in 2013.
\textsuperscript{142} California Act, \textit{supra}, note 11. The California Act took effect in June 2016 and expires January 1, 2026 unless it is renewed. California Act, \textit{id.}, at 443, 215.
\textsuperscript{143} Colorado Act, \textit{supra}, note 11. The Colorado Act took was approved by voters November 2016 and went into effect December 2016.
\textsuperscript{144} DC Act, \textit{supra}, note 11. The final reading of the DC Act was November 15, 2016, signed by the Mayor December 19, 2016 and went into effect February 20, 2017, following the expiry of a 30-day period for Congressional Review. See DC Act, s. 19.
\textsuperscript{146} Laws against assisted suicide might have a chilling effect on the caregiver’s ability to provide appropriate medicines. Laws for assisted suicide might discourage efforts to provide good palliative care, could pose serious societal risks, and would be difficult to control. The Vermont Medical Society believes there should be no laws concerning physician assisted suicide and the Society in no way endorses euthanasia.
\textsuperscript{148} AMA Code of Medical Ethics, \textit{supra}, note 132, at Chapter 5, 5.7 and 5.8.
of life while holding the simultaneous view that physicians should not engage in it.\footnote{Id.}

Although the California Medical Association opposed PAS until 2015, it became the first state medical association to change its position on physician assisted suicide (PAS), officially adopting a “neutral” position in 2015.\footnote{California Medical Association, “California Medical Association removes opposition to physician aid in dying bill” (20 May 2015), online: CMANET <http://www.cmanet.org/news/press-detail?article=california-medical-association-removes> [hereinafter “CMA 2015”]; see also California Medical Association, \textit{Physician-Assisted Suicide}, Document #3455 (January 2015), online: <http://www.cmanet.org/files/pdf/pas-on-call.pdf>, at 5.} The Oregon Medical Association has maintained a “neutral stance” of neither opposing nor supporting PAS for 20 years.\footnote{Oregon Medical Association, “OMA Board Votes on Opioids, Drones, Aid in Dying” (June 7, 2016) online: OMA <http://www.theoma.org/node/5552>.} During the PAS debate over Proposition 106 in Colorado, the Colorado Medical Society also voted to take a “neutral public stance.”\footnote{Statement by CMS President-elect Katie Lozano, MD, FACP, regarding Ballot Proposition 106 (September 16, 2016), online: CMS <http://www.cms.org/articles/statement-by-cms-president-elect-katie-lozano-md-facr-regarding-ballot-prop>. At the time of writing, the Authors have not located a position statement on PAS from Washington State Medical Association (WSMA) but see the Washington End of Life Coalition created by the WSMA online: WSMA <https://wsma.org/wcm/For_Patients/End_of_Life/End_of_Life_Consensus_Coalition.aspx?hkey=4afa96bd-6605-40dc-95a3-2da466c43c19>.} Even with a “neutral” position on PAS, none of these associations equate PAS with the practice of palliative care.\footnote{For discussion of “studied neutrality” and euthanasia see Megan-Jane Johnston, “Organization Position Statements and the Stance of ‘studied neutrality’ on Euthanasia in Palliative Care” (2012) \textit{44:6} Journal of Pain and Symptom Management 896.}

\textit{(c) Tolerance, Last Resort, Marginal Choice}

In the Netherlands, euthanasia and PAS were legalized in 2002.\footnote{Dutch Act, \textit{supra}, note 9.} The Royal Dutch Medical Association (KNMG) continues to affirm the WHO Definition of palliative care, under which life and death are normal processes and treatment is not intended to hasten or prolong death.\footnote{KNMG Palliative Sedation Guideline, \textit{supra}, note 101, at 17; see also VIKC Guideline, \textit{supra}, note 101.} That said, the KNMG is said to “tolerate” euthanasia and PAS. For the KNMG, \textit{termination of life} is always a “last resort, to be used in cases in which the patient and physician have exhausted all options and the suffering cannot be remedied or alleviated by any means other than by
ending the life of the patient at his request.\footnote{155} It is to be a “last resort” because euthanasia and assisted suicide present conflicting obligations to the physician: “on the one hand, physicians have a duty to protect the lives of their patients; on the other, they have to alleviate their patients’ suffering.”\footnote{156} Ultimately, the physician may defer to the patient’s request for termination of life: “Medical ethics and the law recognize that physicians confronted with such conflicting obligations may decide that their duty to honour a patient’s request to end suffering can outweigh the duty to preserve that patient’s life.”\footnote{157}

The KNMG therefore distinguishes palliative care from termination of life which presents conflicting obligations for medical workers. Nevertheless, the KNMG believes that there are instances when termination of life requests can be granted, resting that belief on the central role choice should play in medical decisions, i.e., patient autonomy.

Prior to the passing of Bill C-14 (the federal medical assistance in dying legislation), the Canadian Medical Association (CMA) expressed a tolerance/last resort position on termination of life similar to the KNMG. In a 2014 policy the CMA stated that there will be “rare occasions where patients have such a degree of suffering, even with access to palliative and end of life care, that they request medical aid in dying,” and in those circumstances, “and within legal constraints, medical aid in dying may be appropriate.”\footnote{158} Note how this observation implicitly links palliative care to termination of life requests in that it perceives how palliative care may not be sufficient to relieve the suffering of all patients. A similar view was expressed by the President of the California Medical Association when it also announced a neutral position on termination of life.\footnote{159}

In 2013, prior to the passage of the Quebec Act which introduced medical aid in dying in Quebec,\footnote{160} the Quebec Medical Association (QMA) provided its views (based on physician consultation) on the legislative proposal which included inter alia, views on palliative care


\footnote{156} Id.; see also de Jong & van Dijk, supra, note 121, at 13.

\footnote{157} Id.

\footnote{158} Id.


\footnote{160} CMA 2015, supra, note 149.

\footnote{160} See Quebec Act, supra, note 3, and associated text.
and medical aid to die.\textsuperscript{161} The QMA’s position is largely consistent with what is ultimately captured in the later Quebec Act, clearly distinguishing between palliative care and medical aid to die and advocating for a right to palliative care.\textsuperscript{162} For the QMA, the right to palliative care is critical as it argues that access to quality palliative care services will render medical aid to die a “marginal” phenomenon.\textsuperscript{163} Indeed, the QMA described the development and accessibility of palliative care services as the “cornerstone of Bill 52.”\textsuperscript{164}

It is important to note that the QMA concurrently describes majority support for medical aid to die as an appropriate form of end-of-life care. At the same time, however, the QMA also recommended restriction of the practice to patients instead in a state of decline and where death is “imminent”. This again ties to the QMA’s view that medical aid to die is to remain a “marginal” choice.\textsuperscript{165}

(d) Silence, Pragmatism

With the passing of Bill C-14 and the legalization of MAiD, the Canadian Medical Association (CMA) shifted focus from tolerance/last resort considerations towards the “ethical and practical challenges” associated with the practice of MAiD.\textsuperscript{166} Under its 2017 Medical Assistance in Dying policy, the CMA describes support for “maintaining the balance between three equally legitimate considerations: respecting decisional autonomy for those eligible Canadians who are seeking access, protecting vulnerable persons through careful attention to safeguards, and creating an environment in which practitioners are able to adhere to their moral commitments.”\textsuperscript{167}

In its 2017 MAiD policy, the CMA is exceptionally clear regarding the difference between “other acts within the realm of end-of-life care” and MAiD (which includes eligibility assessments, patient deliberation

\textsuperscript{161} Association médicale du Québec, Mémoire sur le projet de loi n° 52 Loi concernant les soins de fin de vie (September 17, 2013), at 6, online: QMA <https://www.amq.ca/index.php?option=com_flexicontent&view=items&id=552:prises-de-position>.

\textsuperscript{162} Id., at 6 and 8.

\textsuperscript{163} Id., at 9-10.

\textsuperscript{164} Id., at 9.

\textsuperscript{165} Id., at 14.


\textsuperscript{167} Id., at 1.
and accompaniment through the decision process) and explicitly states that MAiD does not encompass palliative care, continuous palliative sedation therapy, withdrawing or withholding treatment or treatment cessation or voluntary refusal of nutrition and hydration.\textsuperscript{168}

In a separate \textit{Palliative Care} policy,\textsuperscript{169} the CMA affirms that the practice of \textit{assisted dying} is distinct from the practice of \textit{palliative care} and recommends that comprehensive, quality palliative care services be made available to all Canadians and that all relevant legislation be amended to recognize that any person whose medical condition warrants it is entitled to receive \textit{palliative care}.\textsuperscript{170}

The CMA \textit{Palliative Care} policy further describes how \textit{palliative care} is not limited to end of life but is beneficial to “all those living with life-limiting acute or chronic conditions, including, or perhaps especially, when it is initiated earlier in the disease trajectory.”\textsuperscript{171} Additionally, CMA describes support for the development and implementation of an “integrated” palliative approach to care:

An approach that focuses on quality of life and reduction of suffering as a goal of care. This approach may coexist with other goals of care — prevention, cure, management of chronic illness — or be the sole focus of care. The palliative approach integrates palliative care services throughout the treatment of a person with serious life-limiting illness, not just at the very end of life.\textsuperscript{172}

Accordingly, not only is \textit{palliative care} distinct from MAiD, according to the CMA, it can be the sole focus of care or integrated with standard treatment such that “it transcends the conventional view that palliative care is care delivered at the very end of life”.\textsuperscript{173}

The CMA \textit{Palliative Care} policy is silent with respect to the relationship between \textit{palliative care} and MAiD and the process for dealing with MAiD requests. Insight, however, can be gleaned from the CMA’s 2017 MAiD policy \textit{inter alia} as follows.

\begin{flushright}
\textsuperscript{168} \textit{Id.}, at Glossary.
\textsuperscript{170} \textit{Id.}, at 1-2. The CMA defines palliative care as follows: “Palliative care is an approach that aims to relieve suffering and improve the quality of life of those facing life-limiting acute or chronic conditions by means of early identification, assessment, treatment of pain and other symptoms and support of all physical, emotional and spiritual needs.”
\textsuperscript{171} \textit{Id.}, at 4.
\textsuperscript{172} \textit{Id.}, at 8.
\textsuperscript{173} \textit{Id.}, at 4.
\end{flushright}
First, the CMA states that “[i]t is important that physicians be aware of this distinction and the relationship between legal, medical and ethical norms with respect to medical assistance in dying”, and similar to the KNMG, emphasizes that “physicians’ ethical norms and duties, arising from long-standing traditions that entail moral commitments to preserve and protect life, have not changed.” The CMA goes on to describe the importance of physician choice with respect to participation in MAiD (including referrals, decisional guidance about, eligibility assessments for, or provision of MAiD). A potential conflict thereby intimated by the CMA is one between traditional medical commitments to preserve and protect life and the act of MAiD (the termination of life), the resolution of which is first a question of participation based on an individual physician’s moral commitments to ethical norms and duties and a subsequent exercise of conscience. Note that the traditional medical ethical norms and duties to preserve and protect life exist separate from a given physician’s individual commitment to them.

Regardless of that choice to participate in MAiD or not, the CMA states that pursuant to the “Duty of Non-Abandonment”, physicians must respond to a request and “ought to explore the reasons motivating the request” and that there should be no “undue delay in providing access to assistance in dying and all other end-of-life options”. Here the duty of patient non-abandonment is considered within the context of access to MAiD (a key part of the Canadian discussion as described earlier in Part III). But rather than suggesting that MAiD and palliative care exist on a continuum, or that MAiD be embedded into palliative care, (as proposed by the FPCF in Belgium) or that individual moral commitments of HCPs be restricted, the CMA suggests that MAiD access be addressed and implemented by specific mechanisms within the health system. Accordingly, while supporting the exercise of conscience by individual physicians, the CMA doesn’t subject the interpretation of palliative care or termination of life practice to internal perspectives of individual physicians. Addressing access through health system mechanisms can assist in achieving legal certainty and clarity with respect to the varied

174 CMA MAiD 2017 Policy, supra, note 166, at 1.
175 Id.
176 Id., at 1, 3 and 4.
177 Id., at 3; see also id., at 4, “Addressing adherence to moral commitments”.
178 Id., at 2-3 under Foundational Principle 3, Respect for freedom of conscience.
179 Note that the CMA describes a physician obligation to: respond to a request in a timely fashion; provision of information on all options available including MAiD; advise on separate central information, counselling or referral services; and transfer care upon the patient’s request. Id., at 4.
legal, medical and ethical frameworks and foundations that regulate and shape the practice of MAiD and in turn help support HCP accountability, transparency and public scrutiny.

Second, the CMA clarifies that “the provision of specific assessments for eligibility to access medical assistance in dying is a distinct service unrelated to consultations for general palliative end-of-life care.”

Through this position, the CMA separates specific MAiD processes from palliative care generally which also seems to respond to the concern that palliative care not be reduced to a mere gatekeeping role for MAiD.

Third, the CMA sets out four foundational principles: Respect for autonomy; Respect for vulnerability; Respect for freedom of conscience; and Accountability. Under “Respect for autonomy”, the CMA asserts that persons have inherent dignity regardless of their circumstances. Services ought to be delivered, and processes and treatments ought to be applied, in ways that strive to preserve and enhance dignity. End-of-life care strives to maintain the integrity of personhood even as bodily functions deteriorate in advance of death.

Under “Respect for vulnerability” the CMA calls for a legislated and regulated system of monitored safeguards to minimize harm and to address issues of vulnerability and coercion. There is nothing inherent in these principles that require the merging of palliative care and MAiD and, if taken together with the distinctions between palliative care and MAiD as described by the CMA, they call for careful deliberation as to what kind of health system mechanisms might assist in realizing their respective objectives.

Fourth, under the foundational principle “Accountability”, the CMA calls on physicians, in service of their patients’ needs and values, to work to ensure “equitable access to all end-of-life options, including palliative and end-of-life care provided by skilled practitioners”. In this way, the CMA reinforces inter alia the importance of actual access to palliative care for patients seeking MAiD or otherwise.

Most of the Canadian provincial medical associations are either silent with respect to the relationship between palliative care and termination of life or defer to CMA policy and/or the Canadian Hospice Palliative

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180 Id., at 1.
181 Id., at 2.
182 Id., at 3.
183 Id., at 3.
184 See, for example, Doctors Manitoba, online: Doctors Manitoba <https://doctorsmanitoba.ca/>.
Care Association (CHPCA). Where a definition of palliative care is provided, it is consistent with the standard WHO Definition, i.e., care that is life affirming and regards dying as a normal process.

3. Medical Colleges

The distinction between palliative care and termination of life is also present in the views of Canadian and international medical colleges.

For example, in accordance with Bill C-14, the medical college policies for the provinces/territories of British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, Prince Edward Island, Quebec, and the United Kingdom, Australia, Netherlands, Belgium, Luxembourg, the states of Oregon, Washington, Vermont, California Colorado, Montana and Washington, D.C. in the United States.

185 See, for example, Alberta Medical Association, “Medical Assistance in Dying” online: <https://www.albertadoctors.org/leaders-partners/clinical-resources/maid>; Saskatchewan Medical Association, “Medical Assistance in Dying”, online: <http://www.sma.sk.ca/resources/50/medical-assistance-in-dying.html>.

187 Medical colleges and medical licensing/regulatory bodies reviewed include those in the jurisdictions of Canada, United Kingdom, Australia, Netherlands, Belgium, Luxembourg, the states of Oregon, Washington, Vermont, California Colorado, Montana and Washington, D.C. in the United States.

188 Bill C-14, supra, note 8. Note Quebec College guidelines also describe as cause death of patient but limit to administration of substance in accordance with the Quebec medical aid in dying legislation, Quebec Act, supra, note 3. The Authors were unable to locate a medical college/council policy for Northwest Territories and Nunavut but see Government of Northwest Territories, Medical Assistance in Dying, Interim Guidelines (effective June 17, 2016) online: <http://www.hss.gov.nt.ca/sites/www.hss.gov.nt.ca/files/interim-guidelines-medical-assistance-dying.pdf>.


190 College of Physicians and Surgeons of Alberta, Standard of Practice – Medical Assistance in Dying (June 2016) online: CPSA <http://www.cpsa.ca/standardspractice/medical-assistance-dying/> [hereinafter “Alberta College”].


192 College of Physicians and Surgeons of Manitoba, Medical Assistance in Dying, Schedule M attached to and forming part of By-law No.11, online: CPSM <http://cpsm.mb.ca/cgi39alckF30a/wp-content/uploads/PAD/MAIDschm.pdf>, at 1 [hereinafter “Manitoba College”].


Nova Scotia,195 Newfoundland,196 and Yukon,197 (the “Provincial College MAiD policies”) define MAiD as an act (administering, prescribing or providing of a substance) that “cause[s]” the death of the patient.

_Palliative care_ on the other hand is not always defined in these MAiD policies despite it being expressly referenced in connection to MAiD eligibility and obtaining informed consent. When _palliative care_ is defined, it is consistent with the WHO Definition (e.g., Nova Scotia and Newfoundland and Labrador).198 When a definition of _palliative care_ has not been included, one can usually be found within other college policies (including those specific to _palliative care or end of life_)199 and/or through reference to other health bodies or services.200 Here too, _palliative care_ is defined as distinct from MAiD and consistent with the WHO Definition. For example, the College of Physicians and Surgeons of Ontario (CPSO) policy on Quality End-of-Life Care201 provides a MAiD definition that tracks the language of Bill C-14 (i.e., causes death) while the _palliative care_ definition reads as follows: “active total care that improves the quality of life of patients and their families facing life-threatening illnesses or life-limiting chronic conditions, with a focus on...


196 The College of Physicians and Surgeons of Newfoundland and Labrador, Standard of Practice, Medical Assistance in Dying (2017), online: <https://imis.cpsnl.ca/web/files/2017-Mar-11%20-%20MAID.pdf> “intentionally brings about the patient’s death”, at 3.1.1(f); see also id., at 10.1(c) and (d) [“Newfoundland and Labrador College”].

197 Yukon Medical Council, Standard of Practice, Medical Assistance in Dying (July 16, 2016 approved, updated September 22, 2017), online: Yukon medical council <http://www.yukonmedicalcouncil.ca/pdfs/MAID.pdf>, at 1 [hereinafter “Yukon College”].

198 Nova Scotia College, supra, note 195, at 9.1.9; Newfoundland and Labrador College, supra, note 196, at Article 3.1(i).


201 CPSO Policy 6, 2016, supra, note 199.
relieving pain and other symptoms and addressing psychological, social, and spiritual distress; it is applicable in all phases of illness, from early in the course of illness to bereavement.202

Within this same policy in a separate section entitled, “Wishes or Requests to Hasten Death”, the CPSO recognizes that some requests to hasten death may be genuine but may also be motivated by underlying and treatable conditions or other unmet care needs.203 The CPSO describes how physicians are to respond to these wishes and/or requests: they must be prepared to engage patients in a discussion, to seek to understand the motivation for their expression and to resolve any underlying issues that can be treated or otherwise addressed.204 The CPSO also stresses the paramount importance of communication in order to improve patient understanding (and avoid misunderstanding) as to what palliative care entails.205 The policy however directs physicians seeking guidance or more information on MAiD to its “Medical Assistance in Dying Policy”.206 Accordingly, while information about palliative care options is mandated under its MAiD policy as per legal requirements, CPSO expectations and directives with respect to the practice of palliative care pursuant to its end-of-life policy are broader and exclude the specific practice of MAiD.207

Similar construction of the distinction between palliative care and MAiD and focus on the importance of specifically communicating to patients, the scope and practice of palliative care can be found in the Nova Scotia College MAiD Policy;208 the Collège des médecins du Québec (CMQ) practice guidelines, Medical Care in the Last Days of Life;209 and The College of Family Physicians Canada (CFPC) Guide for

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202 Id., at 2-3; see also description regarding interventions (aggressive pain management and palliative sedation) with no intention to hasten death, id., at 8.

203 Id., at 9-10; see also description by CPSO on how palliative care is sometimes misunderstood by patients and the obligation of physicians to clearly explain to patients what palliative care entails; id., at 6.

204 Id., at 10.

205 Id., at 4 and 6.

206 Id., at 9-10; see also description by CPSO on how palliative care is sometimes misunderstood by patients and the obligation of physicians to clearly explain to patients what palliative care entails; id., at 6.


208 Nova Scotia College, supra, note 195, at 3.2, at 4: “This Standard is not about palliative care. It is not intended to affect the ongoing provision of palliative care, or to provide a substitute for it.”

Reflection on Ethical Issues Concerning Assisted Suicide and Voluntary Euthanasia.

Within the Provincial College MAiD policies, precision regarding the distinctions between palliative care and MAiD is critical because college policies must accurately reflect the strict legal requirements that must be adhered to before a physician can participate in MAiD. Accordingly, consistent with the legal requirements imposed by Bill C-14, respective policies require that a patient requesting MAiD must be informed of other or “alternative” means available to relieve/address their suffering, including palliative care.

In this way, Provincial College MAiD policies require physicians to adopt the substantive distinctions between MAiD and palliative care, as physicians are mandated to inform patients of palliative care (whether it is ultimately provided or not), as way of ensuring that the requesting patient has given informed consent to proceed with MAiD. Furthermore, physicians are required to adopt these distinctions procedurally, as a MAiD discussion between the physician and the patient will not be within the law unless the patient has voluntarily raised or requested it — unlike other end-of-life treatment decision-making.

Given that within the MAiD scheme, palliative care is critically positioned to operate as an alternative to MAiD in order to help ensure that a patient has consented to death, the Provincial College MAiD policies do not appear to promote the notion of an end-of-life continuum
of care. The majority of these policies, however, reference the principles of continuity of care and/or non-abandonment in a manner similar to that of the Canadian Medical Association (discussed above in Part IV.2). That is, the non-abandonment/continuity of care dialogue emerges in relation to contemplation of MAiD access and possible physician refusal to participate.\textsuperscript{216} While the Provincial College MAiD policies vary in terms of the permissible scope of that physician objection,\textsuperscript{217} what is arguably signalled here, again, is the recognition of the paramount importance of communication with patients.

Thus one can see medical colleges in non-permissive jurisdictions also promoting this kind of patient-physician dialogue. For example, notwithstanding that termination of life remains illegal in the United Kingdom,\textsuperscript{218} the British licensing body for physicians, the General Medical Council (GMC), describes how a patient’s request for assistance to die should prompt the physician to discuss palliative care with the patient in order to see if there are any “unmet palliative care needs.”\textsuperscript{219} In such a discussion, the physician “must not be motivated by a desire to bring about the patient’s death, and must start from a presumption in favour of prolonging life.”\textsuperscript{220}

The same can also be observed in jurisdictions currently contemplating termination of life legislation. For example, without evidencing support to proposed legislation, the Royal Australasian College of Physicians (RACP) in consultation with “key College bodies”, provided feedback in response to both the NSW Parliamentary Working Group on Assisted Dying’s (PWGAD) Draft Voluntary Assisted Dying Bill 2017\textsuperscript{221} and to the questions raised in the Victorian

\textsuperscript{216} BC College, supra, note 189, at 2, 6; Saskatchewan College, supra, note 191, at 4; Manitoba College, supra, note 192, at 2; Nova Scotia College, supra, note 195, at 4; Yukon College, supra, note 197, at 4-5; for Ontario see Fact Sheet: Ensuring Access to Care: Effective Referral, online: <http://www.cps.on.ca/CPSO/media/documents/Policies/Policy-Items/PAD-Effective-Referral-FactSheet.pdf>; and CPSO, Professional Obligations and Human Rights Policy #2-15 (September 2008, updated March 2015) online: CPSO <http://www.cps.on.ca/Policies-Publications/Policy/Professional-Obligations-and-Human-Rights>.

\textsuperscript{217} Compare to Manitoba College, id., at 2-3.


\textsuperscript{219} General Medical Council, When a patient seeks advice or information about assistance to die, (2013), at 2.


\textsuperscript{221} Royal Australasian College of Physicians, RACP Submission: Draft Voluntary Assisted Dying Bill 2017 (‘NSW’) (July 2017), online: racp <https://www.racp.edu.au/docs/default-source/
Government Discussion Paper on a proposed Voluntary Assisted Dying Bill.\textsuperscript{222} In both submissions, the RACP recognized that medical assistance in dying (administration, prescription or supply of lethal drug to a requesting patient) “is distinct from the practice of palliative care”, further stating that:

Regardless of the many issues raised by legalising access to medical assistance in dying, the RACP holds that physicians and society have a duty to provide high quality end of life care to patients and their families and carers. This is set out in the RACP’s position statement ‘Improving Care at the End of Life: Our Roles and Responsibilities’ (May 2016), the RACP advocates for:

- High quality end of life care for patients and the duty of all physicians to provide this;
- Open and honest communication with patients about impending death;
- A doctor-patient relationship based on openness, trust and good communication;
- The positive contribution a physician can make to end of life care; and
- Acknowledging and respecting different cultural preferences and approaches to death and dying and providing culturally sensitive end of life care.

The RACP recognises that medical assistance in dying as defined above is distinct from the practice of palliative care. It should be noted that the Australian and New Zealand Society of Palliative Medicine has strongly stated that the practices of euthanasia or assisted suicide are not part of the Palliative Medicine discipline.\textsuperscript{223}

Accordingly, whether through palliative care practice or through professional obligations of non-abandonment and continuity of care, there is recognized practical clinical and ethical foundation that enables and requires physicians to communicate and explore care options with


\textsuperscript{223} RACP NSW Submission, supra, note 221, at 3; \textit{id.}, at 3. Note that at the time of submission of this article, Victoria Parliament passed the Voluntary Assisted Dying Act 2017 and which is anticipated to be implemented in 2019. \textit{Supra}, note 14.
patients experiencing life-limiting illness including those who express a wish for hastened death. This foundation has not changed post-termination-of-life legalization. What has changed however is the possibility of a termination of life option which, along with its attendant criminal law framework, regulates particular aspects of communication (including communication related to palliative care), and allows for the exercise of HCP conscience with respect to participation in it.

4. Observations

Palliative care associations consistently distinguish between the practice of palliative care and the practice of termination of life even in jurisdictions where the latter has been decriminalized. While some continue to challenge the boundaries of palliative care on the basis that certain practices may run the risk of hastened death, it remains that all clinical practices developed within palliative care are consistent with its life-affirming philosophy. The practice of termination of life contradicts this philosophy. Additionally, palliative care practice has demonstrated that not all requests for hastened death indicate a genuine wish to die and furthermore, requests for termination of life may — though not always — be altered with palliative care.

There is also no blending of the respective definitions by medical associations in permissive and non-permissive jurisdictions. Even where an association has taken a neutral position with respect to termination of life, it is arguably not on the basis that it is medically indicated but rather in acknowledgment of its decriminalization (or pending decriminalization), the limits of palliative care in addressing all forms of suffering and recognition of patient autonomy, notwithstanding the palpable conflict with the norms and ethics of medicine to protect and preserve life. Accordingly, many medical associations in permissive jurisdictions appreciate termination of life as a last resort or marginal choice.

Both these sets of considerations are embedded, conveyed, and promoted in the view (whether arising from palliative care or medical associations or colleges) that requesting patients must be offered palliative care or other alternatives to termination of life.

Behind the concept of “complementarity” used by certain palliative care associations in the Netherlands and Belgium lies a distinction between the conception of termination of life as a choice on the margins and termination of life as simply a patient’s “choice”. Reflecting on the
enduring contradictory definitions through the lens of medical practice however, it is easily observed that the use of the word “complementarity” (or similar) can mislead with respect to the substantive distinctions between the two practices as well as downplay or obscure the specific requirements and procedures under which termination of life is legally permissible. The complementarity concept thus carries with it a shift in control and locus of decision-making away from the patient and towards the physician. Given these risks, but also recognizing the profound value of palliative care to individuals requesting termination of life, access mechanisms other than declarations of complementarity should be explored.

Medical colleges, faced with the practical aspects of termination of life regulation, apply the definitional distinctions between palliative care and termination of life. Particular clarity must be maintained and promoted so that physicians are given clear and consistent direction with respect to the substance, scope and implementation of safeguards in the practice of termination of life. For colleges there can be no grey area between the two practices and accordingly they are also subject to different policy documents.

Within termination of life policy, other clinical considerations, physician obligations and foundational principles come into play, including: continuity of care, non-abandonment of the patient, the “added-value” of palliative care, protection from vulnerability and exercise of physician conscience and judgment. All of these have bearing on the contours of termination of life practice from the practitioner perspective and termination of life and palliative care access from the requesting patient perspective. Note that none of these considerations, obligations or principles compel a particular model, which perhaps accounts for the variations that can be observed in the college policies across Canada, for example. Because application of these considerations, obligations and principles (being grounded in traditional medical ethics and norms) create additional tensions beyond definitional considerations to actual termination of life practice, a balance has to be achieved. This begs two lines of inquiry: what is the appropriate balance; and what are the appropriate mechanisms to achieve that balance? These questions of balance ultimately have implications in determining what the interface between palliative care and termination of life ought to be.

The review of perspectives and policies from palliative care associations, medical associations, and medical colleges disclose at least three potential layers of conflict, namely, conflict between termination of life and:
1. the definition, philosophy, goals and practice of palliative care: life-affirming whole-person care that does not hasten or delay death and is supportive of patient, family and carers;

2. medical ethics and norms: the preservation and protection of life; and

3. physician conscience: participation in termination of life may run counter to a physician’s moral and professional commitments to medical ethics and norms.

The above review also discloses the following procedural/relational considerations:

1. Palliative care can and should be introduced early in the disease trajectory and is appropriate care for any life-limiting illness.

2. All inquiries for hastened death should be met with life-affirming responses.

3. Although it is acknowledged that even the best palliative care is unlikely to eliminate all requests, access to and provision of palliative care can reduce requests for and/or follow through with termination of life and can help to distinguish between “genuine” requests to die from other requests to die.

4. Both termination of life and palliative care are aimed at addressing suffering, however termination of life seeks to cause death, whereas palliative care does not.

5. To ensure autonomy and respect for persons, palliative care should be available to all, especially to those who might be regarded as specifically vulnerable to termination of life.

6. Palliative care can bring profound value to persons requesting termination of life.

7. Termination of life is inconsistent with the medical ethics and norms regarding the preservation and protection of life but in some jurisdictions is a legally available option (advanced on the basis of autonomy and compassion) to requesting patients who meet particular medical criteria.

8. A physician (or other health care professional) must not discuss termination of life unless it has been expressly introduced or requested by a patient.
9. The requirement of “continuity of care” always carries with it professional obligations such as communication and non-abandonment of the patient.

10. Health care professionals have “the right to set their own ethical limits”\textsuperscript{224} i.e., a right to conscientious objection.

11. There is a difference between “continuity of care” and “continuum of care”. Patient choice can exist within an over-arching “continuum of care” (i.e., health care) but patient choice with respect to \textit{termination of life} cannot be the sole defining feature in terms of how the regulatory system is structured as specific procedural safeguards must also be infused into the design. A notion of “complementarity” as between \textit{palliative care} and \textit{termination of life} carries significant risk of undermining the operation of \textit{termination of life} safeguards.

12. Patient-centeredness, transparency and accountability can be achieved by upholding (rather than removing) distinctions between \textit{palliative care} and \textit{termination of life} with reliance of health system mechanisms to establish the appropriate balance between equally legitimate competing considerations.

Building on the foregoing considerations, a patient-centred approach to the interface between these two practices might be conceived of as follows:

\textit{Figure 3: Patient-centred Approach to Interface between Termination of Life and Palliative Care}

\textsuperscript{224} Vanden Berghe \textit{et al.}, \textit{supra}, note 108, at 269.
V. POSITIONING OF PALLIATIVE CARE IN RELATION TO TERMINATION OF LIFE LAWS

1. The Netherlands, Belgium and Luxembourg (“Benelux”) Laws — Overview

(a) The Netherlands

On April 1, 2002, the Netherlands’ law, Termination of Life on Request and Assisted Suicide (Review Procedures) Act (the “Dutch Act”) entered into force. The Dutch Act legalized euthanasia and assisted suicide (EAS) for patients with unbearable suffering and no prospect of improvement; there is no requirement for the patient to be suffering from a terminal condition or a limited life expectancy. In addition to adults, the Dutch Act allows euthanasia and assisted suicide for minors between 16 to 18 years of age deemed to have a reasonable understanding of their interests (in consultation with parents/guardians) and for minors between ages of 12 to 16 (with consent of parents/guardians). Euthanasia may also be permitted pursuant to an advance written statement if made by a patient when the patient was deemed to have a reasonable understanding of the patient’s interests.

The Dutch Act is understood to be the culmination of legal discussions and codification of long-standing practices and jurisprudence which recognized a necessity defence for physicians to the Penal Code prohibitions of euthanasia and assisted suicide. The Dutch Act continues to recognize euthanasia and assisted suicide as criminal offences, but amends the Penal Code to exempt physicians who

225 Dutch Act, supra, note 9.
226 Dutch Act, id., at Chapter II, Articles 2(3) and (4).
229 Wetboek van Strafrecht or Dutch Penal Code provisions: Article 293 (termination of life at a person’s express and earnest request liable to a term of imprisonment not exceeding 12 years or
provide euthanasia and assisted suicide in accordance with specific due care requirements from criminal liability.\textsuperscript{230}

In order to receive criminal law immunity under the Dutch Act, the physician must:

a. be satisfied that the patient’s request is voluntary and well-considered;
b. be satisfied that the patient’s suffering is unbearable with no prospect of improvement;
c. have informed the patient about his situation and prognosis;
d. have come to the conclusion, together with the patient, that there is no reasonable alternative in the patient’s situation;
e. have consulted at least one other, independent physician, who must see the patient and give a written opinion on whether due care criteria referred to in a. to d. above have been fulfilled; and
f. have exercised due medical care and attention in terminating the life or assisting the suicide.\textsuperscript{231}

Though not expressly described in the Dutch Act, requirement (d.) above — that there is “no reasonable alternative” — obligates the physician to ascertain “whether there are further possibilities in the area of palliative care to reduce the suffering.”\textsuperscript{232}

Providing or participating in EAS in the Netherlands is entirely voluntary and physicians who refuse to provide or participate are not legally required to refer to a physician who will.\textsuperscript{233} Thus, as stated by the Royal Dutch Medical Association (KNMG):

Patients have the right to request euthanasia, but physicians are not obligated to grant their request: fundamental objections to euthanasia and assisted suicide must be respected. After all, euthanasia and assisted suicide are anything but ordinary medical procedures.\textsuperscript{234}

\textsuperscript{230} Dutch Act, supra, note 9, Preamble and Chapter IV, Article 20.
\textsuperscript{231} Id., at Chapter II, Article 2(1) (emphasis added).
\textsuperscript{232} Francke, supra, note 228, at 28; see also RTE Code, supra, note 227, at 15-16; see Netherlands Ministry of Foreign Affairs, \textit{FAQ Euthanasia 2010, The Termination of Life on Request and Assisted Suicide (Review Procedures) Act in practice}. (2010), at 13 [hereinafter “FAQ Euthanasia”].
\textsuperscript{233} Government of the Netherlands, “Is euthanasia allowed?”, online: Government of the Netherlands <https://www.government.nl/topics/euthanasia/is-euthanasia-allowed>.
\textsuperscript{234} KNMG Position Paper, supra, note 155, at 33.
Similarly, as described by the Dutch Ministry of Health, Welfare and Sport:

The option of rejecting a request for euthanasia or assisted suicide guarantees that the doctor never needs to act in conflict with his own standards and values. In other words euthanasia does not come under a doctor’s duty to provide care.235

The voluntary nature of participating in termination of life in the Netherlands is in contrast to the provision of palliative care which is understood to be part of regular health care.236 As put by the KNMG, palliative care

is not a specialism. The approach of the Dutch government is that palliative care should be provided as much as possible by generalists (general practitioners + nurses + care workers).237

This perspective is grounded on the rule that physicians:

perform their tasks ‘with due regard for the care provided by a good care provider and acting in accordance with the responsibility they bear pursuant to the professional standard to which care providers are subject’ (Section 7:453 of the Dutch Civil Code). The professional standard for physicians encompasses attention to the patient’s overall wellbeing, providing guidance to patients who have existential questions arising from their illness, demonstrating empathy and offering palliative care, terminal guidance and emotional comfort. Or, in the words of the World Health Organization’s definition of palliative care: ‘the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual’. ... There is consensus among physicians that the foregoing properly falls within the domain of medicine.238

In Netherlands law, termination of life and palliative care are distinct activities, the former constructed as an exceptional practice providing criminal law immunity to physicians who fulfill the requirements under the Dutch Act when carrying out termination of life, and the latter part of

235 Francke, supra, note 228, at 28-29.
236 For history of palliative care in the Netherlands and discussion of influence of euthanasia legalization on development of palliative care in the Netherlands see Gordijn & Janssens, supra, note 228, at 198-200; see also J. P. Rien et al., “Hospice and euthanasia in the Netherlands: an ethical point of view” (1999) 25 Journal of Medical Ethics 408, at 408-409; see also Francke, supra, note 228, at 31-32.
237 Francke, id., at 5; see also Gordijn & Janssens, id., at 224.
ongoing standard medical practice.\footnote{FAQ Euthanasia, supra, note 232, at 3-4.} As recently described by de Jong and van Dijk:

In fact, in certain circumstances, euthanasia itself must be seen as a means of giving appropriate care, based on the principles of respect for autonomy and compassion. This does not mean that euthanasia should be regarded as a therapeutic intervention or as ‘regular medical care’. It is neither. Indeed, it is exactly because it is not part of regular medical care that euthanasia is still a punishable offence under the Dutch Penal Code. In this way, Dutch law acknowledges the very specific character of euthanasia. To assert otherwise does not correspond with the reality of the situation in the Netherlands, neither legally nor in the experience of physicians and the broader public in this country, as reflected in the recent third evaluation of the Wtl.\footnote{de Jong & van Dijk, supra, note 121, at 14.}

This is also evident from the fact that euthanasia is not a right that patients have, and the fact that doctors are never obliged to honour a request for euthanasia.\footnote{Belgian Act, supra, note 9.}

(b) Belgium

On September 23, 2002, \textit{The Belgian Act of Euthanasia of May 28th, 2002} (the “Belgian Act”) entered into force.\footnote{Belgian Act, supra, note 9.} Like the Dutch Act, the Belgian Act “conditionally decriminalizes euthanasia” (and PAS)\footnote{PAS is not expressly included in the Belgian Act but the oversight body, the Federal Control and Evaluation Commission (FCEC), has described that PAS falls within the laws definition of euthanasia. Commission Fédérale de Contrôle et d’évaluation de l’euthanasie, \textit{Premier Rapport aux Chambres Législatives 22} (Septembre 2002 - 31 Décembre 2003), at 24; See also Carter BCSC, supra, note 27, at para. 508.} exempting physicians from criminal liability if they have fulfilled the required procedures and conditions in the Belgian Act.\footnote{Belgian Penal Code, Article 393 (voluntary manslaughter) and 394 (murder); J. Griffiths \textit{et al.}, \textit{Euthanasia and Law in Europe} (Hart Publishing, 2008), at 304-305 [hereinafter “Griffiths \textit{et al.}”].} The Belgian Penal Code does not have specific provisions on euthanasia but it is understood to be addressed in the same manner as intentionally causing death under the voluntary manslaughter and murder provisions.\footnote{Griffiths \textit{et al.}, id., at 304-305.} Assisted suicide is not explicitly addressed in the Belgian Penal Code and thus the legal status of PAS was not entirely clear prior to the Belgian Act.\footnote{Belgian Act, supra, note 9, at Chapter II, s. 3, para. 1.}
The Belgian Act is similar to the Dutch Act in that it makes euthanasia available to competent individuals (adults or emancipated minors) with particular medical conditions and unbearable suffering. Before terminating the life of a requesting patient, the attending physician must fulfill the requisite procedures and conditions and ensure that:

- the patient is conscious and competent when making the request;
- the request is voluntary, well considered, repeated and not the result of external pressure; and
- the patient is in a medically futile condition and the patient’s suffering (physical or mental) is constant and unbearable, arising from a serious and incurable disorder caused by illness or accident.

The Belgian Act does not require an adult patient to be suffering from a terminal medical condition but does impose additional procedural safeguards for patients not expected to die in the near future as well as for patients who are no longer conscious and who have requested euthanasia pursuant to an advance directive. In 2014, the Belgian Act was amended to allow euthanasia for non-emancipated minors who are “close to death” provided they have the “capacity for discernment” (as determined by a psychiatrist or psychologist) and the agreement of the parent or legal guardian.

Like the Netherlands, participation by physicians in euthanasia under the Belgian Act is entirely voluntary. Accordingly, like the Dutch Act, the Belgian Act does not create a right to euthanasia only a right to request it.

The Belgian Act includes palliative care as part of its procedural safeguard requirements for ensuring voluntariness of the request and achieving consent prior carrying out euthanasia. Specifically, a physician

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246 Belgian Act, supra, note 9, at Chapter II. Emancipated minor is either the result of marriage or by judicial declaration. Nys, supra, note 228.
247 Belgian Act, supra, note 9, at Chapter II, s. 3 para. 1.
248 For example, consultation with psychiatrist or specialist in the disorder and one month waiting period between request and act of euthanasia. Belgian Act, supra, note 9, at Chapter II, s. 3 para. 3.
249 Belgian Act, supra, note 9, Chapter III.
250 Belgian Act, supra, note 9, at Chapter II, s. 3 para. 1.
251 Belgian Act, supra, note 9, at Chapter VI, s. 14 which states inter alia, “No physician may be compelled to perform euthanasia. No other person may be compelled to assist in performing euthanasia.”
252 See Vanden Berghe et al., supra, note 108, at 269.
is obliged to discuss with a requesting patient any alternatives, including “possible therapeutic and palliative courses of action and their consequences.”\textsuperscript{253}

At the same time the Belgian Act was passed, Belgium passed \textit{The Law of Palliative Care of 14 June 2002}.\textsuperscript{254} The Belgium Palliative Care Law establishes that all patients have the right to \textit{palliative care}.\textsuperscript{255} Accordingly, because there is no similar right to euthanasia established under Belgian Law, euthanasia cannot legally exist as part of \textit{palliative care}.

Notwithstanding, however, the clear legal distinctions as reflected in the separate legislation, as described in Part IV, there has been an ongoing trend in Belgian dialogue to draw euthanasia into the sphere of \textit{palliative care}, \textsuperscript{i.e.}, a movement to shift from “conventional” palliative care to continuous, euthanasia “embedded” or “integrated” palliative care.\textsuperscript{257} In part, this connects to a view that “implies a recognition” of a patient’s “right to decide that pursuing conventional palliative care is no longer serving its purpose and that his or her wish for euthanasia be supported and accepted.”\textsuperscript{258} It should be again noted that supporting a palliative care patient who has requested euthanasia does not mandate drawing euthanasia practice into \textit{palliative care} practice and furthermore, to do so would impliedly extend a right to euthanasia — contrary to Belgium law.

\textsuperscript{253} Belgaian Act, \textit{supra}, note 9, at Chapter II, s. 3 para. 2.

\textsuperscript{255} The Belgian Palliative Care Law, \textit{id.}, at Article 2. The law on palliative care “significantly expands the definition of the art of medicine, specifying that the latter ‘encompasses medicine practiced on human beings as well as preventive, curative, continuous and palliative medical practices that concern them’...” IEB, \textit{supra}, note 106, at 2, and associated footnote 4. Palliative care is “fully reimbursed by health insurance companies and is therefore free of charge”. Karen Van Beek \textit{et al.}, “Enabling patients to stay at home until death: White Yellow Cross in Belgium” in Jeroen Hasselaar and Sheila Payne, eds., \textit{Integrated Palliative Care} (The Netherlands: Radboud University Medical Center, 2016), at 16.

\textsuperscript{256} See discussions in IEB, \textit{id.}, and Vanden Berghe \textit{et al.}, \textit{supra}, note 108.

\textsuperscript{257} IEB, \textit{id.}, at 2-3

\textsuperscript{258} \textit{Id.}, at 4; see also discussion in Vanden Berghe \textit{et al.}, \textit{supra}, note 108; see also Jan L. Bernheim \textit{et al.}, “Questions and Answers on the Belgian Model of Integral End-of-Life Care: Experiment? Prototype?” (2014) 11 Bioethical Inquiry 507, at 508: See also Bernheim & Raus, \textit{supra}, note 118.
In 2009, Luxembourg’s Law of 16 March 2009 on euthanasia and assisted suicide entered into force (the “Luxembourg Law”) and made a “conditional decriminalization” of euthanasia and assisted suicide. Like the Netherlands and Belgium, the Luxembourg Law amends the Penal Code to exempt physicians who provide euthanasia and assisted suicide from criminal liability if they satisfy certain “fundamental conditions” required by the Luxembourg Law. The Penal Code does not have specific provisions concerning euthanasia or assisted suicide, but is considered a form of murder by poisoning under Article 397-1.

To obtain criminal immunity for terminating the life of a requesting adult patient, a doctor must ensure procedural due care requirements are satisfied as well as the following “fundamental conditions”:

1. the patient is a capable and conscious adult at the time of their request;
2. the request is made voluntarily, after reflection and, if necessary, repeated, and does not result from external pressure;
3. the patient is in a terminal medical situation and shows constant and unbearable physical or mental suffering without prospects of improvement, resulting from an accidental or pathological disorder; and
4. the patient’s request for euthanasia or assisted suicide is made in writing.

Before performing euthanasia or assisted suicide certain procedural conditions must be followed. As part of ensuring that the patient’s request is voluntary, the Luxembourg Law, like the Belgian Act, obligates the physician to discuss with a requesting patient, all therapeutic possibilities including those offered by palliative care. The Law also allows euthanasia for unconscious patients pursuant to a written “end-of-life provision” (advance directive) and imposes additional procedural requirements.
In 2009, the Luxembourg Parliament also unanimously passed the *Palliative Care Law*[^266] which establishes a right to *palliative care* and “applies to anyone in a hopeless medical situation as a result of an accident or serious illness”.[^267] There is, however, no similar right to euthanasia or assisted suicide. Like the Netherlands and Belgium, participation by physicians in euthanasia or assisted suicide is entirely voluntary.[^268] Accordingly, euthanasia and assisted suicide cannot legally be part of *palliative care* in Luxembourg.

The respective laws, however, are linked. Under the Luxembourg Law (like the Belgian Act), physicians are required to inform patients who have requested euthanasia or assisted suicide of ongoing therapeutic possibilities including *palliative care* rights and options.[^269] Likewise physicians providing *palliative care* are required to respect a patient’s treatment directions even if it includes those that may advance end of life.[^270]

### 2. Colombia

In a 1997 case, the Constitutional Court of Colombia upheld the constitutionality of a Penal Code provision which carried a lesser punishment for the crime of euthanasia (or “mercy killing”) than the crime of homicide.[^271] The plaintiff in the case had claimed that this distinction violated the right to life (Article 11) and the principle of equality (Article 13) under the Colombian Constitution for persons suffering from grave and incurable illness.[^272]


[^267]: The aim of palliative care, in addition to relieving physical pain and other symptoms, is to take account of the patient’s psychological, social and spiritual suffering. Every effort is made to preserve the best possible quality of life, right up to the moment of death.

[^268]: Luxembourg Law, supra, note 9, at Chapter VI, Article 15; see also discussion in Luxembourg, 25 questions 25 answers, supra, note 9, at 6.

[^269]: Luxembourg Law, id., at Chapter II, Article 2.2.1.

[^270]: Luxembourg Palliative Care Law, supra, note 266, at Articles 3, 4 and 6.

[^271]: C-239/97, supra, note 10.

[^272]: Id.
The Court, however, went on to articulate that it would be unconstitutional to subject a medical doctor to criminal sanction for euthanasia if the individual had a terminal illness and gave full and informed consent to *termination of life*. The Court encouraged the enactment of legislation in this regard.

In a subsequent 2014 case, the plaintiff, after having been refused euthanasia by a health care provider, sought to enforce the “right” as described in the 1997 ruling. The Court found in favour of the plaintiff, and among other things ordered the Ministry of Health and Social Protection to issue guidelines, also urging Congress to pass law to regulate the “right to die with dignity”.

In April 2015, the Ministry of Health and Social Protection adopted Resolution 1216 of 2015, which contains guidelines regulating the medical practice of euthanasia (the “Colombian Guidelines”). Note that euthanasia or “mercy killing” is still a crime in Colombia unless the conditions identified by the Constitutional Court are met. The physician exemption for “mercy killing” does not apply to assisted suicide which remains an offence under the Penal Code.

In order to qualify for euthanasia, requesting patients must be “of age”, have capacity, provide consent, and be in a “terminal phase”. The Colombian Guidelines also permit euthanasia by advance request for patients who may be legally incompetent and/or no longer capable of expressing their wishes.

In Colombia, as with Netherlands, Belgium and Luxembourg (the “Benelux countries”), physician participation in *termination of life* is
voluntary. However, different from the Benelux countries, the Colombian Guidelines require the establishment of Interdisciplinary Scientific Committees (or “ISCs”) within particular health care institutions and set out the procedures to be followed by ISCs and physicians if and when a physician receives a request for euthanasia. In order to receive euthanasia, a patient’s request must be referred to and approved by the relevant ISC.

Also different from the Benelux countries (but somewhat similar to Quebec), the Colombian Guidelines expressly recognize both a “right to palliative care” and a “right to die with dignity”. This dual recognition does not equate palliative care with termination of life nor does it situate these rights on a continuum. Rather, the Colombian Guidelines define palliative care as treatment to “improve the quality of life” of patients and families and is distinct from the “procedure to effect the right to die with dignity.” Palliative care is then positioned within the Colombian Guidelines as a form of procedural safeguard whereby a physician must inform the patient of the right to receive palliative care prior to referring the patient to an ISC for approval of the patient’s euthanasia request. The providing physician must again verify the right of palliative care to the patient just before the euthanasia procedure is implemented. If the patient chooses not to proceed with the euthanasia procedure, palliative care is guaranteed to the patient.

Colombia grounded the right to receive palliative care in Law 1733, which came into effect in September 2014. Law 1733 establishes and regulates “the right of patients with terminal, chronic, degenerative and irreversible conditions to palliative care services, to improve the quality of life of the patients and families through an integrated treatment of pain and other physical, emotional, social and spiritual symptoms...”. Under the law, patients have a right of access to palliative care services and information and the health system and

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281 Id., Article 18.
282 Id., Preamble and Article 5.
283 Id., at Article 4.
284 Right to Palliative care: a right to treatment to “improve the quality of life”, not only of those patients facing illnesses in a terminal phase, but also their families, “through an integral pain treatment, suffering relief and other symptoms, taking into account their psychopathological, physical, emotional, social and spiritual aspects.” Id., Article 4.
285 Id., Article 15.
286 Id., Article 4.
287 Id.
288 Colombian Palliative Care Law (Law 1733, 8 Sep 2014).
289 Id.
government are obligated to offer *palliative care* services with equity and quality in all levels of care throughout the country.\(^{290}\)

*Palliative care and termination of life* are accordingly recognized and treated as distinct rights under Colombian law.


As previously mentioned, physician assisted suicide (PAS) was legalized through statutory instrument in Oregon (1994), Washington (2008), Vermont (2013), California (2015) and D.C. (2016) (the “US PAS laws”).\(^{291}\) All US PAS laws exempt physicians who provide PAS from criminal liability provided their actions are taken in accordance with the requirements of the respective laws.\(^{292}\) The US PAS laws are limited to PAS and do not legalize the practice of euthanasia (“lethal injection”, “mercy killing”, “active euthanasia”)\(^{293}\) which remains subject to the respective criminal law provisions including homicide, murder and/or manslaughter.\(^{294}\)

Key features of the Oregon, Washington, Vermont, California, Colorado and DC PAS laws include the following:\(^{295}\)

- restricted to capable individuals (18 years of age or older);
- patient must be diagnosed with a terminal illness (incurable and irreversible disease that, within reasonable medical judgment, will result in the patient’s death within six months);


\(^{291}\) *Supra*, note 11. The State of Montana is not considered in this section. For discussion of Montana and the ability of physician who has provided PAS to a terminally ill adult patient to raise consent as a defence to a subsequent charge of homicide, see *Baxter v. Montana*, *supra*, note 137.

\(^{292}\) *Oregon Act, supra*, note 11, s. 127.880 para. 3.14; *Washington Act, supra*, note 11, s. 70.245.180; *Vermont Act, supra*, note 11, at para. 5292; *California Act, supra*, note 11, at para. 443.18; *Colorado Act, supra*, note 11, s. 25-48-121; *DC Act, supra*, note 11, ss. 12 and 16.

\(^{293}\) *Id*.


\(^{295}\) *Oregon Act, supra*, note 11, ss. 127.800 para. 1.01(12), 127.805 para. 2.01 and 127.880 para. 3.14; *Washington Act, supra*, note 11, ss. 70.245.010 (13), 70.245.020(1) and 70.245.180; *Vermont Act, supra*, note 11, at paras. 528(6), (10) and 5283; *California Act, supra*, note 11, at paras. 443.1(a), (e), (o), (p) and (q) and 443.2; *Colorado Act, supra*, note 11, s. 25-48-103; *DC Act, supra*, note 11, ss. 2(13), (10), (16), s. 3 and s. 4 (a)(1).
patient may request a prescription for lethal medication from a physician for the purposes of self-administration; and

- a residency requirement.

As with the other permissive jurisdictions, the US PAS laws require that certain procedural conditions be met, including: confirmation of medical condition, assessment of competency and voluntariness; patient is informed of diagnosis, prognosis, risks and alternatives; oral and written requests; referral to a consulting physician; and opportunity to rescind the request. Participation in PAS is entirely voluntary under all US PAS laws.

Under the respective US PAS laws, palliative care is not equated with PAS. Like the other permissive jurisdictions, palliative care is positioned as an “alternative” to PAS and a procedural safeguard before proceeding with PAS. For example, to ensure that a patient is making an “informed decision” for PAS (and thus to receive immunity from criminal law), a physician must inform a requesting patient of treatment alternatives including palliative care options (e.g., “palliative care, “comfort care”, “hospice care” and/or “pain control”).

To date, while certain of these PAS permissive states have begun palliative care initiatives, none have yet passed law recognizing a right to palliative care.

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296 Oregon Act, id., ss. 127.800 para. 1.01(12), 127.805 para. 2.01 and 127.880 para. 3.14; Washington Act, id., ss. 70.245.010, 70.245.020(1), 70.245.040, 70.245.090 and 70.245.100; Vermont Act, id., at para. 5283; California Act, id., at paras. 443.3, 443.4, 443.5, 443.6 and 443.10; Colorado Act, id., ss. 25-48-1021, (14) and (16), 25-48-103 to 25-48-108; DC Act, id., ss. 2, 4, 5, and 6.

297 Oregon Act, id., ss. 127.885§401(2) and (4); Washington Act, id., ss. 70.245.190(1)(b) and (d); Vermont Act, id., at paras. 5285(a), (b); California Act, id., Preamble and paras. 443.14(b), (c)(1) and (2); Colorado Act, id., ss. 25-48-116(2) and 25-48-117; DC Act, id., ss 2(7), 2(8), 11(a), 12(a)(2).

298 Note that the Vermont Act also states that the PAS law has no effect on palliative sedation. Vermont Act, id., at para. 5288; see also DC Act, id., s. 16 “or any other method of medication”.

299 Oregon Act, supra, note 11, ss. 127.800 para. 1.01(7)(e), 127.815 para. 3.01(1)(E), 127.820 para. 3.02, 127.830 para. 3.04 and 127.880 para. 3.14; Washington Act, supra; note 11, ss. 70.245.010 (7)(e), 70.245.040(1)(c)(v), 70.245.050 and 70.245.180; Vermont Act, id., at paras. 5283(a)(6)(C) and (D), 5288, 5289(2), 5290 and 5292; California Act, supra, note 11, at paras. 443.16(i)(S), 443.5(a)(2)(E), 443.6(c) and 443.18; Colorado Act, supra, note 11, ss. 25-48-1025(c)(v), 25-48-106(c)(ii) 25-48-1072(c) and 25-48-110; DC Act, id., ss. 2(10)(E), 4(2)(E).

300 For example, in 2015, Oregon created the Palliative Care and Quality of Life Interdisciplinary Advisory Council in Oregon Health Authority, see online: <http://www.oregon.gov/oha/HPA/CSI/Pages/Palliative-Care-Advisory-Council.aspx>, and in 2009, Vermont passed Act 25, An Act Relating to Palliative Care and Pain Management (H.435), see online: <http://www.leg.state.vt.us/DOCS/2010/ACTS/ACT025.PDF>, to inter alia improve the quality of palliative care and pain management available to all Vermonters and to expand access to palliative care services.
4. Canada: Federal Law Bill C-14 and Quebec’s *Act Respecting End-of-life Care*

As described above, Bill C-14 amended the *Criminal Code* to exempt physicians and other health care professionals who provide or participate in “medical assistance in dying” (euthanasia or PAS) from criminal liability if certain due care criteria are met. Pursuant to Bill C-14, a person can only receive “medical assistance in dying” or MAiD if they meet the following criteria:

(a) eligible for health services in Canada;
(b) 18 years of age and capable of making health decisions;
(c) grievous and irremediable medical condition (serious, incurable illness, disease or disability; advanced state irreversible decline; enduring and intolerable suffering; natural death has become reasonably foreseeable);
(d) voluntary request for MAiD; and
(e) informed consent to MAiD given after having been informed of the means that are available to relieve their suffering, including palliative care.

Participation in *termination of life* in Canada is entirely voluntary, as is the case in all other permissive jurisdictions.

Although the Quebec Act was passed prior to the amendment of the federal *Criminal Code* pursuant to Bill C-14, the criteria that qualify a patient for “medical aid in dying” (euthanasia only) under the Quebec Act are very similar to the federal law:

(1) insured person;
(2) full age and capable of consent to care;
(3) at end of life;
(4) serious and incurable illness;

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301 Bill C-14, *supra*, note 8, s. 3; see also *Criminal Code, supra*, note 39, ss. 241, 227, 241.1 and 241.2.
302 Bill C-14, *id.*, s. 3; see also *Criminal Code, id.*, ss. 241.2(1) and (2).
303 *Carter, supra*, note 2, at para. 132; Bill C-14, *id.*, s. 3; see also *Criminal Code, supra*, note 39, s. 241.2(9); Quebec Act, *supra*, note 3, s. 31.
(5) advanced state of irreversible decline in capability; and
(6) constant, unbearable and intolerable suffering.

In addition to ensuring that the request is free and informed, under the Quebec Act, the procedural safeguards include that patients be informed of palliative care as a “therapeutic possibility” prior to the administration of “medical aid in dying” by a physician.305

Accordingly, palliative care is positioned as a key element for achieving informed consent for termination of life in Canada under both Bill C-14 and the Quebec Act. Furthermore, as discussed earlier, notwithstanding the use of the phrase “continuum of care”, the Quebec Act clearly distinguishes between the two activities, providing distinct definitions and imposing different protocols and safeguards depending on which category of care has been requested.306 It should also be noted that the Quebec Act, like Colombia, establishes both a right to receive “medical aid in dying” as well as a right to receive palliative care.307

On December 12, 2017, Federal Bill C-277, An Act providing for the development of a framework on palliative care in Canada received Royal Assent. The Act inter alia recognizes in its Preamble:

• that the Final Report of the External Panel on Options for a Legislative Response to Carter v. Canada “stated that a request for physician-assisted death cannot be truly voluntary if the option of proper palliative care is not available to alleviate a person’s suffering”; 308 and

305 Id., s. 29(1)(b): “Before administering medical aid in dying, the physician must, … (1) be of the opinion that the patient meets all the criteria of s. 26, after, among other things … (b) making sure that the request is an informed one, in particular by informing the patient of the prognosis for the illness and of other therapeutic possibilities and their consequences”. Presumably, in addition to procedural requirements under the Quebec Act, compliance would also be required with those imposed under Bill C-14.
306 For example, refusal of life-sustaining care or withdrawal of care is addressed in Chapter II, Continuous Palliative Sedation is addressed in Chapter IV, Division 1 whereas Medical Aid in Dying is addressed in Chapter IV, Division 2; see for example, id., at Chapter III, s. 10 and Chapter IV Special Requirements for Certain End-of-Life Care.
307 The Quebec Act, supra, note 3, Title II, Chapter 2, at s. 4. Note that the right is not an unfettered right, as it is to be applied “within the limits of the human, material and financial resources ….” Ibid.
• “the Parliament of Canada recognizes the importance of ensuring that all Canadians have access to high-quality palliative care, especially in the context of physician-assisted death”.309

While the Act does not go so far as to establish a right to palliative care in Canada, the Act requires the Minister of Health to:

devlop a framework designed to support improved access for Canadians to palliative care — provided through hospitals, home care, long-term care facilities and residential hospices — that, among other things,

(a) defines what palliative care is;
(b) identifies the palliative care training and education needs of health care providers as well as other carers;
(c) identifies measures to support palliative care providers;
(d) promotes research and the collection of data on palliative care;
(e) identifies measures to facilitate a consistent access to palliative care across Canada;
(f) takes into consideration existing palliative care frameworks, strategies and best practices; and
(g) evaluates the advisability of re-establishing the Department of Health’s Secretariat on Palliative and End-of-Life Care.310

5. Observations and Comments

In all the permissive jurisdictions discussed, the legalization of termination of life practice has involved, inter alia, amending the criminal law to provide immunity to certain HCPs who provide or participate in termination of life in accordance with the conditions and requirements of the respective laws. There is no right to termination of life, only a right to request it. The health care provider makes the determination regarding whether a request can be legally granted and whether or not to participate.

310 Id., s. 2(1).
None of the termination of life laws define termination of life as a form of palliative care nor is termination of life equated with palliative care. Indeed, the legal relationship between termination of life and palliative care within the termination of life laws is one of antagonism. All of these laws operate to situate palliative care as a life-affirming alternative to termination of life. An offer of palliative care must be brought to a requesting patient’s attention in order to satisfy the legal requirement that a patient has provided consent for termination of life to be carried out. Some jurisdictions require that the offer of palliative care be repeated just prior to the implementation of the life-ending act.

Remarkably, despite the leveraging of palliative care within the respective termination of life laws, not all permissive jurisdictions have guaranteed a right to palliative care or implemented a national strategy guaranteeing equal access to palliative care. Canada is still one such jurisdiction. Although it might be argued that voluntary consent to termination of life might still be achieved even though palliative care options may not be available, there remains the matter of the role of palliative care as a general safeguard. If there is not a genuine commitment (resource or otherwise) behind an offer of palliative care upon which a patient can rely, can it truthfully be said from a regulatory perspective that a patient has meaningful choice? Additionally, outside of the narrow confines of termination of life laws, palliative care plays a significant protective and supportive role in society at large in its offer of life-affirming responses and support to help facilitate flourishing even in the face of limitation and suffering. Its message is not dissimilar to other social institutions and services that — through other areas of expertise — seek to provide support for those experiencing limitations whether those limitations are due to external or internal constraints, conditions or forces.

As part of the practice of medicine, palliative care explores a patient’s suffering in a holistic way which includes identifying the “what” that lies behind requests for hastened death, should they arise. Once causes of

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311 CMA Palliative Care Policy, supra, note 169, at 3.
312 Bill C-277, supra, note 309; see also Mary J. Shariff, “Navigating assisted death and end-of-life care” (2011) 183:6 C.M.A.J. 643; see also Vanden Berghe et al., supra, note 108, at 271, “Given the radical nature of euthanasia — where suffering is ‘solved’ by terminating the life of the sufferer — it can never be a first resort. To avoid the risk of euthanasia being administered for improper reasons, extending it to further populations groups should only be considered if basic palliative care is fully provided to these groups.”
suffering or the “what” behind a request for hastened death is identified, *palliative care* offers care that is whole-person, inclusive of family and carers and regardless of whether the issue is physical, psychological, existential, spiritual or psychosocial. In so doing, it simultaneously delivers forms of preventative medicine and provides opportunity to identify the experience, construction and definition of suffering and vulnerability and to explore the different ways in which society might respond.

Accordingly, the contribution of *palliative care* to society is not only distinct from but broader than the goals of *termination of life* law and it ought to be protected as such. Ensuring *palliative care* access to patients requesting *termination of life* makes sense as it provides patients with options; collapsing *palliative care* into *termination of life* does not. Within *termination of life* laws, *palliative care*’s life-affirming option sits in tension with a request to die and provides the patient (and health care providers) with a precise focussing tool that can aid in achieving clarity around decisions concerning life and death. This kind of precision is no less critical when access to *palliative care* has not been fully realized. Outside of the *termination of life* laws, there does not appear to be legal reason to compel the combining of *palliative care* with *termination of life* nor reason to construe the practices as complementary. Facilitating the exercise of patient choice can be achieved, and has been achieved in permissive jurisdictions, without such a collapse. Furthermore, as discussed in Part IV, describing the practices as “complementary” potentially undermines patient choice within *termination of life* practice as it introduces a coercive dynamic through a conceptual shift in how the choice manifests itself which by law is to be under the patient’s full control. A patient-centered approach arguably leans towards upholding rather than removing the distinction between the two practices.

**VI. CONCLUDING THOUGHTS**

The preponderance of evidence reveals a critical difference between the practices of *palliative care* and *termination of life*: between care that is directed toward a pain-free life, however long it may continue, and care directed toward the ending of pain and suffering through death.

There is some movement, however, to remove the distinctions between these two practices, and place them on a continuum, or otherwise describe them as complementary. Although this position is not
currently a dominant view, it is important to pay attention to it as it carries with it the potential to destabilize various aspects of the safeguard mechanisms associated with termination of life laws. Because it largely emerges from termination of life standpoints, it also elides the nature of palliative care, and may undermine its important contribution to health care and the overall public good.

Within the Canadian dialogue specifically, this movement to collapse the distinction can be seen in at least two aspects of termination of life reform. First, certain palliative care practices are described as hastening death, it seems in order to increase acceptance or approval of termination of life practice. Second, the language of end-of-life continuum (notwithstanding ongoing initiatives to expand termination of life beyond end of life) moves termination of life away from a criminal law construction (federal jurisdiction) into a health matter (provincial jurisdiction). This, as a result, turns the issue towards matters of patient choice and access within which to exercise that choice.

With respect to the first point, caution must be exercised in extending the argument that there is “no ethical distinction” between palliative care and MAiD beyond the advocacy purpose it was meant to serve, namely towards the acceptance and legalization of MAiD. From a policy perspective, the critical distinctions between the two practices remain important as these distinctions are consistently upheld in health care and are specifically implicated in the development and operation of termination of life laws.

With respect to the second point, within the criminal law exception, the regulation of MAiD delivery is a provincial matter. As has been observed from the other permissive jurisdictions, providing access to termination of life and access to palliative care does not require achieving complementarity with palliative care nor does it require restricting the exercise of conscience by health care professionals who do not wish to participate in termination of life. Any number of health system mechanisms can be put in place to achieve access and to ensure that the appropriate balances are struck so that safeguards (including those in the form of critical voices) continue to exist within the regulatory structure.

313 See, for example, Carter, supra, note 2, at para. 23.
314 See discussion in Parts III.2 and IV.3 above.
315 See discussion in Vanden Berghe et al., supra, note 108, at 269.
While Canada continues to debate the scope of its termination of life law in terms of who will ultimately have access to MAiD, the scope of palliative care is clear — to enhance the quality of life of all Canadians suffering from life-limiting illness. If Canada is genuine in its recent recognition that assisted death cannot be truly voluntary if the option of proper palliative care is not available to alleviate suffering, and in its recognition of the importance of ensuring that all Canadians have access to high-quality palliative care, then at minimum, Canada should provide the appropriate regulatory environment to allow for the continued clear and unfettered development of palliative care.

316 See Lamb, supra, note 16. Pursuant to Bill C-14, the Federal Government has tasked the Council of Canadian Academies to review the possibility of extension of MAiD to include: mature minors, mental illness and advance directives. See also discussion in Vanden Bergh et al., id., at 271 which describes how “once the barrier of legalisation is passed, [euthanasia] tends to develop a dynamic of its own and extend beyond the agreed restrictions”, and how efforts to extend the law are “on the agenda of many movements worldwide.”