

<p>Draft Act to introduce Assisted Dying in Canada Based on the “Swiss system” of physician-supported accompanied suicide</p>

Act

Draft Act to Provide for Accompanied Suicide with Assistance by Registered Charitable Not-for-Profit Organisations (Accompanied Suicide Act – ASA)

A. Issue

“Without in any way negating the principle of sanctity of life protected under the Convention, the Court considers that it is under Article 8 [of the European Convention on Human Rights] that notions of the quality of life take on significance. In an era of growing medical sophistication combined with longer life expectancies, many people are concerned that they should not be forced to linger on in old age or in states of advanced physical or mental decrepitude which conflict with strongly held ideas of self and personal identity...”

This view was expressed by the European Court of Human Rights (ECtHR) in its decision in the case of Diane Pretty v. the United Kingdom of 29 April 2002. In doing so, the Court touched upon the question of whether the desire of some people for facilitating “assisted dying” might be a matter that falls under Article 8 of the European Convention on Human Rights (ECHR), “Right to respect for private and family life”.

Since then, the ECtHR has dealt with a series of other cases presenting similar issues. In its decision in one of these cases, Haas v. Switzerland, it recognised the right of a person to decide how and when he or she wishes to die as constituting an aspect of Article 8 ECHR and thus falling within the application of the European Convention on Human Rights as a basic right.

In the public debate on these issues, there has long been a divide between the opinion of a large section of the public and the stance of policymakers. For many years, surveys have shown that a clear majority of Canadians is in favour of making assisted dying possible.

From 2004 until December 2015, a total of 43 people residing in Canada went to Dignitas in Switzerland to put an end to their suffering in a self-determined manner by way of legal accompanied suicide. However, no one should be forced to leave his home, his country to exercise the basic human right of deciding on the time and manner of his end in life.

It must become possible for those residents of Canada who want to put an end to their life for justifiable reasons to do so in a dignified and safe manner of their own choosing and in the presence of their family and friends, in the privacy of their own homes and to be able to have access to professional, competent assistance.

On 6 February 2015, the Supreme Court of Canada released its decision in the case of Carter v. Canada. The Court found that sections 241 (b) and 14 of the Canadian Criminal Code, which made it illegal for anyone to assist in the death of another person who self-determinedly wished to die, were unconstitutional. To the extent that those sections prohibited physician-assisted dying for a competent adult who consents to the termination of his or her life because of a grievous and irremediable medical condition causing suffering that is intolerable to the person.

The Court also acknowledged that there are risks in permitting physician-assisted dying, but found that these risks can be identified and very substantially minimized through a carefully-designed system

imposing stringent limits that are scrupulously monitored and enforced. Stating that a complex regulatory regime on physician-assisted dying is better created by Parliament, the Court ordered that the Criminal Code provisions remain in force until 6 February 2016 to give Parliament time to respond and determine the conditions and circumstances under which physician-assisted dying should be allowed in Canada.

The Court's decision means that Canada faces the situation of physician-assisted dying being decriminalised on 6 February 2016 – depending on the Supreme Court's decision on the Government's request for an extension of additional six months – but potentially not having a specific law regulating physician-assisted dying after 6 February 2016.

B. Solution

This situation (of not having a regulatory regime for physician-assisted dying) would be very much the same situation as exists in Switzerland, where physician-assisted dying in the form of physician-supported assisted/accompanied suicide by private organisations such as Dignitas has been a practice of more than 30 years, but where there has never been a specific Law/Act regulating it. Despite there not being a specific Law/Act, this “Swiss scheme” notably, has been functioning without any of the typical but unfounded pretext arguments having been realised, such as abuse of such system, risks for certain less privileged social groups, “vulnerable people” such as elderly or disabled being pushed to end their days, or a “slippery slope” in the direction of increasing physician-assisted dying. Even after 30 years, only about one per cent of all deaths in the Swiss population are attributable to assisted/accompanied suicide.

The solution lies in the Canadian legal system enacting a law enabling the requirements to be established under which charitable not-for-profit organisations in the territory of Canada are allowed to provide and perform accompanied suicide in a professional manner. The law should enable assisted dying using the gentlest and safest method available, while ensuring that specific quality criteria are being met.

The following two aspects in particular are definitive:

Accompanied suicide should not be provided by commercial businesses that act as “market players”;
and

Accompanied suicide needs to be embedded in charitable not-for-profit work premised on suicide as a legitimate act under some circumstances.

These aspects are taken into account by creating a law which sets conditions allowing only charitable not-for-profit organisations in the form of registered membership societies (associations in the sense of Swiss Civil Code article 60) to act. This condition does away with the incentive to offer assisted dying in a commercial manner.

Switzerland's experience with this system has been very positive. The Swiss Federal Council (Swiss Government) and the Government of the Canton of Zurich (where Dignitas and Exit have their seat, the latter being Switzerland's biggest help-to-live-and-right-to-die membership society with some 90,000 members) – in line with both chambers of the Swiss parliament – have established that this system does not require any statutory measures to prevent abuse. This might be surprising in light of the fact that, as mentioned, Swiss law does not specifically regulate assisted/accompanied suicide. This example shows that “dare to live free!” in seeking a solution to difficult issues may be an eminently reasonable approach. There are no reasons to believe that this approach will be less successful in Canada than in Switzerland.

The Swiss system, which is based on freedom, personal autonomy, and responsibility, is also suited to providing valuable services to society in the area of suicide attempt prevention. This system strives to embody the principle “as many suicides as justified, as few suicide attempts as possible” and in doing so makes a significant contribution to preventing suicide attempts.

In light of the fact that there is obviously a “system that works”, notably for more than 30 years now and this even without a specific Law/Act, the Canadian Government – just like representatives of the

UK House of Lords, parliamentarians of Sweden, Australia, Scotland, etc. – may be interested to see how this system could be put into law. For this reason, Dignitas has drafted an Act, basically a one-to-one image of the “Swiss system” which – as the External Panel on Options for a Legislative Response to *Carter v. Canada* heard during their visit to Dignitas on 7 September 2015 and as it is evident from Dignitas’ literature published on its website www.dignitas.ch – involves 1) a competent individual who wishes to terminate his or her suffering and life, 2) counselling on alternatives to assisted/accompanied suicide and suicide attempt preventive work in general, 3) Swiss medical doctors, 4) a public members society (association) such as DIGNITAS, 5) a safe medication such as sodium pentobarbital, and 6) state authorities reviewing the accompanied suicide.

C. Alternatives

There are no viable alternatives to providing safe, reliable physician-supported assisted dying. The legitimate need and desire for such assistance is justifiable and the demand to have at least such option is great – even though only a small number of people would actually make use of it. Any intention to (again) prohibit professionally assisted dying or to narrow access to such option will lead to the issue not being solved but the situation made worse. All through history, suicide and assistance in suicide have been reality. No criminal law and no making it a “sin” by religious dogmas have changed anything in this. In fact, by criminalising and banning self-determinedly ending one’s suffering and life, the situation only becomes worse: either assistance takes place secretly or people take to drastic measures such as jumping off a high building, going in front of a train, shooting themselves, and so on. All this with the well-known risks of failure and dire consequences for the person and also for third persons (train drivers, emergency rescue teams, etc.), not to mention the costs for the country’s healthcare system and the public in general. Furthermore, narrowing access to assisted/accompanied suicide will lead to unlawful discrimination: those who have the means and/or those who are able to travel abroad may find help elsewhere whilst others are forced to put up with what there is or, rather, what there isn’t.

From a European legal perspective: a law that sets out medical requirements for the admissibility of assisted dying on a professional basis must ultimately be at odds with Article 8(1) in conjunction with Article 14 of the European Convention on Human Rights (ECHR): since the right to die has been recognised by the European Court of Human Rights as a human right, the imposition of any medical requirement would result in discrimination against persons who do not satisfy this requirement.

D. Costs

This draft Act, in Section 14, provides for the creation of a Central Supervisory and Documentation Agency collecting data of the activities of the organisations providing accompanied suicide and forwarding complaints to appropriate entities. It could be set up, for example, within the Department of Justice. It is assumed that this agency can easily be integrated in the department’s organisation. The resulting additional expense should be by far outweighed by a significant reduction in the costs incurred by the federal, state and municipal governments associated with “common” suicides and attempted suicides with all their well-known serious health consequences and costs to society as a whole.

Draft Act to Provide for Accompanied Suicide with Assistance by Registered Charitable Not-for-Profit Organisations (Accompanied Suicide Act – ASA)

The Canadian Parliament has adopted the following Act:

Article 1

Law on Accompanied Suicide with Assistance by Registered Charitable Not-for-Profit Organisations

Section 1

Purpose of the Act

This Act creates the conditions under which charitable not-for-profit organisations may prepare and provide an accompanied suicide as part of the charitable mission of the organisation.

Section 2

Definitions of the terms used

The terms used in this Act are defined as follows:

Organisation: Membership association (members' society) registered as a charitable not-for-profit organisation.

Member: Person who has been admitted as a member of an organisation, as defined in this section.

Request: Written expression of a member to an organisation in which the member seeks preparation for an accompanied suicide.

Preparation for an accompanied suicide: Consideration and clarification of whether the self-determined death intended by a member can be justified for health or other reasons.

Provisional green light: Declaration of a medical doctor to an organisation that he or she is in principle willing to issue a prescription for the medication for a member, based on that member's request and the result of the preparation for that member's accompanied suicide, provided that the medical doctor sees the member wishing to die before issuing the prescription and has no doubts concerning the member's mental capacity.

Accompanied suicide: Rendering of assistance to a member wishing to die with the goal of enabling this member to have a dignified, safe and painless self-determined death in the presence of his or her close ones of personal choice.

Assisting person: Persons who on behalf of the organisation assist a member wishing to die in their self-determined death.

Medication: Pharmaceutical preparations, such as narcotic drugs, individually or combined, in a dosage sufficient to reliably result in death.

Aid: Devices, instruments, equipment or release mechanisms that enable a member wishing to die who is not physically able to take the lethal medication without assistance to self-administer the medication, for example, by way of a previously inserted gastric tube or intravenous drip.

Self-determined death: Death by way of self-administration, with or without aid, of a lethal dose of medication prescribed by a licensed medical doctor for use by the member who has requested it.

Medical doctor: a physician, such as a general practitioner, clinician, etc.

Licensed pharmacy: any pharmacy or drug store which is licenced to sell psychotropic substances / barbiturates / sedatives.

Examination of the corpse: Inspection of the corpse of a deceased member to determine whether actions of a third party can be ruled out and therefore self-determined death can be certified.

Medical examiner: public medical doctor officer, a forensic medical doctor (coroner) or a specially trained medical doctor for performing examinations of corpses.

Section 3

Organisation

(1) It is lawful to found an organisation to counsel people considering suicide without a view to any specific outcome, to show them options enabling them to rethink their intention or, if justified, to aid them in realising their wish to die by providing an accompanied suicide. As soon as the organisation is entered in the register for registered associations, it shall be entitled to engage in accompanied suicide in its professional capacity.

(2) Rendering assistance in an accompanied suicide may not be the organisation's only purpose.

(3) The organisation's articles of association (bylaws / statute / charter) must be drafted in a way that the organisation can be lawfully recognised as being charitable / not-for-profit.

(4) In its articles of association, the organisation must set out the amount of ordinary members' dues and any the additional members' dues for preparing

and conducting an accompanied suicide, if additional dues are to be charged.

(5) The organisation may establish lump-sum fees for other services which may frequently occur in connection with rendering assistance in an accompanied suicide.

(6) The organisation shall ensure that these fees may be reduced or waived for members living in modest economic circumstances.

(7) The organisation shall refrain from aggressive promotion for providing accompanied suicide.

Section 4

Counselling / Advisory service

(1) The organisation shall counsel all persons who are considering suicide in an open-outcome manner.

(2) The organisation shall refrain from making any value judgement in respect of a person's wish to die.

(3) The organisation shall discuss with persons considering suicide the problem(s) that has(have) led to their wish to die and shall make suggestions for solutions that enable them to continue living where these suggestions appear useful and feasible.

(4) When it appears that such solutions do not exist or they are rejected by the person considering suicide, the organisation shall be entitled to engage in preparation for assisting the person, after they have become a member, in their self-determined death.

(5) The organisation shall keep, at least, summarised records of such counselling sessions. These records shall enable, at least, statistical data to be collected on the effectiveness of the organisation's work. Individual privacy shall be protected.

(6) The organisation shall provide this counselling to everyone free of charge.

Section 5

Preparation for accompanied suicide

(1) The requirements to be satisfied for the preparation of accompanied suicide are:

a) The person considering suicide has become a member of the organisation;

b) The organisation has received a request from the member specifically asking for preparation in that member's self-determined death;

c) If the member's request is being made for health reasons, the request must be supplemented with documents which provide information on the member's current health status;

d) If the member's request is being made for other reasons, these shall be set out in detail and, where possible, supported by documentation;

e) The request shall include a short biographical sketch providing information about the member's life history, what has occurred to date, and their family situation;

(2) Where the above requirements are satisfied in the opinion of the organisation, it shall forward the request to a medical doctor who is prepared to cooperate with such organisations. After examining the request including any attached documents, the medical doctor shall inform the organisation whether he or she:

a) can give the member wishing to die a provisional green light; or

b) needs additional information to arrive at a decision; or

c) is not able to give a provisional green light.

(3) Where a medical doctor states that he or she is not able to give a provisional green light, the organisation may submit the request to another medical doctor.

(4) The organisation may at any time notify the member wishing to die that the organisation is not able or willing to assist the member in an accompanied suicide.

Section 6

Arranging to provide accompanied suicide

(1) After a member has been given a provisional green light,

a) the member may wait for an indefinite period of time to set an appointment with a medical doctor so that the medical doctor may make a final decision regarding issuing the lethal dose prescription for the qualified member's use;

b) the member may express the desire to consult a medical doctor immediately so that the medical doctor may make a final decision regarding issuing the prescription for the medication, however the member may wait to apply for arrangements with the organisation to have an accompanied suicide;

c) the member may express the desire to consult a medical doctor immediately with regard to a definitive decision and also may apply immediately to the organisation for an appointed time for their accompanied suicide.

(2) The organisation shall comply with the desire of a member within the framework of the possibilities available to it and the medical doctor. The organisation shall ask the member whether the member has discussed the decision with next of kin and/or friends and shall encourage the member to do

this, where reasonable. The organisation shall also ask the member whether anybody of the member's choosing is to be present at the accompanied suicide and if so, who.

(3) During the consultation with a member who has received a provisional green light, the medical doctor shall evaluate:

a) whether in his or her opinion there are options for a solution enabling the member to continue to live, whether the member knows of these options and whether the member has decided to take advantage of them or not;

b) whether the member steadfastly maintains the wish for an accompanied suicide;

c) whether the member appears to be mentally competent;

d) whether there are other cogent reasons for deciding against going through with an accompanied suicide;

e) whether the member is physically able to self-administer the medication by oral means, such as drinking it or by way of another action;

f) if the member is not physically able to self-administer the medication by oral means, the medical doctor shall determine whether the member is capable of operating an aid for the purpose of self-administering the medication;

g) where there are absolutely no possibilities for the member, by any physical action on his or her own, to initiate the final act of ingesting the medication in any way, the medical doctor shall definitively refuse to issue the prescription.

(4) Where the medical doctor definitively consents to issuing a prescription for the medication, he or she shall forward the prescription to the organisation.

(5) The medical doctor shall document his or her findings in a report which is to be forwarded, together with the prescription, to the organisation.

(6) The organisation shall procure the medication from a licensed pharmacy. The organisation may not give the prescription or the medication to the member. The organisation shall store the medication in a safe place until it is used in the member's accompanied suicide. If the medication is not used, the organisation shall return it to the licensed pharmacy from which it was procured.

Section 7

Assisting persons

(1) The organisation shall ensure that the assisting persons engaged by it possess the necessary training to prevent foreseeable problems arising during an accompanied suicide.

Section 8

Place and participants during an accompanied suicide

(1) As a general rule, an accompanied suicide shall take place at the residence of the member.

(2) Where this is not possible and the member does not designate another appropriate location, the location shall be designated by the organisation.

(3) The member shall determine whether, apart from the assisting persons, other persons are to be present during the member's accompanied suicide.

(4) When the accompanied suicide does not take place at the residence of the member, the organisation shall ensure that the member provides for what is to be done with personal property remaining at the place of the accompanied suicide subsequent to his or her death.

Section 9

Conducting an accompanied suicide

(1) To conduct an accompanied suicide, the organisation arranges for the medication and documentation and at least two assisting persons to be present at the agreed place at the agreed time.

(2) The assisting persons shall ensure that the person they are to assist is identical to the member for whom the medication has been procured.

(3) The assisting persons shall also ask the member whether he or she continues to wish to die or whether he or she would prefer to revoke the decision. In doing so, the assisting persons shall expressly indicate to the member that they would perceive such a change of mind to be positive, as would the organisation. No other persons may be present in the room while these questions are being asked and answered. If other persons have been sent out of the room before these questions are asked and if they then return to the room, these questions shall be posed to the member once more. If any doubts arise with the assisting persons as to the member's wish to die, or if there is any indication that the member might have affirmed the wish to die after being pressured to do so by any third party, the assisting persons shall discontinue the procedure of the accompanied suicide, indicate their reason for doing so, and make a written report to the organisation.

(4) If the member abides by his or her wish to die, they shall sign the relevant document in which they state this wish, the document also indicating who is present at the member's accompanied suicide.

(5) If the member abides by his or her wish to die, the assisting persons shall ensure that the member is able to self-administer the medicine in the intended manner. If self-administration with the aid of a

device is required, the assisting persons shall prepare the device with the utmost care.

(5) The following shall be said to the member before they are given the prepared medication or device enabling them to self-administer the medication: “If you drink this medication (or, for example, push this release mechanism), you will die. Is that what you want?” If the member responds in the affirmative, the prepared medication or the release mechanism is given to the member so they can self-administer the medication.

Section 10

Obligations after the medication has been self-administered

(1) The assisting persons shall ensure that, after the member has drunk the medication or self-administered it with the aid of a device, he or she is continuously monitored.

(2) If there are signs which enable the assisting persons to establish with certainty that death has occurred, they shall report this case of accompanied suicide to the competent police authority and indicate the name of the organisation. The police authority shall notify the medical examiner and ensure that the examination of the corpse takes place without undue delay.

(3) After the assisting persons have determined that death has occurred, the scene with the deceased member shall not be altered by them or any other persons who might be present.

Section 11

Examination of the corpse

(1) The medical examiner shall establish death according to medical principles, ensure that the deceased is identical to the individual named in the documents for the accompanied suicide, and inquire whether the actions of a third party can be ruled out as the cause of death.

(2) If there are any doubts concerning this, the medical examiner shall ensure that the matter is investigated by the competent police authority.

(3) When there are no doubts or they have been ruled out, the corpse shall be released for funeral provided that the public prosecutor raises no objections.

(4) A medical doctor who issues a prescription for accompanied suicide may not act as the medical examiner in the same case.

Section 12

Ensuring proper arrangements for handling the deceased's remains

(1) Generally, the relatives of the deceased member or another person designated in advance by the deceased member shall ensure that the deceased's remains are appropriately taken care of.

(2) Before the organisation assists a member in his or her accompanied suicide, it shall confirm that arrangements have been made for the member's remains. The organisation may be tasked with these arrangements.

Section 13

Maintaining a journal

(1) The assisting persons shall maintain a journal chronicling the accompanied suicide by itemising each step of the protocol, the time each step occurs, and any incidents of particular note.

(2) The journal is to be put in the member's file maintained by the organisation; the medical examiner is to be sent a copy of the journal. The medical doctor who provided the prescription shall also receive a copy.

Section 14

Central Supervisory and Documentation Agency

(1) The medical examiner or the competent police authority shall forward the documentation provided by the organisation to a Central Supervisory and Documentation Agency to be designated by the Department of Justice.

(2) This agency shall review the documentation to ascertain whether the persons acting under this Act comply with its provisions.

(3) When the agency finds that shortcomings or errors have occurred, it shall contact the relevant persons and ensure that the shortcomings and errors are remedied and not likely to occur again.

(4) In the event of serious violations by medical doctors of the relevant provisions, the agency shall report them to the competent medical board for the purpose of examining whether proceedings are to be initiated against these doctors under the professional code of conduct.

(5) Serious violations repeatedly committed by an organisation shall be reported to the registration court competent at the organisation's registered office to examine whether legal action is to be taken against the organisation.

(6) The Central Supervisory and Documentation Agency shall publish annually a report on its findings in respect of its supervisory activities, including statistical figures on accompanied suicide.

Section 15

Legal classification of a death by
accompanied suicide

A death that has been brought about by an accompanied suicide shall be deemed to constitute a natural death in respect of population statistics and in terms of civil law.

Article 2

Amendment of the Controlled Drugs and Substances Act

Section 1

In the Controlled Drugs and Substances Act, the following shall be entered:

“Sodium pentobarbital, sodium salt of
(±)-5-ethyl-5-(1-methylbutyl)-barbituric acid
The sodium salt of pentobarbital may be prescribed by medical doctors for the purpose of an accompanied suicide in a dose of up to 20 grams; the prescription and the substance itself may not be made available to the member wishing to die themselves but only to the competent organisation. If sodium pentobarbital is or becomes shorted or unavailable for any reason, other substances with the same or similar effect may be prescribed for accompanied suicide”

Explanatory Memorandum

A. General Part

I.

The first organisation advocating for the right of people to decide when and where they wish to die was founded in England in the mid-1930s. It was later called “Exit” or “The Voluntary Euthanasia Society”, which is today the members’ society known as “Dignity in Dying”. According to historical surveys, 60% of the British people favoured such a possibility at that time – and still do today.

On 17 January 1938, *The New York Times* wrote that a “Society for Voluntary Euthanasia” had been founded in the USA.

It is worth re-examining what circumstances led to these societies being founded. It is conceivable that this was a reaction to the introduction of antibiotics in medicine, Sir Alexander Fleming having discovered penicillin in 1928. Each major medical advance not only has a good but also a downside.

With Penicillin and other antibiotics developed in due course, life expectancy of humans could be

Entry into Force

Article 3

This Act shall enter into force on the day following its promulgation

Ottawa, [date] (signatories)

extended significantly because medication was now available to eliminate the lethal effect of minor infections, infections which previously often led to the death of even young people. For example, the German dramatist Georg Büchner died in 1837 at the young age of 24 of a typhoid infection, an illness that no longer inspires abject terror since the advent of antibiotics.

Yet for the elderly or the seriously ill, minor infections that used to lead to a quick and painless death for the most part were sometimes felt to be like a welcomed relief. Thus, it comes as no surprise that in their advance health care directives today, many people stipulate that if they were to contract pneumonia, no antibiotics should be administered so that nature can take its course.

II.

The mid 1950s saw another revolutionary medical development which not only had a beneficial but also a downside: the introduction of medical intensive care. This prompted Hermann Kesten (1900–1996), German author and principal literary figure of the New Objectivity movement, to exclaim: “Medical progress is terrific and terrifying. One can no longer be sure of one’s death.”

When in 1979 the gastric tube was invented which can be inserted directly through the abdominal wall

so that artificial feeding became significantly easier to handle compared to tubes inserted through the nasal cavity, the possibility arose of keeping those alive who were actually in the process of dying, not only for weeks but for an almost unlimited period of time.

With intensive care it had thus become possible to biologically keep alive the bodies of people who would have previously died as the result of failure of essential biological systems. The saying of being “hooked up to machinery” became a common expression after this time.

Generally, since around 1970, a growing resistance can be observed in various countries with regard to “exaggerated life-sustaining measures” (in French: *thérapie acharnée*).

At about the same time, sleeping pills commonly based on barbiturates came to be replaced by benzodiazepines in many countries. Barbiturates, the gentlest method to end one’s life at that time, disappeared. This gave further boost to the movement in favour of implementation of a right to die.

III.

This development took place with a slight delay in German-speaking countries. 7 November 1980 saw the founding of the German Society for Dying with Dignity (DGHS) in Nuremberg. This was followed in April 1982 by the founding of EXIT (Swiss-German section) in Zurich, preceded by the founding of EXIT A.D.M.D. (Swiss-French section) in Geneva in February of the same year (A.D.M.D. = *Association pour le Droit de Mourir dans la Dignité*; English: Association for the Right to Die with Dignity).

During the first years after its founding, EXIT (Swiss-German section) provided its members (after at least three months’ membership) with a brochure depicting comparatively safe methods for committing suicide. Starting in the mid-1980s, the organisation began to directly provide accompanied suicide to its members: having assistance provided by someone who is knowledgeable is the best guarantee that a suicide attempt does not go wrong and fail. With the aid of medical doctors who provided prescriptions for a combination of medications, accompanied suicides could now take place in a way that those wishing to die could perform the last definitive actions leading to their death themselves whilst the assisting persons ensured that the risks due to lacking knowledge about a certain method would be avoided.

In the Netherlands, developments took place differently. In the Dutch health care system, general practitioners (GPs) had and continue to have an important position. Gradually, a practice established

among doctors, illegal at that time, in which they helped severely ill patients to die, either by procuring medication to enable them to safely commit suicide on their own or by administering an injection containing a lethal dose of medication to patients who wished to put an end to their lives but were no longer able to do so, or for whom committing suicide was untenable.

IV.

The view ultimately prevailed in the Netherlands that it was not right that, although such an act was punishable under the law – even when performed by a medical doctor – the justice authorities did not intervene. It was considered better for assisted dying by medical doctors to be legalised and regulated under the law.

Consequently, Dutch legislator enacted a law on 1 April 2002 which permits Dutch medical doctors to aid patients with a specific illness status to end their lives either by assisted suicide or by voluntary euthanasia (“killing on request”). The law provides for special procedure for both.

Belgium, and then Luxembourg, later followed this example.

A similar law, for assisted suicide, the “Death with Dignity Act”, was approved in the US State of Oregon through ballots via people’s initiatives; attempts of the Federal Administration in Washington D.C. to reduce or even make impossible the use of the law by narrowing access to the necessary medication failed before the US Supreme Court. Neighbouring US-State Washington, also located in the American Northwest, followed the example of Oregon in 2008. In 2014, a similar law went into effect in the first State on the US east coast: Vermont. A few years earlier, in 2009, the Montana Supreme Court ruled in *Baxter v. Montana* that there was no public interest in prohibiting a medical doctor from providing assistance in suicide to one of his patients. On 5 October 2015, the US-State with the highest population followed when Governor Edmund G. Brown Jr. signed legislation to allow physician assisted suicide for terminally ill – the End of Life Option Act. “I do not know what I would do if I were dying in prolonged and excruciating pain. I am certain, however, that it would be a comfort to be able to consider the options afforded by this bill. And I wouldn’t deny that right to others.” he wrote in his signing message.

V.

Advances to permit assisted dying in various forms are to be noted throughout the world. The debates in the UK and France are commonly known throughout

Europe. The British House of Lords has dealt with the matter several times. The right to a voluntary death was an election promise of the current French president François Hollande in his presidential election campaign. According to his statements in a press conference on 14 January 2014, a draft Act was to be tabled that same year.

A mostly liberal attitude abounds in Switzerland: Since the cantonal criminal codes were superseded by the Swiss Criminal Code of 1 January 1942, article 115 stipulates: “Any person who for selfish motives incites or assists another to commit or attempt to commit suicide is, if that other person thereafter commits or attempts to commit suicide, liable to a custodial sentence not exceeding five years or to a monetary penalty.”

Therefore, inciting or assisting someone to commit suicide is not an offence in Switzerland as long as selfish motives are not the controlling motive. This enabled the service of assisted/accompanied suicide to be established, generally provided by membership associations / not-for-profit members societies. EXIT (Swiss-German section), today the largest of a total of five associations, now counting some 90,000 members, which is equal in size to a medium-size political party represented in the Swiss Federal Parliament.

This account of the worldwide developments is far from complete, but it indicates increasing demand for implementing the possibility of assisted dying in many different countries.

VI.

This is quite regularly confirmed by the findings of scientific surveys. The figures of a representative FORSA survey were recently published, that was conducted on behalf of health insurance “DAK-Gesundheit” in Germany. According to the survey, more than two thirds of all Germans support assisted dying. The German magazine “*Der Spiegel*” reported on a survey in its issue dated 3 February 2014. According to the article, TNS Forschung, an opinion research institute, surveyed 1,000 persons over the age of 18 in January. 55% of those surveyed could imagine wanting to put an end to their life in old age if faced with the prospect of a serious illness, prolonged care dependency, or dementia.

The figures are similar throughout Europe. A survey conducted by Swiss pollster Isopublic in 2012 in twelve European countries revealed that even in Orthodox Catholic Greece, 52% were of the opinion that everyone should be allowed to determine when and how they die. In Germany this figure was as high as 87%.

All this is not different in Canada: According to a Forum poll survey of 1,400 voters in August 2015, 77% of the population support doctor-assisted suicide for people who are terminally ill; the result

being strong across all age groups and political affiliations. Another poll in April 2015, which crossed location, age and gender, asked 1,035 Canadians if they supported or opposed physician-assisted suicide: the survey found that only 15% are opposed to the idea of doctor-assisted suicide. There are many more such polling results

VII.

In view of the democratic principle, which forms the basis of public policy in Canada, it is not appropriate to rely on Switzerland to offer a way of responding to Canadians’ desires and needs for assisted dying, preventing the pressure in Canada from becoming too high. Canadians should be able to implement this important decision in their home country, in their homes, and with friends and family nearby.

But there is another element besides respect for individual Canadians’ right to receive assistance in dying in their home country. The experience gained from 30 years of assisted dying practice in Switzerland shows that the slippery slope feared by many critics in allowing assisted dying has not materialised. The number of Swiss residents who choose an accompanied suicide every year is still just about one per cent of all deaths. Furthermore, the possibility of an accompanied suicide in the municipal old-age and care homes of the City of Zurich, where this has been introduced as early as in 2002, proves the opposite of what was feared back then: that this could put pressure on the 3,000 elderly living there. In fact, since then the number of lonely, violent suicide attempts has declined and the number of people dying by accompanied suicide in these facilities has remained constant year on year, between zero and three cases.

Now, the Canadian legislator is tasked with adapting a statutory instrument to its own situation in a meaningful manner, an instrument that has proven itself in a comparable European legal system.

This is the goal of this proposed Act.

VIII.

The proposed Act follows a liberal principle. The Act is designed to give individual legal subjects the possibility of asserting their human right to self-determination also, and in particular, at the end of their lives in a practical and efficient manner. At the same time, it ensures that the fears and reservations frequently voiced against this form of assisted dying will not materialise.

With a coherent, comprehensive legal structure in place, discussion can return to a matter-of-fact basis. For instance, the claims that were made in Germany in connection with a failed draft Act on prohibiting assistance in suicide, according to which Germany

would have to be “saved from the danger of a commercialised campaign promoting premature death by way of suicide”, have not only been recognised as untrue but also called as such: there has not yet been any commercialised assisted dying in the territory of the Federal Republic of Germany. It also does not exist in Switzerland, nor does it exist in the Benelux countries, nor anywhere else. By grounding the lawful provision of assistance with dying in charitable not-for-profit organisations acting under clear guidelines, this Act ensures that commercial assisted dying will never come to pass.

The proposed Act contains provisions stipulating that organisations which provide for accompanied suicide in Canada are to be constituted as registered membership associations / members societies, making them subject to Canadian association law, which permits associations to be regulated to a certain extent. The proposed Act also stipulates that these organisations must frame their articles of association in a way that they satisfy the requirements for recognition as a charitable not-for-profit organisation. Apart from the purpose of offering the service of counselling in end-of-life issues to anyone and, for members only, where justified, providing for a safe and dignified accompanied suicide, they must establish another purpose that pursues a charitable goal, such as for example suicide attempt prevention. The requirement of a charitable organisation status enables audits to be conducted by the tax authorities to monitor compliance. From the very outset this precludes organisations from taking in revenue other than as appropriate compensation for the work performed by them and not have such monies flow to members of the organisations’ governing bodies (i.e. the board) or other members.

In setting out the accompanied suicide procedures of such organisations the Act is based on the established and proven procedures of the organisations in Switzerland. These procedures have been developed and fine-tuned over the course of thirty years. As a consequence, they have been recognised by all competent Swiss authorities as being properly organised, it being expressly stated that no special provisions going beyond article 115 of the Swiss Criminal Code are required in Swiss law. And, no irregularities existed that would require the intervention of the legislator.

The details of these procedures are discussed in Section B. Explanatory Notes below.

IX.

It might be asked why the proposed Act is silent on one question that could be theoretically posed: What should happen if private individuals, cooperative societies or even commercial enterprises were to

come up with the idea of offering accompanied suicide in Canada, since this would not be prohibited under Canadian criminal law?

Since the proposed Act permits the medication sodium pentobarbital to be dispensed only to organisations in line with this Act, there is no way for other parties to offer a similar service – meaning the question no longer arises.

The medication sodium pentobarbital enables a quantitatively comparatively small dose (up to approx. 20 g in approx. 50 cc of water) to be administered; other medication combinations which have been used to date in different countries in accompanied suicide consist of much larger quantities and always presuppose that the person wishing to die is capable of self-administering these quantities by swallowing and ingesting them.

X.

The proposed Act provides for another opportunity to make a significant contribution to resolving a major social problem that for the most part is not talked about: the issue of the high number of suicide attempts year after year that are almost entirely hidden from public awareness. Among the public at large, as well as policymakers and researchers, constant reference is made only to the high number of suicides that must be reduced.

There is no agreement on the dark figure, that is, the number of suicides which are not detected as such, and on the number of attempted suicides that have to be assumed. The literature on the subject generally indicates that in order to determine the total number of attempted suicides during a year, the number of committed suicides must be multiplied at minimum by a factor of 10.

In its response to an inquiry from the Swiss parliament of 9 January 2002, the Swiss government stated that, based on the research work of the National Institute for Mental Health in Washington D.C. done in the 1970s, a factor of up to 50 had to be applied in industrialised countries.

This means that the 3,926 suicides in 2012 in Canada translate into up to 196,300 attempted suicides of which no fewer than up to 192,374 fail.

Whether the number of attempted and failed suicides is 9 out of 10 or 49 out of 50: a failed suicide attempt has serious consequences not only for the person attempting it but also for others. Moreover, suicide attempts that are not seriously meant quite frequently inadvertently end fatally. In conclusion, prevention policy should actually focus on the vast field of suicide attempts, not just those actually committed and statistically registered as suicides.

Therefore, when employing societal resources to reduce the number of deaths by suicide – that is suicide prevention – the question should be asked whether just as many resources should be added for making efforts to reduce the number of suicide attempts.

The experience of the five “right-to-die”-organisations in Switzerland shows that the availability of people with whom someone who has become suicidal can talk without fearing loss of their freedom or reputation, and in whose presence they can voice an – objectively even nonsensical – wish to die, has a suicide-attempt-preventive effect.

This applies particularly to suicide among the elderly, which is on the rise throughout industrialised countries, and among younger people who find themselves in a personal crisis.

For this, the proposed Act stipulates that in such cases organisations must provide free of charge counselling to those seeking help. The funding for this work can be obtained by ordinary members’ dues as well as special members’ dues, the latter being payable by the member when an accompanied suicide is to be prepared or conducted.

The principal charitable / not-for-profit orientation of the articles of association of these organisations must also enable these services to be made available to persons who are of modest economic means and cannot afford to avail themselves of these services at the normal rates.

XI.

In summary, it can be established that by approving this Act, an issue in Canada that has remained unresolved for decades can be regulated in a favourable manner.

The Act deliberately refrains from touching upon the highly controversial issue of legalising voluntary euthanasia (act of killing a person on this competent persons’ explicit request, sometimes called “mercy killing”), which always arises when a person wishing to die is physically totally incapable of performing an act of suicide, even if this only involves actuating a specially constructed aid/device to this end. Based on the Swiss experience, these cases are so rare in comparison to the others that this issue can remain open for now.

B. Specific Explanatory Notes

Article 1 (Enactment of an Accompanied Suicide Act)

Section 1

Section 1 sets out the purpose of the Act.

The Act governs the requirements with which organisations that prepare and conduct accompanied suicide in a professional capacity must comply.

Section 2

Section 2 provides definitions of the specific terms used in the Act.

Section 3

Section 3 contains provisions stipulating how an organisation – registered membership associations (members societies) according to Section 2 – can draft their articles of association so that they are entitled to perform accompanied suicide in a professional capacity for which the medication that is most suitable – which is sodium pentobarbital – is made available.

Subsection 1

Subsection 1 contains a description of the organisation’s most important work. The organisation’s primary purpose is to provide counselling to people who are thinking of suicide and end-of-life-options. Counselling is to be done open-outcome, that is, without a view to achieving a predetermined specific result. This means that the organisation itself has no preference for either of the two basic possibilities, which are that the person either continues to live or puts an end to their life.

Only if this condition is satisfied can the organisation be credible in the eyes of people who are thinking of suicide, and therefore effectively act as a help-point to counsel people for resolving the issue which brought them to consider suicide and therefor help them to regain quality in life.

This issue previously arose in another context, in abolishing the illegality of abortion. Only those counselling centres prescribed under the law which did not take an up-front disapproving stand on a decision for abortion could be perceived by pregnant women as being suitable for offering counselling.

Subsection 2

Subsection 2 stipulates that in its articles of association an organisation should not only include as its purpose advising, preparation and conducting with regard to accompanied suicide, but it should also include another purpose. Such as, for example, free-of-charge counselling for suicide attempt prevention, advisory work on how to establish advance care directives, establishing a network of medical doctors specialising in palliative care, etc.

Subsection 3

Subsection 3 stipulates that the organisation's articles of association are to be framed so that it can be recognised as being charitable / not-for-profit.

Consequently, in selecting its second purpose, the organisation is limited to objectives that are deemed charitable. This also prevents the organisation from providing monies to natural persons from its funds for purposes other than appropriate compensation for work or services rendered or goods supplied.

This also averts the danger that an organisation may be used to establish a commercialised form of accompanied suicide. The regulatory supervision by the tax authorities to which charitable organisation must answer is a suitable means to this end.

Subsection 4

The organisation requires funding in order to finance its activities. That is why its articles of association must establish ordinary members' dues (such as a yearly membership subscription) as well as special dues / lump sum fees for the services routinely provided by the organisation in preparing and conducting accompanied suicide. The articles of association may also provide for the receipt of charitable donations from any person, to facilitate the fulfilment of the organisation's charitable mission.

Subsection 5

Apart from its usual services, the organisation also provides additional services that are more or less frequently associated with its usual services. For example, the organisation assumes liability vis-à-vis the medical doctors with whom it cooperates for the payment of their fees for their expert opinions and consultation with members. For this, as with subsection 4, the organisation may set up special dues / lump-sum fees that are collected in advance from a member going through the process of preparing his or her accompanied suicide. Only in this way can amounts payable to the organisation to meet its operating expenses and obligations to various providers be acquired without the risk of having to sue a deceased's estate.

Subsection 6

A key principle for an organisation that provides these services is showing solidarity with people of modest economic means. Consequently, the articles of association are to contain provisions that permit these persons to pay reduced ordinary and special fees or for these fees even to be waived entirely where these people are destitute. It would be discriminatory to enable only those who have the financial means to pay fees in full to assert the

human right and freedom to determine time and manner of one's own end in life.

Subsection 7

In the debate to date, the demand has been sometimes made to prohibit intrusive promotion of (accompanied) suicide as an easy way out of a personal crisis. Even though there has never been such advertising, the demand is theoretically still justified. This subsection is designed to satisfy this demand.

Section 4

Section 4 governs the organisation's counselling work.

Subsection 1

This subsection governs the principle of open-outcome counselling offered to persons who are thinking of suicide. Whoever is thinking of suicide normally has hardly any possibility to access counselling; they must fear being confronted with someone who does not take them seriously, who seeks to deter them of their wish to die in an intrusive manner, or they must fear that an attempt will be made to subject them to therapy – if need be, even against their express will. Only with open-outcome counselling can someone feel that he or she is being taken seriously in a situation which may arise from a crisis just as much as it may arise after long and careful reflection, and thus will be able to open up after establishing trust with the counsellor. This is an indispensable base for a genuine chance to reach the decision to go on living, provided that the objective conditions for this actually exist.

Subsection 2

Subsection 2 also serves this idea; whoever provides counselling in such cases should refrain from making any value judgement with regard to the person's wish to die.

Subsection 3

This subsection describes how counselling is to take place. First, the cause for the person's wish to die is to be ascertained. Then, a discussion should follow to determine whether there are solutions enabling the person to go on living.

Subsection 4

However, it is conceivable that, although solutions may exist, they are not accepted. In this case the organisation is to be entitled, but not obligated, to engage in preparation for an accompanied suicide.

Subsection 5

This subsection governs the minimum obligations regarding record keeping in respect of the counselling services.

Subsection 6

Counselling of this type, which is generally provided to persons who are not (yet) members of the organisation, is to be done free of charge. This is intended to create the basis for the effective prevention of potentially ill-considered suicide attempts.

Section 5

Section 5 governs the preparation of accompanied suicide. In a carefully drafted procedure it is determined whether accompanied suicide can be viewed as justified in a specific case.

Subsection 1

Subsection 1 sets out the requirements that must be satisfied for the preparation of an accompanied suicide. Paragraphs a and b set out two formal requirements: first, the person must be a member of the organisation so that a special personal relationship develops between the person and the organisation; then the person – now a member – must submit to the organisation an explicit request for the preparation of an accompanied suicide. Paragraphs c to e set out material requirements; the result of satisfying them is that the organisation is actually able to examine such a request based on the documents submitted.

Subsection 2

Subsection 2 governs the procedure from the point in time at which the requirements of subsection 1 are satisfied. If in the view of the organisation these requirements are satisfied, it is to forward the request including documents to a medical doctor who has expressed a willingness to cooperate with the organisation.

The medical doctor reviews the request and then informs the organisation of his or her decision. Three alternatives are open to the doctor: the doctor can either approve of the request; the doctor can request supplementary information; or the doctor can reject the request.

If the medical doctor approves the request, this only means a provisional consent to issue the prescription for the member wishing to die; a definitive approval is not possible until the medical doctor has seen and talked to the member. That is why the provisional approval is referred to as the provisional green light in the definitions in section 2. The medical doctor always remains free in respect of the final decision.

Subsection 3

Subsection 3 enables the organisation to submit a member's request to another medical doctor if it is turned down by the first medical doctor. Experience shows that medical doctors do not all share the same views with regard to questions of life and death.

This option also makes it easier for medical doctors to come to a decision free of any constraints.

Subsection 4

This subsection establishes the organisation's option of notifying a member wishing to die at any time that it is not able or willing to assist them in an accompanied suicide. This follows from respect for the right to self-determination on the part of the persons who act on behalf of the organisation. Reasons for not being able or willing could be, for example, if the member wishing to die causes personal frictions such as threatening or harassing the persons who act on behalf of the organisation. In case of such dissolution of the relation between the member wishing to die and the organisation, monies received by the organisation for the service of an accompanied suicide that will not take place must be refunded.

Section 6

Section 6 governs the procedure after the provisional green light has been given by the medical doctor. The member then has various options.

Subsection 1

In paragraphs a to c, this subsection outlines the three available options:

The first one is that upon being notified of the provisional green light, the member simply waits and perhaps later on makes application for proceeding towards an accompanied suicide.

The second option enables the member to swiftly have the provisional green light become definitive by consulting the medical doctor right away and having the medical doctor make his final decision. Then, the member can wait to make an application for further proceedings towards an accompanied suicide. However, it is understood that in order for an accompanied suicide to actually take place, the condition must be satisfied that the member is mentally competent at the time that the medication is actually prescribed and also at the time of ingestion of the medication.

The third option is for the member to consult the medical doctor, followed swiftly by applying for and agreeing on an accompanied suicide to take place as soon as possible.

Subsection 2

As a general rule, the organisation complies with a member's wishes; however, this is limited by the constraints imposed by virtue of the possibilities and capacity with regard to the medical doctor. Furthermore, the organisation should discuss with the member whether he or she has talked about their plans for an accompanied suicide with relatives and/or friends. If this is not the case, the organisation

should try to persuade the member to do this. This is in the best interest of the wellbeing of relatives and friends so that after the member has passed away these individuals need not ask themselves questions that no one is any longer able to answer. However, the member cannot be compelled to inform these third parties; unfortunately there are many dysfunctional families in which it is not possible to talk objectively about serious issues.

Subsection 3 sets out the tasks of the medical doctor to be performed during the consultation with the member.

As to paragraph a, the medical doctor should discuss options with the member that the medical doctor thinks would enable the member to go on living, after which the member can make his or her decision.

Paragraph b requires the medical doctor to verify once again that the member still wishes to die. If the member's wish to die falters during the consultation with the medical doctor, the member cannot be considered to have the required clear and settled wish to end his or her own life.

Paragraph c requires the medical doctor to determine whether the member still appears to be mentally competent. In principle, people who are of age are assumed to be mentally competent unless there are indications that their mental capacity is limited or no longer present. This matches common law which recognises – as a 'long cherished' right – that all adults must be presumed to have capacity until the contrary is proved. An indication that mental competence might not be given is the situation that the person is suffering from a serious psychiatric illness. However, a psychiatric illness may impact a person's mental capacity but it need not. This is why it is the task of the medical doctor – and of the assisting persons immediately prior to accompanied suicide – to look for such signs and properly interpret them.

As a rule, this takes place by virtue of an appropriate conversation.

Paragraph d sets out other conceivable reasons that militate against going through with an accompanied suicide in a specific case.

A special case of this question is covered in paragraph e: It deals with the situation of a member being physically unable to drink the medication. It must be determined whether he or she can ingest the medication by way of an aiding device.

Paragraph f stipulates that in the absence thereof, no accompanied suicide can lawfully take place.

Subsection 4

This subsection stipulates that the medical doctor must forward the prescription for the medication to the organisation. The doctor may not give it to the member.

Subsection 5

Subsection 5 stipulates that the medical doctor must document his or her findings. The doctor must forward the resulting report to the organisation. By examining this report, the organisation can determine, if it has not already looked into this matter through direct contact with the member wishing to die, whether the use of an aid is required for the accompanied suicide.

Subsection 6

Subsection 6 stipulates that the organisation (and not the member) is to procure the medication using the prescription provided to it by the medical doctor. If the medical doctor has prescribed a narcotic, a controlled substance, this provision grants the organisation the authorisation to procure it in the prescribed dose for the member and to transport and store it. The organisation is obligated to store the medication in a safe place until it is used. The Act also requires return of any unused medication to the licenced pharmacy from which it was procured.

Section 7

Section 7 covers the topic of those persons assisting in accompanied suicide. They are to be trained by the organisation so that they are able to safely conduct accompanied suicide, even in difficult circumstances. Subsection 1 stipulates in particular that the care is to be taken to prevent foreseeable problems potentially arising during the accompanied suicide. Such foreseeable problems, for example, can be that a member, due to vigorous tremor caused by his or her illnesses (typical for example with Parkinson's disease), would spill the medication.

Section 8

Section 8 concerns the place of and the people present at an accompanied suicide.

Subsection 1

It is the goal to have an accompanied suicide take place at the member's residence, that is within their own four walls: this is the standard location. The goal of the Act is for someone to be able to die at home, which is what most people want. This enables dying to take place in the protection of privacy and in the bosom of the person's family.

Subsection 2

Where this is not possible, the member wishing to die will normally designate the location. If this location should not be appropriate, a location will be designated by the organisation.

Subsection 3

It is also up to the member to determine whether any other persons are to be present at his or her death.

Subsection 4

This provision is relevant if the place of death is not the member's home. If someone dies at home, their personal belongings are not in a foreign place. The purpose of this provision is for the organisation to know what is to be done with the deceased member's personal belongings (clothing, shoes, jewellery, wallet, etc.) when the accompanied suicide has taken place at a location that is not the deceased's home.

Section 9

Section 9 establishes how an accompanied suicide is to take place.

Subsection 1

Accompanied suicide could actually be performed by one assisting person without further ado. However, practice has shown that it is useful when at least two assisting persons are present. This ensures a two-way supervision. It also has the advantage that at all times and especially after the member has passed away, one assisting person can attend to the member's relatives and friends, and the other can attend to the work involving the member and later the work involving the authorities.

Subsection 2

Subsection 2 specifically stipulates that the assisting persons verify whether the individual who declares to be the member wishing to die is identical to the person indicated in the documents. In other words, an identity check should be performed.

Subsection 3

Subsection 3 stipulates that once more it has to be verified whether the member really wants to die. By including the provision that no other persons should be present in the room, it is ensured that the member can respond freely. When the relatives and/or friends return to the room, the questioning is to be repeated. If there are any doubts whatsoever, the accompanied suicide proceedings are to be stopped. Signs indicating that the member's decision was brought about under pressure exerted by a third party should also lead to the accompanied suicide proceedings being stopped. In these cases, the Act requires that a written report must be submitted by the assisting persons to the organisation.

In this penultimate questioning to determine the member's wish to die – the last and final clarification takes place immediately before the medication is ingested (see Subsection 5 below) – the member is expressly told that he or she is free to revoke their decision to die and that this would be viewed in a positive light by the assisting persons and the organisation. The member's reaction to this clarification is an important indicator enabling the assisting persons to determine whether the member actually has a clear and settled wish to die. By

experience, such questioning and insisting by the assisting person that the member may well rather revoke their wish to go through with the accompanied suicide, leads to a reaction of annoyance from the member, they will object to this "impertinence" as such clarification is sometimes perceived – which is a clear sign that the member's wish to die is clear and settled.

Subsection 4

Subsection 4 stipulates that the member should establish a written suicide declaration, which is a document in which they state that they wish to end his or her own life. Following the firm oral declaration by the member that he or she now wishes to die, this is such confirmed by the member in a written document. The document also lists the persons who are present at the member's accompanied suicide.

Subsection 5

The medication is prepared once the member's wish to die is unequivocally confirmed. The medication is normally drunk as a liquid. If the member is unable to drink the medication, the aid indicated in the medical doctor's report is to be used. The aid is prepared by the assisting persons.

Subsection 6

Subsection 6 stipulates a last and final clarification to determine the member's wish to die. This is done by showing the member the prepared medication, or the release mechanism when an aid is used, and explaining that if the member drinks this medication or actuates the release mechanism they will die, followed by asking them if they want this. The member is not given the medication or the release mechanism until he or she has answered this question in the affirmative so that he or she can then perform this last act in their lives on their own. The actions taken by the member then lead to his or her death.

Section 10

Section 10 governs the duties of the assisting persons after the member has self-administered the medication.

Subsection 1

Since the medication, sodium pentobarbital, generally acts quickly – in the vast majority of cases it causes the member to fall asleep within two to five minutes – the member is to be monitored continuously. The sleep onset phase, which causes the member to lose consciousness completely, is followed by the dying phase. The assisting persons' duty to monitor the member also continues during this phase.

Subsection 2

When there is subsequently sufficient indication that death has occurred – during their training the assisting persons learn what they must look for – they notify the police, reporting that the death is the result of an accompanied suicide provided by their organisation.

It is then up to the police to ensure that an official examination of the corpse takes place without undue delay; the police notify the medical examiner / coroner.

Subsection 3

Subsection 3 ensures that the scene resulting after the preliminary establishment of death is not changed by the assisting persons.

Section 11

Section 11 deals with the examination of the corpse to be performed after an accompanied suicide. The purpose of the examination is to determine whether death resulted from actions taken by the deceased or whether there is evidence that death might be due to the intervention of a third party.

Subsection 1

The medical examiner, who according to the definitions of Section 1 must be a public medical doctor officer, a forensic medical doctor or a specially trained medical doctor for performing examinations of corpses, first verifies the identity of the deceased person. The medical examiner then certifies the death of the deceased person according to medical principles. This includes determining whether death might have been brought about by the intervention of a third party.

Subsection 2

If there are any doubts in this respect, subsection 2 stipulates that the medical examiner calls in the police authorities, who must then determine how death actually occurred. This Act need not set out how the police authorities are to proceed further in the matter; the police have their own standard operating procedures for such matters.

Subsection 3

However, if there are no doubts that death has come about as a result of actions taken by the decedent, subsection 3 stipulates that the decedent's remains are to be released for funeral. The final decision on this is made by the legally competent public prosecutor.

Subsection 4

Subsection 4 precludes a medical doctor who has issued the prescription in a specific accompanied suicide from acting as the medical examiner in the same case.

This provision is one of the rules ensuring that the risk of any abuse is kept to an absolute minimum. A system of reciprocal control is also ensured by virtue of the fact that an entire group of people is involved in an accompanied suicide prior and subsequent to the death.

Section 12

Section 12 ensures that proper funeral arrangements are made after the accompanied suicide.

Subsection 1

Since accompanied suicide normally takes place in a member's home, funeral arrangements are assumed by the member's next of kin such as in the case of a death by natural cause. Frequently, the deceased member has made arrangements in advance by designating someone or a funeral home to attend to this task.

Subsection 2

In cases in which the organisation performs accompanied suicide for a member who is alone and has no family, the organisation has discussed this matter with the member during the preparation phase. If the organisation has been tasked with making the necessary arrangements, it assumes this task in place of the (absent) family.

Section 13

Section 13 stipulates that the assisting persons are to maintain a journal. The journal is intended to enable the process of an accompanied suicide to be reconstructed.

Subsection 1

Each individual step in the course of the accompanied suicide, with the respective time, is to be noted in this journal.

Subsection 2

Subsection 2 establishes that the original of this journal is to be stored in the member's file maintained by the organisation; the medical examiner is to be given a copy of the journal. A further copy is to be sent to the medical doctor who issued the prescription, so that he or she is informed of the decease of the member.

Section 14

Section 14 provides for a central supervisory and documentation agency for all of Canada to be designated by the Department of Justice. This agency is of key importance in collecting data and forwarding complaints to appropriate entities, and through this monitoring the activities of the organisations.

Subsection 1

The documents that are furnished by the assisting persons to the medical examiner or the police after an accompanied suicide are forwarded by the latter to the central agency.

Subsection 2

Subsection 2 stipulates that the central agency is to check the file forwarded to it to determine whether the persons who have acted have complied with the provisions of this Act.

Subsection 3

Subsection 3 stipulates that where shortcomings or errors are detected by the central agency, it will contact the relevant and responsible persons and ensure that the shortcomings are remedied and that the errors are not repeated.

Subsection 4

Subsection 4 stipulates that in the event that the central agency discovers serious violations on the part of acting medical doctors, serious violations are to be reported to the competent medical board. This board must then examine whether profession-legal proceedings are to be initiated against this medical doctor.

Subsection 5

Subsection 5 deals with serious violations that are repeatedly committed by an organisation. In these cases, the central agency must report misconduct to the registration court, which then examines whether legal action is to be taken against the organisation.

Subsection 6

Subsection 6 provides for a significant task of the central agency: it is charged with collecting sufficient statistical data on accompanied suicides, analysing the data, arriving at findings and publishing them. This ensures that this area can be subjected to public scrutiny, while members' privacy is protected.

Section 15

Section 15 stipulates the legal construction of a death that has been brought about by accompanied suicide: that it is to be considered to constitute a natural death in respect of population statistics and in terms of civil law.

This distinction as compared to a "common suicide" is not only significant but also essential. Frequently, common suicides can be subsequently unequivocally established as being justified only with great difficulty and uncertainty. An accompanied suicide in line with this Act is a completely different matter. For the most part, the justification results from the deceased member's illness or other health impairment and lack of physical integrity. In the case of the elderly it can also consist of being

profoundly tired of living or an unremitting profound sense of loneliness and loss.

Article 2 (Amendment of the Narcotics Act)

Section 1

Section 1 stipulates that the Narcotics Act is to be amended such that the medication sodium pentobarbital is entered in the alphabetical list which contains substances which have been approved for marketing and prescription. It is explicitly established that this medication may be prescribed by medical doctors in a dosage of up to 20 g for the purpose of accompanied suicide by organisations. It is also stipulated that neither the prescription nor the medication should be made available to an individual but only to a competent organisation. Additionally, the section leaves room for other substances than sodium pentobarbital, with similar effect, to be used, if sodium pentobarbital becomes shorted or unavailable for any reason. This is necessary because pharmaceutical companies could, on purpose or for any other reason, stop supplying sodium pentobarbital.

Section 2

Section 2 imposes upon the Federal Government the task of accordingly amending the Regulations for the Prescription of Narcotics / Psychotropic substances within three months of the promulgation of this Act.

Article 3 (Entry into Force)

Article 3 provides for the entry into force of the Act on the day following its promulgation since there are no grounds for having the Act go into effect at a later point in time.