In its report the Special Committee makes palliative care one of its priorities and recommends that it be improved. The Special Committee considers a further option ("medical aid in dying") to be necessary in end-of-life care, in exceptional circumstances. It reached its conclusions after listening to expert testimony and conducting a broad consultation of citizens and, of course, through the reflection and intensive work of its members following the expert testimony and consultation.

**Improving end-of-life care**

The first conclusion reached by the Special Committee is that end-of-life care must be improved. In this regard, it has selected four goals that must underlie government policy.

**A BETTER UNDERSTANDING OF WHAT CONSTITUTES THE REFUSAL OR WITHDRAWAL OF TREATMENTS**

The law fully recognizes the right of a competent adult to refuse a treatment or request the withdrawal of a treatment, even if death is likely to follow from such a
decision. There is still, however, confusion on this topic, because some persons consider the withdrawal or refusal of treatment as a form of euthanasia. Moreover, the citizens are not sufficiently aware of this right, and health professionals do not always respect it. In order to remove ambiguities and help patients reach better decisions, it is essential to increase the awareness of the public and to improve the training of caregivers.

A DEVELOPMENT OF PALLIATIVE CARE

Palliative care is not available to all patients who need it at the end of their lives. Such care, however, is a central component of end-of-life care. Its importance is universally recognized; the development of palliative care must be a priority. One can make four fundamental observations:

* In 2004 the Department of Health and Social Services has adopted a policy on palliative care at the end of life, but this policy has not been fully implemented (far from it). Since there is a consensus on the relevance of this policy, its implementation must be completed quickly.

* It is well known that the majority of people wish to die at home. Unfortunately, for various reasons, most of them will resign themselves to ending their lives in a hospital. Although one must ensure that palliative care is available in diverse environments, the development of palliative care in a home environment must be given an absolute priority.

* The training of health professionals in palliative care is insufficient. This shortcoming must be remedied.

* Palliative care must be explicitly mentioned in the Law on Health and Social Services. Moreover, it seems essential to remedy the fact that there is no obligation, on the part of health institutions, to organize palliative care and provide it to patients.

A FRAMEWORK FOR PALLIATIVE SEDATION

At the end of life, there are exceptional situations where it is impossible to relieve the suffering of a patient through the usual means. Physicians may then resort to palliative sedation, whose goal is to make the patient unconscious. Through powerful sedatives, one induces an artificial sleep in the patient, in an intermittent or continuous fashion, in order for him to stop being aware of his suffering. Palliative sedation, especially in its continuous version (lasting until the patient's death), raises many questions in the medical community. For some health
professionals, this medical practice is very close to euthanasia. On the other hand, palliative sedation is rigorously controlled in some environments but controls are weaker in other environments. This shortcoming may lead to the use of unsuitable medication for inducing the sedation or to the decision not to offer palliative sedation (even if it is called for and requested by the patient). This situation is worrisome. A rigorous framework, including a practice guide and ethical norms, must be provided for palliative sedation wherever it is offered.

A LEGAL RECOGNITION OF ADVANCE MEDICAL DIRECTIVES AND THE PROMOTION OF END-OF-LIFE CARE PLANNING IN CASE OF INCAPACITY

Advance medical directives in case of incapacity are a tool for reassuring persons that their wishes will be respected should they be incapacitated. Those wishes, however, are not always respected by health care professionals or close relations. Indeed advance medical directives are not explicitly recognized in the Québec Civil Code. This shortcoming must be remedied by making advance medical directives legally binding.

On the other hand, too few people plan their end-of-life care. Citizens must be made aware of the importance of discussing their wishes with their doctor and close relations, should they become incapacitated. To this end, means of communication must be developed in order to inform the population, health professionals, and social services professionals of issues surrounding the end of life.

A FURTHER OPTION: MEDICAL AID IN DYING

The second conclusion by the Special Committee is that a further option is necessary in the continuum of end-of-life care: "medical aid in dying." The word "aid" refers to the undisputable value of being near a patient until the very end. The term "medical" refers to the nature of this nearness, which implies the intervention of a physician.

AN OPTION FOR EXCEPTIONAL CASES

Some sufferings cannot be adequately relieved and sick people who want these unbearable (and to them meaningless) sufferings to stop come up against a refusal that does not correspond to the values of compassion and solidarity of Québec society. The medical aid in dying then becomes an option for these people in exceptional situations. It will also bring a form of serenity to all persons
who are afraid of suffering at the end of their lives and will know that this option may be available should their sufferings become unbearable.

AN OPTION COMPATIBLE WITH THE EVOLUTION OF SOCIAL VALUES, OF MEDICINE, AND OF THE LAW

Social values have distanced themselves from ideological or religious beliefs. Nowadays they gather society’s members around notions such as individual freedom, autonomy, and a person's integrity and inviolability. These notions are compatible with medical aid in dying.

Also progress in medicine can delay death for weeks, months, and even years, but at the expense of chronic pains that result in a prolonged agony. A new approach to end-of-life care (palliative care) is now available. This approach, based on the relief of the patient's symptoms rather than on the preservation of his or her life at all cost, seems to be compatible with medical aid in dying.

If we now turn to the law, we note that in the cases of aid in dying, no charges are laid, and symbolic sentences or no sentences at all are handed out. Furthermore, the obligation to secure the patient's free and informed consent before embarking upon any medical treatment, as well as the right to refuse or cease a treatment even if this decision results in short-term death, are recognized in the Québec Civil Code. From this point of view, medical aid in dying appears more as an evolution than a revolution in Québec law.

AN OPTION THAT TAKES INTO CONSIDERATION THE ISSUES RAISED DURING THE CONSULTATION

In its decision to propose medical aid in dying as a further option in the continuum of end-of-life care, the Special Committee takes into consideration the diverse issues raised during the consultation. Among the issues raised were the following: the development of palliative care, the respect for human life, the search for the common good, and the risk of a wayward trend. The Special Committee is also relying on the information gathered during its trip to the Netherlands and Belgium. In these two countries, where euthanasia has been allowed for about ten years, the feared abuses have not taken place and the population and the medical profession strongly support euthanasia. Thus it is possible to avoid abuses through the application of strict safeguards.

In the opinion of the Special Committee, the option of medical aid in dying corresponds to a need expressed with maturity and is a secure option, provided necessary precautions are taken in a determined way. The physicians whom we
heard have confirmed that in Québec, no abuse has been connected to the fact that in the last 20 years, some patients and even their close relations have been allowed to ask for a treatment withdrawal (for instance the withdrawal of an artificial respirator).

**AN OPTION IN NEED OF SAFEGUARDS AND NEEDING TO BE CIRCUMSCRIBED**

The Special Committee was guided by three great principles when trying to circumscribe the option of medical aid in dying and provide safeguards, in order for this option to correspond to the evolution of social values, medicine, and the law, and to the issues raised during the consultation. These principles are the following:

* Insert medical aid in dying within the continuum of end-of-life care;

* Associate medical aid in dying to the relief of suffering;

* Ensure respect for the autonomy of the person.

The Special Committee makes recommendations (to circumscribe the option of medical aid in dying and provide safeguards) that follow from these three principles and take precaution into account. The criteria and safeguards considered by the Special Committee, and which cannot be separated from the introduction of medical aid in dying, are related to the following questions.

**Who could request medical in dying?**

A person satisfying all the following criteria at a given point in time may request medical aid in dying.

* He or she is a resident of Québec (according to the Law on Health Insurance).

* He or she is an adult with the legal capacity to consent to treatment.

* He or she formulates a request for medical aid in dying in a free and informed manner.

* He or she suffers from a grave and incurable illness.

* His or her medical condition is characterized by a profound degradation of his or her capacities, with no possibility of improvement.
* He or she endures physical or psychological suffering that is constant and unbearable and cannot be relieved by means that the person is willing to tolerate.

**Who could administer medical aid in dying?**

Medical aid in dying can only be administered by a physician.

**How should a request for medical aid in dying be formulated?**

The person requesting it should, among other procedures, formulate its request in writing, in a voluntary and reflective manner, and reiterate its request within a time frame deemed reasonable for the relevant illness.

**What control mechanisms should be instituted?**

Two mechanisms are proposed by the Special Committee. An *a priori* control would consist of the procurement of a second medical opinion. An *a posteriori* control would be carried out by a national body that would check all medical aid in dying declarations and evaluate the overall process.

**A LEGAL FRAMEWORK FOR MEDICAL AID IN DYING**

Medical aid in dying is part of the continuum of appropriate end-of-life care. It is, actually, a medical act taking place in a rigorous context with safeguards and as such, it falls within the jurisdiction of Québec in matters of health. The proposed framework consists of all the criteria and safeguards mentioned above and these criteria and safeguards should be included in the law, specifically the Québec Civil Code and the Law on Health and Social Services. Moreover, since Québec has the power to regulate the professions, it can ensure that medical practice conform to the new option of medical aid in dying through professional legislation and regulation as well as ethical and deontological norms (for the relevant professional associations).

Finally, although criminal law falls under the jurisdiction of the federal parliament, Québec has the competency to administer justice and apply criminal law. Therefore the decision to lay charges and initiate a criminal prosecution is taken by the attorney general of Québec. To ensure that doctors have the freedom of mind they need in their practice, the attorney general of Québec should issue directives ("orientations and measures") to the director of criminal and penal prosecutions. These directives should state that a physician who administers medical aid in dying according to the legal criteria will not be prosecuted.
24 RECOMMENDATIONS
PROPOSED BY
THE SELECT COMMITTEE
ON DYING WITH DIGNITY

The Special Committee is convinced that its recommendations will make some ends of life more serene and deepen the solidarity that our society extends to sick people, their close relations, and caregivers. It hopes that the seriousness of its work and the extensive involvement of citizens will convince the Government to implement its recommendations within a short time frame. The respect for persons who are at the end of their lives demands it.

RECOMMENDATION 1
The Special Committee recommends that the Department of Health and Social Services make sure that a portrait of palliative care in Québec is drawn. In particular this portrait should:

* Include a description of the existing resources on the whole Québec territory;
* Include a description of the needs and the resources necessary to meet them;
* Include a description of palliative care in each of the regions;
* Be updated regularly.

RECOMMENDATION 2
The Special Committee recommends that the Department of Health and Social Services emphasize the development of palliative care in a home setting.

RECOMMENDATION 3
The Special Committee recommends that the Department of Health and Social Services ensure that all health professionals receive adequate training in palliative care.

RECOMMENDATION 4
The Special Committee recommends that the Department of Health and Social Services create an administrative unit devoted to palliative care within the department. This unit should, among other things, complete the implementation
of the *Policy on Palliative Care at the End of Life*, especially the following elements:

* Access to palliative care, at an earlier stage than is currently the case, as soon as the evolution of the patient’s illness requires it;

* Access to palliative care for persons suffering from incurable illnesses other than cancer;

* Helping persons suffering from incurable illnesses to remain in their natural environment;

* Providing individual rooms to patients;

* Sharing of clinical information needed for the patient's medical follow-up and creating stable multidisciplinary teams.

**RECOMMENDATION 5**
The Special Committee recommends that the Department of Health and Social Services transmit, for the purpose of study, a report on the implementation of the *Policy on Palliative Care at the End of Life* to the relevant committee of the National Assembly; this report should be transmitted one year after the publication of the report of the Special Committee on the Death with Dignity Question. The report on the palliative care policy implementation should include a portrait of palliative care in Québec.

**RECOMMENDATION 6**
The Special Committee recommends that the Law on Health and Social Services be modified so that:

* the right to palliative care for any person whose medical condition justifies it is recognized;

* any health institution providing end-of-life care (in a hospital-like setting or at home) includes palliative care in its services.

**RECOMMENDATION 7**
The Special Committee recommends that the College of Physicians of Québec develop a practice guide and deontological norms on palliative sedation.

**RECOMMENDATION 8**
The Special Committee recommends that the relevant laws be modified so that advance medical directives are recognized and such directives:
* Are legally binding;

* Are implemented as an act signed in front of a notary or a mandatory form signed in front of a witness;

* May include the names of one or several trustworthy persons who will make advance medical directives known so that they can be implemented.

**RECOMMENDATION 9**
The Special Committee recommends that the Department of Health and Social Services:

* Take the appropriate measures so that advance medical directives appear in the person's medical record and are entered into a register;

* Ensure that the attending physician checks whether advance medical directives have been issued or not.

**RECOMMENDATION 10**
The Special Committee recommends that the Department of Health and Social Services put in place a mechanism for inciting citizens to update their advance medical directives periodically.

**RECOMMENDATION 11**
The Special Committee recommends that communication tools on end-of-life care planning be developed in order to inform the population, as well as all personnel of health and social services, of the issues surrounding the end of life.

**RECOMMENDATION 12**
The Special Committee recommends that an information guide be handed out to the person with a diagnosis of incurable illness; this guide would include information on his or her rights and on available services and resources.

**RECOMMENDATION 13**
The Special Committee recommends that the relevant laws be modified so that medical aid in dying is recognized as an appropriate form of end-of-life care if the request made by the person respects the following criteria:

* He or she is a resident of Québec (according to the Law on Health Insurance);
* He or she is an adult with the legal capacity to consent to treatment;

* He or she formulates a request for medical aid in dying after reaching his or her decision in a free and informed manner;

* He or she suffers from a grave and incurable illness;

* His or her medical condition is characterized by a profound degradation of his or her capacities, with no possibility of improvement.

* He or she endures physical or psychological suffering that is constant and unbearable and cannot be relieved by means that the person is willing to tolerate.

**RECOMMENDATION 14**
The Special Committee recommends that the relevant laws be modified so that the following safeguards are put in place:

* Any request for medical aid in dying should be in writing and bear the patient's signature;

* This request is reiterated within a reasonable time period (depending upon the type of illness);

* The attending physician should consult another physician on whether the request respects the admissibility criteria;

* The consultant must be independent from both the patient and the attending physician, and be considered as competent in the relevant pathology;

* The attending physician must submit a formal declaration of medical aid in dying.

**RECOMMENDATION 15**
The Special Committee recommends that a supervisory board control and evaluate medical aid in dying. Concretely this board will:

* Verify whether acts in the "medical aid in dying" category have been carried out under legal conditions;

* Publish an annual report including statistics on acts falling in the "medical aid in dying" category;

* Publish, every five years, a report on the implementation of provisions concerning medical aid in dying.
RECOMMENDATION 16
The Special Committee recommends that the relevant committee of the National Assembly study the five-year report by the control and evaluation board.

RECOMMENDATION 17
The Special Committee recommends that the relevant laws be modified in order to recognize the right of an adult and competent patient to make an advance request of medical aid in dying should he or she be in an irreversible state of unconsciousness (according to the current scientific criteria). This advance request for medical aid in dying:

* is expressed in a free and informed manner;

* is legally binding;

* takes the form of an act signed in front of a notary or signed by two witnesses, including a commissioner for oaths;

* may include the names of one or several trustworthy persons who will make the request known so that it can be implemented.

RECOMMENDATION 18
The Special Committee recommends that the relevant laws be modified in order to establish the following safeguards:

* The attending physician must consult another physician regarding the irreversible character of the patient’s unconsciousness;

* The consulting physician must be independent from both the patient and the attending physician.

RECOMMENDATION 19
The Special Committee recommends that the Department of Health and Social Services:

* Take the appropriate measures so that the advance request for medical aid in dying appears in the person’s medical record and is entered into a register;

* Ensure that the attending physician checks whether such a request is included in the medical record or the register;
* Ensure that the local complaints and service quality commissioner checks periodically that the advance requests for medical aid in dying are being respected.

**RECOMMENDATION 20**
The Special Committee recommends that the Attorney General of Québec issue directives ("orientations and measures") to the director of criminal and penal prosecutions so that a physician who administers medical aid in dying according to the legal criteria will not be prosecuted.

**RECOMMENDATION 21**
The Special Committee recommends that the College of Physicians of Québec modify its Code of Conduct in such a way that physicians may provide medical aid in dying according to legal criteria, while confirming their right to conscientious objection and their eventual obligation to refer their patient to another physician.

**RECOMMENDATION 22**
The Special Committee recommends that the Order of nurses of Québec modify its Code of Conduct so that its members are allowed to participate in a "medical aid in dying" treatment in accordance with legal criteria, while confirming their right to conscientious objection.

**RECOMMENDATION 23**
The Special Committee recommends that a bill reflecting the recommendations of its report be tabled in the National Assembly by June 2013 (at the latest).

**RECOMMENDATION 24**
The Special Committee recommends that a mixed group of experts be created under the aegis of the College of Physicians of Québec in order to examine the possibility of allowing a person afflicted with dementia (caused by a degenerative brain disease) to make an advance request for medical aid in dying.

Living with Dignity translation by Odile Marcotte from the following source: http://www.marysegaudreault.com/communiques/mourir_dignite_2012/resume_rapport.pdf