"WL10"

Expert Report: James Downar

January 13, 2025

James Downar, MDCM, MHSc, FRCPC
Head and Professor, Division of Palliative Care, Department of Medicine, University of Ottawa
Clinical Research Chair in Palliative and End of Life Care, Faculty of Medicine, University of Ottawa
Adjunct Professor, Queensland University of Technology School of Law
Staff Physician, Department of Critical Care, The Ottawa Hospital
President, Canadian Critical Care Society
60 Cambridge St. N. Suite B103, Ottawa ON, K1R 7A5
jdownar@toh.ca

1. I have prepared this report to aid the court in the matter of the above-mentioned case. I am aware that I have a duty to assist the court and that I may not be an advocate for any party. I have prepared this report in conformity with my duty to the court. If I am called upon to give oral or written testimony in relation to this matter, I will give that testimony in conformity with my duty to the court.

2. I am a critical Care and Palliative Care physician working at The Ottawa Hospital and Bruyere Health in Ottawa, Canada. I am a Professor and Head of the Division of Palliative Care in the Department of Medicine at the University of Ottawa. I graduated from McGill Medical School in 2002 and completed residency training in Internal Medicine, Critical Care and Palliative Care at the University of Toronto. I have a master's degree in Bioethics from the Joint Centre for Bioethics at the University of Toronto. I have been a physician in independent practice for almost 20 years, working clinically as an Intensive Care and Palliative Care physician (what South Africans might call a "consultant") at academic hospitals affiliated with the University of Toronto and the University of Ottawa.

3. I have served or am serving in several roles that are relevant to critical care, palliative care, ethics, and medical assistance in dying.

PKI

4. In terms of Critical Care:

4.1. I am the current President and former chair of the Ethics Committee of the Canadian Critical Care Society.

4.2. I was previously the co-chair of the Working Group on Developing Guidelines for the Withdrawal of Life-Sustaining Measures, also for the Canadian Critical Care Society. We developed and published the world's first clinical guidelines for the withdrawal of life-sustaining measures[1].

5. In terms of Palliative Care:

5.1. I am the lead for the Hospital-Based Models of Care (Adult) at the Ontario Palliative Care Network (part of Ontario Health).

5.2. I am the co-founder and co-chair of the Pan-Canadian Palliative Care Research Collaborative.

5.3. I was previously a member of the Palliative Medicine Subspecialty Working Group at the Royal College of Physicians and Surgeons of Canada, which established the standards of subspecialty training in Palliative Care in Canada.

5.4. I am the former chair of the postgraduate education committee of the Canadian Society of Palliative Care Physicians, and the former chair of the education committee of the Ontario Palliative Care Network.

---

[1] Downar J, Delaney JW, Hawryluck L, et al. Guidelines for the withdrawal of life-sustaining measures. *Intensive Care Med* 2016; 42: 1003-1017. DOI: 10.1007/s00134-016-4330-7.

MK

OKI

5.5. I founded and directed the first accredited subspecialty palliative care residency training program in Canada at the University of Toronto (2016) and was a program director for the conjoint palliative care residency training program prior to that.

6. In terms of bioethics and Medical Assistance in Dying (MAID):

6.1. I was called as an expert witness in the case of *Truchon v. Attorney General of Canada* in 2019, which struck down the requirement that Canadians needed to have a natural death that was reasonably foreseeable to be eligible for MAID. The Quebec Superior Court recognized me as an expert in Critical Care, Palliative Care, Bioethics and MAID at that time.

6.2. I was involved in policy discussion around the legalization of MAID in Canada since 2013, being invited to give presentations and authoring several publications on the subject prior to the Supreme Court of Canada's ruling in Carter vs. Canada AG (2015)[2].

6.2.1. I provided input to both the Federal and the Provincial/Territorial Committees on Medical Aid in Dying in 2015.

6.2.2. I provided input to Canada's Ministries of Health and Justice and gave testimony before the Senate Committee on Legal and Constitutional Affairs regarding Bill C7.

---

[2] Downar J. Care, compassion, respect. CMAJ 2014; 186: 1336. 2014/10/29. DOI: 10.1503/cmaj.141340 ; Downar J, Bailey TM, Kagan J, et al. Physician-assisted death: time to move beyond Yes or No. CMAJ : Canadian Medical Association journal = journal de l'Association medicale canadienne 2014; 186: 567-568. 2014/04/09. DOI: 10.1503/cmaj.140204; Downar J, Boisvert M and Smith D. Data to support assisted dying. BMJ 2014; 349: g4966. Letter 2014/08/07. DOI: 10.1136/bmj.g4966 ; Downar J. Is physician-assisted death in anyone's best interest? Yes. Can Fam Physician 2015; 61: 314-316.

DFI

6.2.3. I provided testimony for Canada's Special Joint Committee on Medical Assistance in Dying, which published their latest report in February 2023.

6.3. I have been invited to present on Canada's experience with MAID to parliamentarians in other jurisdictions around the world, including:

6.3.1. Western Australia (May 2019)

6.3.2. United Kingdom (June 2023)

6.3.3. Scotland (September 2023)

6.4. I co-developed the Canadian Medical Association's Medical Aid in Dying course, which was delivered to more than 400 practitioners across Canada and served as the model for similar instruction in Australia.

6.5. I was also the co-chair of the steering committee for the Ontario College of Family Physicians' Collaborative Mentorship Networks for MAID and Palliative and End-of-Life Care.

7. I have published more than 160 peer-reviewed articles and have been primary investigator on more than thirty peer-reviewed grants, mostly relating to the care of people who are at or near the end of life. My research relating to MAID has largely focused on population-level studies of MAID recipients in Canada, and comparative studies looking at different jurisdictions around the world. I have also co-authored multiple articles reviewing the published evidence around MAID in Canada and other jurisdictions to show how this evidence refutes many of the common narratives and fears about the consequences of legalizing MAID.

8. I have been asked to respond to a series of questions about MAID in Canada and other jurisdictions.

DKI

An overview of MAID in Canada

9. *What is the position in Canada in relation to assisted dying?*

9.1. Briefly, assisted dying (which we refer to as MAID) is a legal option for Canadians who meet the following eligibility criteria:[3]

9.1.1. be 18 years of age or older and have decision-making capacity

9.1.2. be eligible for publicly funded health care services

9.1.3. make a voluntary request that is not the result of external pressure

9.1.4. give informed consent to receive MAID, meaning that the person has consented to receiving MAID after they have received all information needed to make this decision

9.1.5. have a serious and incurable illness, disease or disability (excluding a mental illness until March 17, 2027)

9.1.6. be in an advanced state of irreversible decline in capability

9.1.7. have enduring and intolerable physical or psychological suffering that cannot be alleviated under conditions the person considers acceptable

9.2. These criteria were established by Canada's parliament in 2016 in response to a unanimous ruling by the Supreme Court of Canada in *Carter v. Canada*

---

[3] https://www.justice.gc.ca/eng/cj-jp/ad-am/bk-di.html Accessed on Jan 4, 2025; https://www.canada.ca/en/health-canada/services/health-services-benefits/medical-assistance-dying.html Accessed on Jan 4, 2025

DKI

(2015).[4] Parliament initially added a criterion that the person must have reached a point where their natural death was "reasonably foreseeable". This criterion was not part of the *Carter* ruling, and the Superior Court of Quebec ruled that it was unconstitutional in *Truchon v. Canada* (2019).[5] In response, Canada's parliament allowed MAID for people who did not have a natural death that was "reasonably foreseeable" with additional safeguards (see below). This is sometimes referred to as "Track 2" MAID, to distinguish it from MAID for people with natural deaths that are reasonably foreseeable (Track 1).

9.3. MAID is currently not permitted for the following situations:

9.3.1. Mature minors (anyone under age 18, regardless of decisional capacity)

9.3.2. Mental illness as the sole underlying medical condition

9.3.3. Advance requests, where a person makes a request for MAID when they are still competent for a future situation when they are no longer competent.

9.4. All of these scenarios have been explored at a policy level, and Canada's Special Joint Committee on Medical Assistance in Dying (2023) issued recommendations to proceed with legislative changes allowing MAID for mature minors and for advance requests.[6] Canada's parliament has passed a law that would allow MAID for mental illness as the sole underlying medical condition, that would take effect March 17, 2027 (the delay was established to allow more time to develop mental health resources and practice standards for MAID).[7]

---

[4] https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/14637/index.do

[5] *Truchon v Canada (AG)*, 2019 QCCS 3792.

[6] https://www.parl.ca/documentviewer/en/44-1/AMMAID/report-2/page-5

[7] https://www.justice.gc.ca/eng/cj-jp/ad-am/bk-di.html#s1_1

DCI

9.5. Canada's MAID laws are slightly complicated by our constitution, in which Health Care has shared jurisdiction between the federal and provincial levels of government. Moreover, while the federal government defines the criminal code, the enforcement of the criminal code is handled at the provincial level by the Attorney General. As a result, shortly before the *Carter* decision, Quebec's National Assembly passed legislation (*Bill 52- An Act respecting end-of-life care* (June 5, 2014))[8] that essentially legalized MAID by defining it as a medical act that would not be prosecuted in Quebec as a violation of the criminal code provisions relating to homicide or aiding a suicide.

9.6. This is relevant because Quebec's MAID law now exists alongside the federal MAID law, and it includes eligibility criteria that differ slightly from the federal law. In Quebec, the person must have a serious and incurable *illness*; the terms "disease" or "disability" are not included in the eligibility criteria. This distinction becomes relevant when we look at oversight and compliance data, because a small number of cases in Quebec are compliant with federal criteria, but are classified as "noncompliant" with Quebec criteria (see below). Quebec has also recently legalized MAID by advance request, effective October 2024, following legislation passed by Quebec's National Assembly (Bill-11), in June 2023.[9]

9.7. I provide this information about Quebec's laws for completeness, but will not explore constitutional questions about whether federal or provincial laws would or should take priority in cases of MAID.

10. *How do requests for assisted dying work in Canada and what specific measures have been put in place as safeguards against abuse?*

---

[8] https://www.assnat.qc.ca/en/travaux-parlementaires/projets-loi/projet-loi-52-40-1.html

[9] https://www.quebec.ca/en/health/health-system-and-services/end-of-life-care/medical-aid-in-dying/advance-request-medical-aid-dying

DKI

10.1. Requests for MAID are initiated by the patient, and generally start with a verbal request made to a healthcare provider or a member of a MAID coordination team. There are regional and hospital-based teams that coordinate MAID provision in many parts of the country, and there are also provincial coordination services which are sometimes the first point of access for a person requesting MAID. After an initial conversation, these verbal requests will sometimes become formal requests. Formal MAID requests include the following safeguards as outlined in legislation (adapted for brevity):[10,11]

10.1.1. The request for MAID must be made in writing, and a written request must be signed by one independent witness. The witness can be a paid professional personal or health care worker but not someone who is expected to be a beneficiary of the person's will.

10.1.2. Two independent doctors or nurse practitioners must provide an assessment and confirm that all of the eligibility requirements are met. In practice this includes:

10.1.2.1. An assessment of the underlying condition to confirm that it is serious and incurable.

10.1.2.2. An understanding of the suffering that is prompting the MAID request, that it is intolerable and that it cannot be relieved by means acceptable to the person.

---

[10] https://www.justice.gc.ca/eng/cj-jp/ad-am/bk-di.html#s1_1

[11] https://www.canada.ca/en/health-canada/services/health-services-benefits/medical-assistance dying.html

DKI

10.1.2.3. An assessment of the person's functional capability, to determine whether it has reached an advanced state of irreversible decline.

10.1.2.4. An assessment of decisional capacity, which involves ensuring that the person understands their condition, the consequences of what they are requesting, as well as the alternative options for treating their suffering including palliative care.

10.1.2.5. An assessment of potential coercion by others (generally involving a conversation with the patient as well as other providers, and a review of the medical record).

10.1.3. The person must be informed that they can withdraw their request at any time, in any manner.

10.1.4. The person must be given an opportunity to withdraw consent and must expressly confirm their consent immediately before receiving MAID. This "final consent" requirement can be waived in certain circumstances, as long as the patient has signed a "waiver of final consent" form.

10.2. If the person requesting MAID does not have a natural death that is reasonably foreseeable (Track 2 as indicated above), then additional safeguards are required (specifically outlined in the law for Track 2):If neither of the two practitioners who assesses eligibility has expertise in the medical condition that is causing the person's suffering, they must consult with a practitioner who has such expertise. In track 1, most patients also have been managed by an expert in their condition (e.g. an oncologist), but they do not have to be one of the MAID assessors.

DK-1

10.2.1. The person must be informed of available and appropriate means to relieve their suffering, including counselling services, mental health and disability support services, community services, and palliative care, and must be offered consultations with professionals who provide those services. In track 1, the person must be informed of alternative options including Palliative Care.

10.2.2. The person and the practitioners must have discussed reasonable and available means to relieve the person's suffering, and agree that the person has seriously considered those means.

10.2.3. The eligibility assessments must take at least 90 days. This period can be lengthened to assess response to any new therapies, and it can be shortened if the person is about to lose the capacity to make health care decisions, as long as both assessments have been completed (effectively it becomes a Track 1 case).

10.3. It is important to understand the distinction between an eligibility criterion (which defines who is eligible or not eligible for MAID) and a safeguard (which is a procedural step to establish whether one or more eligibility criteria are met). The two concepts are often confused when discussing MAID legislation and practice. Safeguards only function correctly if they are logically tied to an eligibility criterion, and prevent people from accessing MAID only if they fail to meet the necessary criteria. Procedural steps that make MAID generally more difficult to access, but do not discriminate between those who are eligible and those who are not eligible, are not safeguards. They are simply obstacles.

10.4. In Canada, some safeguards have been removed because they were found to be substantial and indiscriminate barriers to access. An example is the number of witnesses required (and the eligibility requirements to be a witness) for the

DKI

person's signature on their initial request. This was initially two witnesses with many restrictions, but changed to only one witness with fewer restrictions after many Canadians complained that it was challenging for someone who was eligible for MAID to find two witnesses who met eligibility criteria in a timely manner without substantial assistance.

11. *Who are the recipients of assisted dying are in Canada since assisted dying has been legal? Specifically:*

11.1. *Which illnesses do patients seeking assisted dying generally have? Does this align with the data pertaining to those seeking assisted dying in other places that assisted dying is permitted?*

11.1.1. In Canada, as in other jurisdictions where MAID is legal, the large majority of MAID recipients have cancer or a neurodegenerative condition such as Amyotrophic Lateral Sclerosis (ALS, also known as motor neurone disease). This was observed for years before MAID was legalized in Canada,[12] and confirmed in a recent study that I co-led, which looked at publicly-available data on MAID recipients in more than 20 jurisdictions around the world over decades.[13]

11.1.2. We found that even though the proportion of people receiving MAID did vary, the proportion of MAID recipients dying from Cancer, ALS

---

[12] Emanuel EJ, Onwuteaka-Philipsen BD, Urwin JW, et al. Attitudes and Practices of Euthanasia and Physician-Assisted Suicide in the United States, Canada, and Europe. *JAMA* 2016; 316: 79-90. DOI: 10.1001/jama.2016.8499.

[13] Heidinger B, Webber C, Chambaere K, et al. International Comparison of Underlying Disease Among Recipients of Medical Assistance in Dying. *JAMA Intern Med* 2024 2024/12/09. DOI: 10.1001/jamainternmed.2024.6643.

DKI

or other illnesses was remarkably similar among jurisdictions and over time. We also found that the proportion of people who received MAID at the end of life (as opposed to dying naturally) was dramatically different depending on their underlying illness. It was highest for those dying of ALS (17%), followed by cancer (4%), with other illnesses falling below 1%. The relative difference in MAID rates by disease were far larger than the differences in MAID rates among different jurisdictions, and previously-reported differences related to sociodemographic factors (see below). In other words, a person's illness appears to be the single most important factor associated with their decision to request MAID.

11.2. *What are the usual demographics, levels of education and/or socioeconomic status of people seeking assisted dying in Canada? Does this align with the data pertaining to those seeking assisted dying in other places that assisted dying is permitted?*

11.2.1. We have fairly detailed information about the sociodemographics of MAID recipients in Canada. In summary, people from marginalized or structurally vulnerable demographics are not more likely to receive MAID than people from privileged demographics. On the contrary, literally every objective indicator of vulnerability or marginalization is associated with a lower likelihood of receiving MAID. Even our Track 2 MAID recipients, where concern about marginalization has been raised in the media, are either as privileged or more privileged (depending on the metric used) than people living with chronic illness or people with terminal illness who do not request MAID.

11.2.2. Canada's data collection and reporting system is more comprehensive than other jurisdictions that have legalized MAID, but the data from other jurisdictions is consistent with what we have seen

DKI

in Canada. Specifically, data from Oregon, Washington, Switzerland, Belgium and the Netherlands all show that MAID recipients are more privileged in terms of income, education or other measures than those who do not receive MAID.[14]

11.2.3. Age and Sex

11.2.3.1. Canada's most recent annual report[15] (covering 2023) indicates that for Track 1 MAID (which accounts for 96% of all MAID) the median age was 78 years, with 85% over age 65, and 60% over age 75. Slightly more men received MAID than women (51.6% vs. 48.4%). As expected, the age and sex of Track 1 MAID recipients are very similar to the age and sex of Canadians who die naturally.[16] Track 2 MAID recipients (who account for 4% of MAID) are slightly younger than Track 1 recipients, with a median age of 75 years and ~75% over age 65.

11.2.3.2. More women receive Track 2 MAID than men (58.5% vs. 41.5%), which is expected for two reasons. First, older Canadians are more likely to be women; 54% of

---

[14] Loggers Loggers ET, Starks H, Shannon-Dudley M, et al. Implementing a Death with Dignity program at a comprehensive cancer center. *The New England journal of medicine* 2013; 368: 1417-1424. 2013/04/12. DOI: 10.1056/NEJMsa1213398 ; Steck N, Junker C, Maessen M, et al. Suicide assisted by right-to-die associations: a population based cohort study. *International journal of epidemiology* 2014; 43: 614-622. 2014/02/20. DOI: 10.1093/ije/dyu010 ; Dierickx S, Deliens L, Cohen J, et al. Comparison of the Expression and Granting of Requests for Euthanasia in Belgium in 2007 vs 2013. *JAMA Intern Med* 2015. DOI: 10.1001/jamainternmed.2015.3982 ; Groenewoud AS, Atsma F, Arvin M, et al. Euthanasia in the Netherlands: a claims data cross-sectional study of geographical variation. BMJ Support Palliat Care 2021 2021/01/16. DOI: 10.1136/bmjspcare-2020-002573.

15 https://www.canada.ca/content/dam/hc-sc/documents/services/publications/health-system-services/annual-report-medical-assistance-dying-2023/annual-report-medical-assistance-dying-2023.pdf

16 https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1310070901

OKI

Canadians aged >65 are women, and 63% if Canadians aged >85 are women. Second, the sex distribution follows the known sex distribution for the chronic illnesses that that result in a MAID request, as shown in a detailed analysis from the 2022 federal report (see figure below).

11.2.3.3. Track 2 MAID recipients for neurological conditions (the most common category for Track 2 MAID) were actually more likely to be men. This makes sense if you know that Parkinson's Disease (the most common condition in this category) occurs in men almost twice as often as women.[17] In contrast, Track 2 MAID recipients for "multiple comorbidities" (e.g., frailty conditions) and "other" (e.g., chronic pain) were more likely to be women. This makes sense if you know that frailty is almost twice as common among women as it is among men[18], and chronic pain is also more common among women.[19] The remainder of Track 2 conditions show no sex difference, consistent with the fact that the age-adjusted incidence of these conditions (postmenopausal cardiovascular disease,[20]

---

17 Bianco et al. Sex and Gender Differences in Neurodegenerative Diseases: Challenges for Therapeutic Opportunities. Int J Mol Sci. 2023 Mar 28;24(7):6354.

[18] Collard et al. Prevalence of Frailty in Community-Dwelling Older Persons: A Systematic Review. J Am Geraitr Soc 2012;60:1487-92.

[19] Blyth et al. Fact Sheet: Gender Differences in Chronic Pain Conditions. International Association for the Study of Pain. (June 2024)

[20] Betai et al. Gender Disparities in Cardiovascular Disease and Their Management: A Review. Cureus . 2024 May 5;16(5):e59663.

DKI

respiratory disease,[21] cancer,[22] etc.) is similar between sexes.

11.2.3.4. I have provided this explanation because some MAID opponents have raised concerns about the sex difference among Track 2 cases, suggesting that this might indicate abuse. As we can see, the sex differences observed in Track 2 MAID recipients can be easily explained by sex differences among seniors overall and in the conditions that are prompting MAID requests, not any gender bias against or risk of abuse for women. It is unreasonable to justify a selective concern about female predominance in a subset of Track 2 cases, when there is either no sex bias (or there is a male predominance) for every other condition in Track 2, and a male predominance in Track 1 cases (which are 25 times more common than Track 2 cases).

Chart 4.5A: Main Condition, MAID, Natural Death Not Reasonably Foreseeable, 2022

[21] Chronic Obstructive Pulmonary Disease (COPD) in Canada. Health Canada Data Blog. Accessed on December 2, 2024 at https://health-infobase.canada.ca/datalab/copd-blog.html#did

[22] Cancer statistics at a glance. Canadian Cancer Society. Accessed on December 2, 2024 at https://cancer.ca/en/research/cancer-statistics/cancer-statistics-at-a-glance#:~:text=Cancerpercent20incidencepercent20forpercent20malespercent20andpercent20femalespercent20inpercent20Canadapercent20inpercent202024&text=127percent2C100percent20malespercent20andpercent20120percent2C000percent20femalespercent20wouldpercent20bepercent20diagnosedpercent20withpercent20cancer

11.2.4. Race and Ethnicity

11.2.4.1. Canada has also begun collecting and reporting data on race and ethnicity among MAID recipients. In our latest federal MAID report, ~96% of MAID recipients who answered the question were white/Caucasian, with 1.8% East Asian. Only 139 identified as indigenous, metis or both (0.9%). There were <5 cases (possibly zero) of track 2 MAID among indigenous/metis populations (small numbers are censored in large datasets to prevent identification of individuals).

11.2.4.2. We don't have race and ethnicity data for all Canadian decedents, but we know that 86% of Canadian seniors living in private dwellings are White, 4.6% are East Asian, and 2% are indigenous or Metis.[23] Thus, MAID recipients are very disproportionately from White/majority culture regardless of the comparator you might use, and the proportion of MAID recipients from each minority group (including indigenous groups), is much lower than in the general population.

11.2.4.3. To be transparent, Canada does not have a long history of collecting and reporting data on race, ethnicity and religion compared to other countries like the US and South Africa, so many Canadians refuse to provide this

---

23 https://www.canada.ca/en/public-health/services/publications/diseases-conditions/aging-chronic-diseases-profile-canadian-seniors-report.html#:~:text=Demographic%20shift,-Canada's%20population%20demographic&text=As%20such%2C%20the%20proportion%20of,could%20reach%2022.7%25%20in%202031.&text=In%202019%2C%20around%206.6%20million,the%20most%20recent%20population%20estimates

PEI

information. In this report, 9619 (63%) people responded to the ethnicity question, which is pretty high for a Canadian survey. In some studies of hospitalized patients during the COVID-19 pandemic, more than half of respondents left the race and ethnicity question blank.

11.2.5. Indices of Income, Material Resources and Education

11.2.5.1. We have other indicators of marginalization that are not measured directly, but are useful for any discussion of marginalization and MAID. Before showing this data, it is important to have a brief primer in how these measures are generated, and how they should be interpreted.

11.2.5.2. Canada has developed area-based indices to try to capture different dimensions of marginalization in our population, including income, education, housing quality, employment, race and ethnicity.[24] These indices are based on census data according to postal code, which means that for any given person, there are metrics that reflect the average of the people in their immediate vicinity. The specific metrics are not published, but any given metric, we know which quintile of marginalization for each postal code falls in. The first quintile is the least marginalized, and the fifth quintile is the most marginalized.

11.2.5.3. Of course, there are limitations to using area-level metrics for individuals; in any small region, there may individuals

[24] https://www150.statcan.gc.ca/n1/pub/45-20-0001/452000012019002-eng.htm

DKI

who differ substantially from their neighbours. However, these metrics are reliable when used for large populations, and particularly for comparisons with other large populations. These metrics can be helpful for learning about the people who receive MAiD, but they don't necessarily indicate why they are seeking MAiD. You must also be sure to compare the metrics for MAiD recipients to an appropriate comparator group, such as people with similar conditions (e.g. terminal or chronic illness) who are not asking for MAiD.

11.2.5.4. We do this to avoid a "cohort effect", which is well known in research.[25] For example, if you study a group of people who are all followed by a cardiologist, it is very likely that these people will have a higher risk of mortality than the general population. This is not because cardiologists are dangerous, but because they follow people with heart disease, a "cohort" that carries an elevated risk of mortality. To learn about the association between cardiologists and mortality, you would need to control for this confounding effect by looking exclusively at people with heart disease (for example), and compare those who are followed by cardiologists to those who aren't.

11.2.5.5. In MAiD recipients, you might expect a certain degree of marginalization (e.g. higher age, lower socioeconomic status) compared to the population average due simply to the fact that terminally- or chronically-ill individuals are

[25]https://www.nature.com/articles/s41433-021-01897
0#:~:text=Cohort%20studies%20are%20at%20serious,influences%20the%20outcome%20of%20interest.

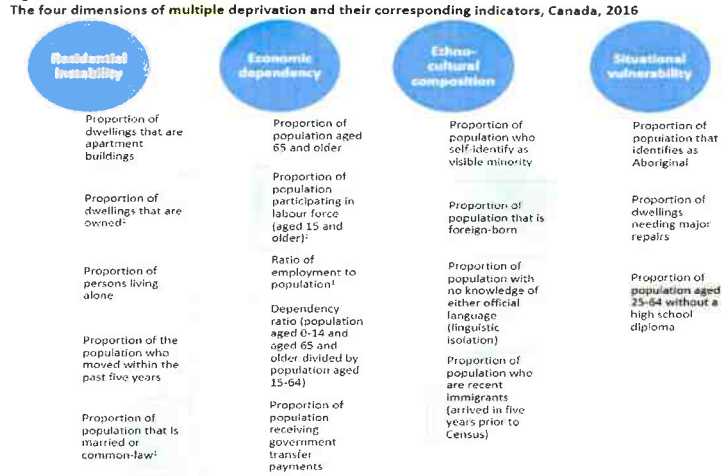
DKI

older than the average person, and chronic illness has a negative impact on socioeconomic status. If you want to understand specifically the degree of marginalization associated with MAiD, you need to look for the degree of marginalization in MAiD recipients relative to those with terminal and chronic illnesses who are not seeking MAiD.

11.2.5.6. Aside from income, there are four indices: residential instability, economic dependency, ethnocultural composition, and situational vulnerability. The elements that make up each index are provided below. Some indices are potentially helpful for measuring vulnerability among MAID recipients, while others are not. Economic dependency is helpful because it includes the proportion receiving government assistance payments. Situational vulnerability is helpful because it reflects education, dwellings in need of major repairs, and the proportion of indigenous people. Residential instability is not helpful for understanding MAID recipients because (despite the name) it doesn't measure how stably someone is housed, or anything about the quality of their housing. It relates to the proportion living in apartment buildings, people living alone, or who have moved in the past 5 years. Any neighbourhood with many seniors would be considered "marginalized" by this index, including some of the wealthiest areas in Canada.

DKI

Figure 1
The four dimensions of multiple deprivation and their corresponding indicators, Canada, 2016



[1] This indicator was reverse-coded, meaning it was coded opposite of the measure. For example, proportion of population that is married or common-law becomes proportion of population that is single, divorced, separated or widowed.
Note: The dimensions are ordered such that the dimension on the left explains the highest percentage of the variance of the data and the dimension on the right explains the lowest percentage. Excludes the territories.

11.2.5.7. With this primer in mind, the most recent Canadian report showed that by all useful metrics, MAID recipients were less marginalized/more privileged than people who died naturally.[26]

11.2.5.7.1. In terms of income, MAID recipients in both tracks were from wealthier neighbourhoods overall than people who died naturally.

11.2.5.7.2. In terms of economic dependency (e.g. proportion receiving government assistance payments), MAID recipients from both tracks were *dramatically* less likely to come from deprived neighbourhoods than those who died naturally.

[26] https://www.canada.ca/content/dam/hc-sc/documents/services/publications/health-system-services/annual-report-medical-assistance-dying-2023/annual-report-medical-assistance-dying-2023.pdf

OKI

11.2.5.7.3. In terms of situational vulnerability (e.g. education, dwellings in need of major repairs, and the proportion of indigenous people), MAID recipients from both tracks were much less likely to come from marginalized neighbourhoods than those who died naturally.

11.2.5.8. The federal report included analyses of subgroups, and found that among Track 2 recipients, women were *slightly* more likely to be from lower income neighbourhoods compared with decedents overall (both men and women). However, women in Canada are known to have *much* lower average income than men (CDN$48,400 vs CDN$66,000),[27] meaning that this small difference in a subgroup of a subgroup of MAID recipients is likely to reflect known demographic differences and not any aspect of MAID practice.

11.2.5.9. There has also been a recent provincial report produced by the Office of the Chief Coroner of Ontario that used area marginalization metrics similar (but not identical) to those in the federal reports and reported very similar findings. I am mentioning this report because although it was not released publicly, it has been circulated widely and was the subject of some misleading reports in the media based on inappropriate comparisons by MAID

---

[27] https://www.statista.com/statistics/1314929/average-employment-income-canada-gender/#:~:text=In%202022%2C%20Canadian%20women%20had,Canadian%20dollars%20more%20per%20year.

MM

PKI

opponents who failed to account for the "cohort effect" described above.

11.2.5.10. In brief, the report found that in Ontario: [28]

11.2.5.10.1. MAID recipients are more privileged in terms of "material resources" (a metric that captures income as well as other economic factors) than the average dying Ontarian.

11.2.5.10.2. MAID recipients with self-reported disabilities are more privileged in terms of "material resources" than the average dying Ontarian, and more privileged than the average Ontarian living with a neurodegenerative disease.

11.2.5.10.3. Track 2 MAID recipients are approximately as privileged in terms of "material resources" as the average dying Ontarian.

11.2.5.10.4. Racialized and newcomer populations have very low involvement in MAID regardless of Track, although no comparator was provided.

11.2.5.11. Notably, one MAID opponent responded to the Ontario report by highlighting the fact that many MAID recipients

[28] https://valuejudgments.substack.com/p/the-ontario-chief-coroners-reports

OKI

were in the highest quintile for "housing instability".[29] However, the author clearly misunderstood the housing and dwellings index, which is similar to the "residential instability" index described in the federal report above. This index has nothing to do with the quality of their housing or whether people are "stably housed", and would be high for any area with many seniors. I mention this because this concern has been echoed by others without a proper understanding of the index.

11.2.5.12. I should also mention that these reports echo the findings of previous large studies looking at income of MAID recipients from the period prior to the establishment of Track 2. I co-led a study of people who died with and without MAID in Ontario, finding that MAID recipients came from much higher income postal codes on average than those who died naturally.[30] Redelmeier et al. subsequently published a larger study in which they compared MAID rates among the wealthiest and the poorest Ontarians.[13] They found that even when they adjusted their analysis for age, sex, diagnosis, rurality, healthcare utilization and other factors, the poorest Ontarians had a 39% lower odds of receiving MAID compared with the wealthiest Ontarians.

11.2.6. Other potential indicators of marginalization

---

[29] Gaind S. MAID and marginalized people: Coroner's reports shed light on assisted death in Ontario. *The Conversation* (October 24, 2024).

[30] Downar J, Fowler RA, Halko R, et al. Early experience with medical assistance in dying in Ontario, Canada: a cohort study. *CMAJ* 2020; 192: E173-E181. 2020/02/14. DOI: 10.1503/cmaj.200016.

DKI

11.2.6.1. There are other demographic measures that might indirectly suggest marginalization, such as whether the person was widowed or divorced rather than married, or whether they were living in an institutional setting at the time of death. Ontario data reveal that MAID recipients are far less likely to be admitted to a care facility than people who die naturally (6% vs. 28%), and more likely to be married (49% vs. 41%).[31]

11.2.6.2. We also have data about the type of suffering experienced by people requesting MAID. I will review this in more detail below, but two Canadian data points have commonly been flagged for concern by people opposed to MAID. The first is the proportion of MAID recipients who report a sense that they are a burden on others. The second is the proportion who report a sense of loneliness.

11.2.6.3. First and foremost, we must recognize that these are never the sole reasons why someone requests MAID. This data is collected as part of routine MAID oversight, and people can indicate (from a list of pre-set options) more than one form of suffering. The federal reports indicate that everyone selects two or more forms of suffering, and aforementioned forms of suffering are the least frequent (or nearly the least frequent) reported by MAID recipients. They would almost invariably be selected alongside the loss of ability to engage in

[31] Supra note 30.

PKI

meaningful activities (96%) or loss of ability to perform activities of daily living (83-87%).

11.2.6.4. With that said, self-perceived burden was reported by ~45% overall in the federal report. This figure is actually *lower* than the prevalence of self-perceived burden in studies of people with advanced illness who don't request MAID.[32] To be clear, self-perceived burden is also not the same thing as being made to feel like a burden by others. It is a form of distress that relates to an illness or condition, and how this affects function and independence. Many people define themselves and their sense of meaning in terms of the activities they do, and the roles they perform for others in their lives. When an illness or condition rapidly robs them of the ability to do these things, this can cause immense distress and suffering. For some, this means transitioning from being a provider of support to being a recipient of support, which can be very distressing. To be clear, this is quite distinct from "ableism". These are generally people who are happy to be providers of support, and deeply value the people whom they have been supporting. But when it is clear that they will not be able to resume these activities or provide support to others for the rest of their lives (which may be short), some will choose MAID.

---

[32] Saji A, Oishi A, Harding R. Self-perceived Burden for People With Life- threatening Illness: A Qualitative Systematic Review. J Pain Symptom Manage. 2023 Mar;65(3):e207-e217. doi: 10.1016/j.jpainsymman.2022.10.016.

11.2.6.5. Not everyone will agree with this decision, and some will feel that it is important for people afflicted by illness to find other activities or purposes. But this is clearly within the scope of a person defining their own quality of life, and definitely part of the intended purpose of the law.

11.2.6.6. In terms of loneliness, the 2023 federal report indicated that approximately 21% of Track 1 and 47% of Track 2 MAID recipients reported loneliness as one of their forms of suffering. We have population data showing that 19-24% of community-residing Canadian seniors feel isolated and wish they could participate in more social activities.[33] This number increases with age and chronic illness. So given the average age of MAID recipients (78 for Track 1, 75 for Track 2) plus the fact that the large majority had their illness for years, the reported numbers for Track 1 are likely lower than the population average among similar people who did not seek MAID. The reported number for Track 2 may be higher, the same, or lower than appropriate comparators (but specific data does not exist).

11.2.6.7. Loneliness is a well-recognized phenomenon among elderly Canadians with chronic illness, and it can be a source of suffering. It is often a product of chronic illness and loss of function related to an underlying illness.

---

[33] https://www.canada.ca/en/employment-social-development/corporate/seniors-forum-federal-provincial-territorial/social-isolation-toolkit-vol1.html#:~:text=About%2030%25%20of%20Canadian%20seniors,risk%20of%20becoming%20socially%20isolated.&text=Reports%20by%20Statistics%20Canada%20estimate,participate%20in%20more%20social%20activities

DKI

People often form their social connections based on shared interests and activities; when illness prevents someone from engaging in these interests and activities, this causes loneliness and distress that often cannot be addressed by simply assigning them a companion or encouraging them to find other interests. Although there are social interventions that can help address some factors that cause loneliness, loneliness is not a purely social phenomenon.

11.2.6.8. Of course, we should always try to support people who are lonely and isolated, and attempt to reduce their suffering regardless of whether or not they are asking for MAID. But we shouldn't trivialize or mischaracterize their suffering, either. And we must acknowledge that the data in the federal report do not suggest at all that the loneliness experienced by MAID recipients is distinct from other forms of suffering caused by their illness, or that it is greater than the loneliness experienced by similar people not requesting MAID.

11.2.7. <u>There are no direct costs associated with accessing MAID in Canada</u>

11.2.7.1. It is important to note that Canada has a universal healthcare system, where all citizens, legal immigrants and refugees have insurance to cover a broad range of medical care, including MAID. There are still barriers to accessing MAID and other healthcare services, and these barriers are likely to be more pronounced for structurally marginalized people, but nobody is expected to pay out of pocket for MAID (as they might in Austria,

for example). In other words, the fact that MAID recipients appear to be more privileged could not be due to the cost of accessing MAID in Canada.

12. *What has been Canada's experience in relation to instances of misuse or abuse of the permissive regime since the legalisation of assisted dying? Are you aware of any instances of misconduct against vulnerable patients, or substantiated claims of abuse in relation to assisted dying in Canada?*

12.1. In brief, I am not aware of any substantiated claims of misconduct against vulnerable people, or substantiated claims of abuse related to MAID in Canada. Although we do not have detailed public reports about regulatory compliance from all parts of the country, substantial violations of the law would prompt referral to regulatory colleges or the police, which would receive some publicity. There have been a small number of cases referred to our regulatory colleges, but I am not aware of any in which a patient received MAID that they did not apparently want, or that they were not apparently eligible for.

12.2. Although Canada's MAID law was enacted by federal parliament, the administration of healthcare and regulatory oversight is handled at the provincial level. As a result, Canada's system of MAID oversight varies by province. There are common data elements that are federally mandated (which are used in the annual federal reports), but regulatory oversight and review of individual cases is handled at the provincial level. In Canada's four most populous provinces (Ontario, Quebec, British Columbia and Alberta- which collectively account for ~90% of the population) every case is formally reviewed by a MAID review committee or the coroner's office.

12.3. This includes a review of the documentation from the MAID assessors and provider, the pharmacist who dispenses the medication used in MAID, and

MA

DKI

any relevant consultants, and may also include an conversation with family members (e.g. Ontario). Given the multiple sources of input, as well as the need for anesthetic medications that are generally obtainable only in a hospital or through specific pharmacies, I think that oversight of MAID in Canada is comprehensive and that unreported cases of MAID would be highly unlikely. We have data from Ontario and Quebec, which together comprise the majority of the population and the majority of MAID cases in Canada.

12.4. Compliance reports from Quebec

12.4.1. Quebec has produced annual reports about MAID oversight since legalization.[34] These are available only in French, but I will summarize the findings from 2018 until March 2024 using my own translation or Google Translate where indicated. These six reports cover approximately 19908 cases of MAID that took place in Quebec over that time.

12.4.2. The reports identify a total of 81 cases (0.4%) where at least one requirement of the law was not met. However, this included situations where the witness to the patient's signature was not a "health or social services professional" as required in Quebec's law (this is not a requirement of the federal law), or the person was technically "not insured within the meaning of the Health Insurance Act", which likely meant an expired health card or a Canadian insured in another province.

12.4.3. There were also a handful of cases in which one of the assessments took place before the official written request was signed. This

[34] https://csfv.gouv.qc.ca/en/publications

DKI

generally occurs because of delays obtaining a witness to the signature, and confusion about the correct order of events (in Ontario, published guidance previously indicated that one assessment had to precede the written request to ensure competence). The committee flagged two cases in the 2021-2 report because the patient had received MAID under a waiver of final consent (see above) during the period after this practice became legal under federal law but before it was allowed under Quebec law. I consider these cases to be examples of the fastidiousness of the review committee, rather than any abuse or serious lapse in care.

12.4.4. In 43 cases (0.2%) the committee felt that the person did not have a "serious and incurable illness" as required under Quebec law. As indicated above, Quebec law differs from federal law in that only an "illness", not a "disease" or "disability", would meet eligibility criteria. This means that people with conditions like multimorbid frailty (which is common and well-understood by the Canadian medical community) or spinal cord injury, who are eligible under federal law, are flagged by the Quebec committee as ineligible. The committee acknowledges this in their 2022-3 report [Google Translate aside from words in square brackets]:

12.4.5. *"It should be recalled that, according to the [federal] Criminal Code, a person is eligible for MAID if they have a serious and incurable illness, condition or disability, whereas according to the [Quebec Law], the person must have a serious and incurable illness. Persons with a disability, but without a serious and incurable illness, are therefore not eligible for MAID under the [Quebec Law]. In all cases, the person had made a free and informed request for MAiD, was [competent] and met all other eligibility criteria, including the presence of constant, intolerable and unrelievable suffering."*

DFI

12.4.6. As far as I am aware, all 43 such cases were referred to Quebec's regulatory college, which felt that no disciplinary action was necessary in any of them.

12.4.7. Otherwise, there were 5 cases in which only one assessment was performed prior to MAID. In one case, this appeared to be an honest mistake that was immediately reported by the physician (2021-2). In one case, the patient had previously been found eligible by two assessors but chose not to proceed with MAID, and then later requested MAID for a different underlying condition and received only one assessment (2022-3). In two cases, one of the assessments was performed more than a month before the request (2023-4). Finally, in one case, no further explanation was provided except that only one assessment was performed (2023-4). In addition, there was one reported case in which a person received MAID under a waiver of final consent, but this was done verbally rather than in writing, which is required under law (2021-2). The six cases mentioned in this paragraph are examples of significant procedural errors, but in no case did the committee suggest that the person who received MAID was not eligible.

12.4.8. In summary, the data from Quebec suggests that there is a very high degree of compliance with the law, and a very vigilant oversight committee. Where the committee found that the requirements of the law were not met, these were almost always due to differences in eligibility criteria and safeguards between federal and Quebec law (and thus, not criminal code violations). Significant procedural errors were very rare (6 out of nearly 20,000 cases), and in no case did the committee find that someone received MAID who was not eligible under the criminal code.

DKI

12.5. Compliance data from Ontario

12.5.1. Although Ontario has not yet released oversight data, the Chief Coroner of Ontario (who oversees the practice of MAID) has presented information publicly and I have confirmed some statistics with the Office of the Coroner which I have permission to share. We do not have the same level of published detail from Ontario as we do from Quebec, but the Coroner uses a 5-level system of response to any concerns raised during case review, based on the severity of the concern raised.

12.5.2. Level 5 would be a lapse in compliance serious enough to trigger a call to police (e.g. an issue with eligibility criteria). There have never been any Level 5 responses.

12.5.3. Level 4 would be a lapse serious enough to report to the regulatory college. There have been a total of eight Level 4 responses.

12.5.3.1. An example of a level 4 response was a case of a person who met all eligibility criteria, and a provider who observed all of the procedural safeguards, but did not use the standard medication protocol for MAID. Instead, they used inappropriate medications that resulted in a prolonged and clearly uncomfortable death. This provider was disciplined by the regulatory college; they must practice medicine under supervision and are no longer allowed to provide MAID in any context.

12.5.3.2. I do not have any details on the other cases referred to the regulatory college. As in Quebec, the Ontario

DKL

college may determine that no further action or discipline is required (e.g. an error made in good faith for a patient whose eligibility was apparently not in question). If there is an investigation and a disciplinary action is taken, these are posted online- I have not been able to find any other examples of disciplinary action taken for any MAID case.

12.5.4. Levels 1-3 are for issues that would not be serious enough to trigger a referral to a regulatory body or police. This would trigger an email or conversation with the provider or assessor for the purpose of education or notice.

12.5.4.1. An example of a level 3 response would be if an ineligible witness was used for the patient's signature on the MAID request form. If this happened a second time with the same provider/assessor, this would trigger a level 4 response. There have been 42 (0.2%) Level 3 responses.

12.5.4.2. Levels 1-2 may refer to issues with completeness of documentation, but not a serious lapse in compliance with the law or professional standards. There have been 386 Level 1-2 responses (1.6%).

12.5.5. In summary, as with Quebec, there is a very high degree of compliance with the law, and a very vigilant oversight body. Where the coroner's office found that the requirements of the law were not met, the vast majority were not serious enough to warrant a referral to the regulatory college. Significant procedural errors were very rare (8 out of ~23,000 cases), and I cannot find any

DKI

example of someone receiving MAID who was not eligible under the criminal code in the opinion of the regulatory body.

13. *What is your opinion on whether Canada is experiencing a "slippery slope" since assisted dying was decriminalised in 2016?*

13.1. "Slippery slopes" are often cited by people opposed to the legalization of assisted death (MAID), but slopist arguments are difficult to sustain in any academic discourse. Slopism may be focused on MAID law or policy, and the idea that an initial change would trigger a cascade of subsequent law or policy changes that were unintended but unpreventable. Slopism may also be focused on the practice of MAID, and the idea that people may initially receive MAID for intended reasons (e.g. suffering at end of life) but soon receive MAID for undesirable reasons (e.g. poverty or societal pressure). Slopist arguments often fail logically because they are poorly constructed, or because it is difficult to argue that any change in law (whether by court or legislation) is actually unintended or unpreventable. Slopist arguments may also fail statistically, either because the data do not show the undesired effect, or they show the same (or worse) in jurisdictions that did not legalize MAID.

13.2. Briefly, there are several basic components of a conceptual slippery slope argument:

13.2.1. *The initial state*. There must be a current state that is acceptable, or at least justifiable in view of the alternatives. In the case of MAID, the initial state includes the presence of intolerable and refractory suffering.

13.2.2. *The initial change*. There must be a change being proposed. In order for a true slopist argument to apply, the initial change must be

DKI

relatively innocuous or at least superficially acceptable to most people. A change that would be unacceptable from the start would not require a slopist argument, since the initial step would already put society at the bottom of the "slope", or at least beyond the point of acceptability. In that sense, people with a moral opposition to MAID in any form need not appeal to slippery slope arguments.

13.2.3. *The undesirable state.* There is a state (hypothetical or real) in which there are practices that most people would not approve of. In the case of MAID, these practices might include MAID for ineligible people or for reasons not intended under the law (e.g. poverty or easily reversible conditions), or they might include involuntary MAID, or more hyperbolic concerns like state-sponsored genocide. No specific eligibility criteria or safeguards are objectively "correct" or "incorrect", and so there is legitimate scope for disagreement about what might be desirable or undesirable in terms of regulations or practice. In a pluralistic society, we should not expect consensus about what defines an undesirable state, and we must accept certain laws and policies that we disagree with.

13.2.4. *The "slide".* There must be an uncontrollable transition from the initial change to the undesirable future state, and the transition must flow logically from the initial change. The uncontrollability of the change is critical, because laws and ethical codes of practice are constantly being changed or updated to reflect data, experience, or societal values. Conscious, deliberate changes in laws or policy, which arrive as the result of democratic deliberation or constitutionally-valid means (for example) are not uncontrolled transitions. Not every change is a "slide".

DKI

13.3. In order to be internally valid, a slippery slope argument must include all four of the components outlined above. Needless to say, it is a high bar if we insist on seeing data as proof. But even conceptually, a slippery slope argument is very hard to defend in Canada. I will review the changes that have taken place in terms of eligibility criteria, safeguards and practice, and consider whether any of these changes could be considered a slippery slope.

14. Is there a legal slippery slope in terms of eligibility criteria in Canada?

14.1. As mentioned above, MAID was initially decriminalized as a result of a decision by the Supreme Court in *Carter v Canada* (AG) in 2015,[35] allowing MAID for competent adults with a grievous and irremediable medical condition. Initially, Canada's parliament responded to *Carter* by passing Bill C-14 in 2016, which defined a "grievous and irremediable medical condition" to include the fact that the person must have reached the point where their natural death had become "reasonably foreseeable". Since *Carter* did not include this term, or make any reference to prognosis, many experts suggested that this criterion was incompatible with the Court ruling. Moreover, Ms. Carter herself had spinal stenosis, a grievous and irremediable medical condition, but not one that many medical experts would associate with a "reasonably foreseeable" natural death, however defined.

14.2. This criterion was ultimately eliminated as a result of a subsequent ruling by the Superior Court of Quebec in *Truchon v Canada (AG)* in 2019,[36] reaffirming the original *Carter* ruling, and the resulting legislation passed by Canada's legislature (Bill C-7) in 2021,[37] which established a distinct set of

---

[35] Carter v Canada, 2015 SCC 5.

[36] Truchon v Canada (AG), 2019 QCCS 3792.

[37] Legislative Background: Bill C-7: Government of Canada's Legislative Response to the Superior Court of Québec Truchon Decision. https://www.justice.gc.ca/eng/csj-sjc/pl/ad-am/c7/p1.html Accessed Feb 5, 2024

PKT

safeguards for those without a reasonably foreseeable death (see above). Federal reports indicate that people without a reasonably foreseeable death account for only a small percentage of all MAID cases.[38]

14.3. Canada's legislated eligibility criteria may change again in 2027, allowing people to request MAID on the basis of mental illness as a sole underlying medical condition. The Carter decision did not exclude incurable mental illness, but Canadians were initially excluded from MAID eligibility on the basis of incurable mental illness as a sole underlying medical condition for two years under Bill C-7, in order to allow Canada's medical community to prepare practice standards. This delay was extended twice by parliament at the request of the Canadian psychiatric community. To me, this is a clear example of a controlled change.

14.4. Some have argued that the changes in Canada's eligibility criteria constitute an uncontrollable slide, and that the Supreme Court did not intend for people with non-terminal illness to access MAID, but this is a difficult argument to sustain. The *initial change* in Canada was a court ruling that defined eligibility to include:[39]

14.4.1. *"...a competent adult person who (1) clearly consents to the termination of life; and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in circumstances of his or her condition. 'Irremediable', it should be added, does not require the patient to undertake treatments that are not acceptable to the individual. The scope of this declaration is intended to respond to the factual circumstances in this case. We make no pronouncement on other situations where physician-assisted dying may be sought."*

---

[38] https://www.canada.ca/content/dam/hc-sc/documents/services/publications/health-system-services/annual-report-medical-assistance-dying-2023/annual-report-medical-assistance-dying-2023.pdf

[39] Carter v Canada, 2015 SCC 5.

MAL

DKI

14.5. This definition is broad. No aspect of the ruling implies any reference to prognosis (or mental illness as a sole underlying medical condition), and the court specifically considered the potential risks to "decisionally vulnerable" individuals.[40] Some circumstances (e.g. incompetent individuals, non-adults) would appear to be outside the "factual circumstances" of this ruling. However, the initial exclusion of those without a reasonably foreseeable death (in Bill C-14) would not appear to be justified because Ms. Carter would not have had a reasonably foreseeable death in the eyes of many clinicians.

14.6. So anyone who argues that the *Carter* decision was not meant to apply to non-terminal illness is arguing that the Supreme Court never intended the *Carter* decision to apply to Ms. Carter. This is obviously wrong, which is why the Superior Court of Quebec struck down this provision in *Truchon*. Without supporting or opposing the moral correctness of MAID in non-terminal conditions, we can say that the MAID eligibility criteria in C-7 appear to be a more correct interpretation of *Carter* than those in C-14.[41]

14.7. In summary, the eligibility changes in Canada's MAID laws that have taken place since 2016 are not an uncontrolled slide but rather a correction of an unjustified provision that narrowed the original law. I do not feel that this meets the logical standard of a slippery slope.

15. Is there a legal slippery slope in terms of safeguards in Canada?

15.1. Several jurisdictions have changed the safeguards present in their laws, but to understand these changes, we must first review the purpose of a

---

[40] PP114-6

[41] Downie J, Schuklenk U. J Med Ethics 2021;0:1–8. doi:10.1136/medethics-2021-107493

PKI

safeguard. In order to be valid, a MAID safeguard must be rationally connected to a specific eligibility criterion, but not be unnecessarily onerous to the point that eligible people are unable to access MAID as a result. For example, all jurisdictions wish to ensure that the person requesting MAID understands what they are requesting, and mandating a witnessed signature may provide a degree of certainty about this. However, requiring multiple witnesses, and restricting those witnesses beyond anyone with an obvious conflict of interest (e.g. someone who stands to inherit from the person when they die) would not add meaningfully to the degree of certainty about the request, and may be logistically challenging to arrange for someone with advanced illness.

15.2. Many jurisdictions also require a reflection period after the initial request, to ensure that the request is persistent and not the result of a transient frustrating experience or reversible symptom. However, the length of the reflection period must be contextualized for people who may be rapidly approaching the end of their lives, and who might lose decisional capacity due to their illness or a period of delirium. A reflection period that is too long would prevent eligible people from accessing MAID.

15.3. These safeguards – the number of witnesses and the duration of the reflection period – have both been modified in Canada following the initial legalization of MAID. Bill C-14 specified the need for two witnesses, neither of whom could be involved in the care of the patient or be a beneficiary of their will. During public hearings prior to the drafting of Bill C-7, there were many reports that the need for two witnesses, with such restrictions, was a substantial barrier to access for eligible people.[42] As a result, this safeguard

[42] What We Heard Report: A Public Consultation on Medical Assistance in Dying (MAID). https://www.justice.gc.ca/eng/cj-jp/ad-am/wwh-cqnae/toc-tdm.html Accessed Feb 5, 2024

DKI

was revised in Bill C-7 to require only one witness, who could be a member of the care team.

15.4. The original 10-day reflection period included in C-14 was eliminated for Track 1 MAID in C-7. Although the original 10-day reflection period could have been shortened if the patient was at risk of losing decisional capacity, consultation found that the reflection period still "can cause unnecessary suffering for patients or preclude them from accessing MAID", and that "in most cases, patients have already reflected on MAID for a long time before they formally request it, and that this reflection has likely included discussions with families and their health care team".[43] In the United States, California, Hawaii, New Mexico, Oregon, and Washington have also either shortened waiting periods or allowed them to be waived.[44] Notably, Canada's most recent federal report found that despite the removal of the reflection period, the median delay between the initial request and the provision of MAID was still 13 days. We don't have similar data from pre-C-7 reports, but the 2020 report indicated that the reflection period had been shortened in 34% of cases.[45] In other words, the change in safeguard appears to have had little or no effect on practice for the vast majority of MAID recipients.

15.5. One additional change in safeguards in Canada was the option of a "waiver of final consent", which was included in Bill C-7 in 2021. This provision allowed individuals to sign a consent form in advance of MAID, allowing it to proceed in a specific timeframe even if they could not provide contemporary consent at the time of the procedure, which was a safeguard required for MAID to proceed under C-14. This amendment was added because of

---

[43] What We Heard Report: A Public Consultation on Medical Assistance in Dying (MAID). https://www.justice.gc.ca/eng/cj-jp/ad-am/wwh-cqnae/toc-tdm.html Accessed Feb 5, 2024

[44] See Chapter 10 of this Volume: 'Assisted Dying in the United States'

[45] https://www.canada.ca/en/health-canada/services/publications/health-system-services/annual-report-medical-assistance-dying-2020.html#6_4

DKI

anecdotal reports of people proceeding with MAID before they otherwise would have done, out of fear of losing capacity and being unable to receive MAID at all, and thus experiencing a prolonged death with possible suffering.[46] In 2023, fewer than 4% of all MAID procedures were provided under a waiver of final consent. At the same time, 15% of patients who requested MAID ultimately died naturally without receiving it; some of these would have been patients who chose not to proceed with MAID when competent because they felt reassured that their signed waiver of final consent would prevent a prolonged dying process. In other words, changing this safeguard (the need for a competent request at the time of the procedure) likely avoided some cases of MAID, and it is possible that the number of MAID cases avoided in this way actually exceeded the number who received MAID through a waiver of final consent, although this is impossible to prove either way.

16. *Is there a slippery slope in terms of practice?*

16.1. Outside of changes to eligibility criteria and safeguards, common slopist fears include:

16.1.1. People will receive MAID for reasons not consistent with the intent of the legislation, either initially or over time. These reasons include:

16.1.1.1. Social deprivation or other forms of structural vulnerability and marginalization- already addressed above.

[46] Downie, J. From Prohibition to Permission: The Winding Road of Medical Assistance in Dying in Canada. HEC Forum 34, 321–354 (2022). https://doi.org/10.1007/s10730-022-09488-6

DKI

16.1.1.2. Inability to access high quality or timely supportive services, including palliative care.

16.1.2. Suicide will become more common, either because of "suicide contagion" caused by MAID or because the legalization of MAID would undermine suicide prevention.

16.1.3. Palliative care services and/or funding will erode, and people will choose MAID (or be forced to choose MAID) over palliative care.

16.1.4. MAID will become more common.

16.2. When evaluating these arguments, it is important to use *appropriate comparators*. In MAID, as in mathematics, a slope cannot be defined unless there are at least two data points. There are many different possible comparators; the incidence of concerning practices within a jurisdiction (e.g. non-voluntary MAID) could be compared to practices from the same jurisdiction pre-legalization, and/or to other peer jurisdictions (ideally more than one). Concerning characteristics of MAID recipients with terminal illness (e.g. low socioeconomic status) could be compared to those who died naturally. MAID recipients without a terminal illness could be compared to a population with similar conditions who did not receive MAID.

16.3. Comparator data may not always be available, but efforts should be made to determine whether the concerning practices are becoming more common over time, or are more common than in jurisdictions where MAID is illegal. If concerning practices are as common or more common in jurisdictions where MAID is illegal, it is difficult to argue that legalizing MAID leads to concerning practices, or conversely, that prohibiting MAID offers any protection against the concerning practices. By the same token, efforts should be made to determine whether the concerning characteristics of MAID recipients are

MAJ

PKT

more or less prevalent than in those who did not receive MAID, or if MAID was as common or more common in people without the concerning characteristic. As outlined above, some poor people may receive MAID, but if wealthy people receive MAID more often than poor people, it is difficult to sustain the narrative that poverty is driving the practice of MAID to any substantial degree.

16.4. To be clear, all of the data that informs this discussion is observational, and so we have to be careful about causal inference. We should not necessarily assume that legalizing MAID was the cause of the positive developments that followed in Canada or any other jurisdiction (e.g. increases in palliative care utilization, decreases in suicide rates). A direct test of causality – such as an interventional study in which some jurisdictions were randomly assigned to have MAID legalized while others were not – is impossible for these hypotheses.

17. Inability to access high quality or timely supportive services, including palliative care.

17.1. Canada collects and publishes this data in our federal reports. This data relies on the subjective judgment of the assessor to determine whether the person had access to supportive or palliative care services. Of course, it may be easy to objectively determine whether someone *received* a type of care, but if they did not, it is impossible to objectively prove that someone did or did not have *access* to that care.

17.2. With that said, MAID recipients in Canada appear to have a very high degree of involvement of palliative care services. Our federal reports indicate that almost 80% of MAID recipients received palliative care services, with 50%

PKI

receiving it for more than a month before they died.[47] By comparison, 59% of Canadians overall receive palliative care services prior to their death,[48] and in high-income countries, the average person receives palliative care only 19 days before a *natural* death. In other words, the average MAID recipient in Canada is much more likely to receive palliative care services, and to receive them much earlier than people who die naturally.

17.3. For those who did not receive palliative care, the large majority were felt to have had access to it (but presumably refused it). In only 2.8% of cases, the assessor felt that the MAID recipient would have benefitted from palliative care but did not receive it. In only six cases (out of 15,343), the assessor felt that the MAID recipient would have benefitted from palliative care services but did not have access to them. The federal reports also collected similar data based on the need for and access to disability support services. Similar to palliative services, the vast majority of MAID recipients either received or did not require disability support services. Only 5 MAID recipients were felt to have needed disability support services but did not have access to them.

17.4. Canadian opponents of MAID have suggested that these reports may be unreliable and overestimate the involvement of palliative care, as they are based on the subjective assessment of the MAID assessors. I disagree with this argument because in Ontario, every MAID case is reviewed by a nurse investigator working for the office of the Chief Coroner. Among other things, they make an independent assessment of whether they believe the patient had received palliative care. The percentage from the Coroner's database is

---

[47] https://www.canada.ca/content/dam/hc-sc/documents/services/publications/health-system-services/annual-report-medical-assistance-dying-2023/annual-report-medical-assistance-dying-2023.pdf

[48] Access to Palliative Care in Canada 2023, https://www.cihi.ca/sites/default/files/document/access-to-palliative-care-in-canada-2023-report-en.pdf (2023, accessed May 15 2023).

almost exactly the same as in the federal reports.[49] Considering that these people have training and expertise in reviewing medical files, and they are not connected to the case in any way, their assessment is as objective as we could ever hope to achieve.

17.5. Opponents have also argued that these reports do not assess the quality of the palliative care provided, and that earlier or higher-quality palliative care would have addressed the suffering of those who received MAID and thus, they would not have requested it. This is a challenging claim to evaluate directly, because there is no objective measure of PC quality or an objective standard for the ideal timing of PC involvement. But there is still a lot of objective data that refutes this argument.

17.6. There are well-known differences in the accessibility and use of palliative care among people with different illnesses- particularly when comparing cancer and non-cancer illnesses. In Ontario, for example, people with cancer are twice as likely to receive palliative services compared with people who are dying of organ failure (88% vs. 44%), and four times as likely to receive palliative services in the home (68% vs. 17%)[50]. Among those who receive palliative care, people with cancer receive it much earlier than those with organ failure (median 105 days vs. 22 days).[51] If we compare lung cancer with end-stage lung disease (two conditions with a similar burden of symptoms and other palliative needs in the final months of life[52]), we find that

---

[49] Supra note 30.

[50] Seow H, O'Leary E, Perez R, et al. Access to palliative care by disease trajectory: a population-based cohort of Ontario decedents. *BMJ Open* 2018; 8: e021147. DOI: 10.1136/bmjopen-2017-021147.

[51] Supra note 50.

[52] Habraken JM, ter Riet G, Gore JM, et al. Health-related quality of life in end-stage COPD and lung cancer patients. *J Pain Symptom Manage* 2009; 37: 973-981. 2009/04/28. DOI: 10.1016/j.jpainsymman.2008.07.010 ; Steinhauser KE, Arnold RM, Olsen MK, et al. Comparing three life-

DKT

people with lung cancer are substantially more likely to receive palliative home visits from a physician or home palliative services in general compared to those with end-stage lung disease.[53] So we know that the access, quality and timing of palliative care in cancer is far better than it is for non-cancer illness in Canada (as it is elsewhere in the world). So if poor palliative access, quality or timing were responsible for MAID to any degree, we would expect to see a much higher incidence of MAID among people with non-cancer illness compared to cancer. In fact, we see the opposite- Ontarians with cancer are three times more likely to receive MAID than those dying of respiratory illness, and eight times more likely than those dying of cardiovascular illness[54]. Another surrogate of service access is rurality- people who live in cities generally have much better access to palliative and disability support services. Again, MAID recipients are less likely to live in a rural area than Canadians who die naturally.[55]

17.7. In summary, we have a lot of subjective and objective data about palliative and supportive service use in people who receive MAID. By any standard, Canadian MAID recipients have exceptionally high access and involvement of palliative care services. And if poor quality or poor timeliness of palliative care were driving MAID to any degree, we couldn't possibly see the MAID data that we are seeing.

18. Suicide

---

limiting diseases: does diagnosis matter or is sick, sick? *Journal of Pain and Symptom Management* 2011; 42: 331-341. Research Support, N.I.H., Extramural 2011/02/01. DOI: 10.1016/j.jpainsymman.2010.11.006.

[53] Kendzerska T, Nickerson JW, Hsu AT, et al. End-of-life care in individuals with respiratory diseases: a population study comparing the dying experience between those with chronic obstructive pulmonary disease and lung cancer. *Int J Chron Obstruct Pulmon Dis* 2019; 14: 1691-1701. 2019/09/20. DOI: 10.2147/COPD.S210916.

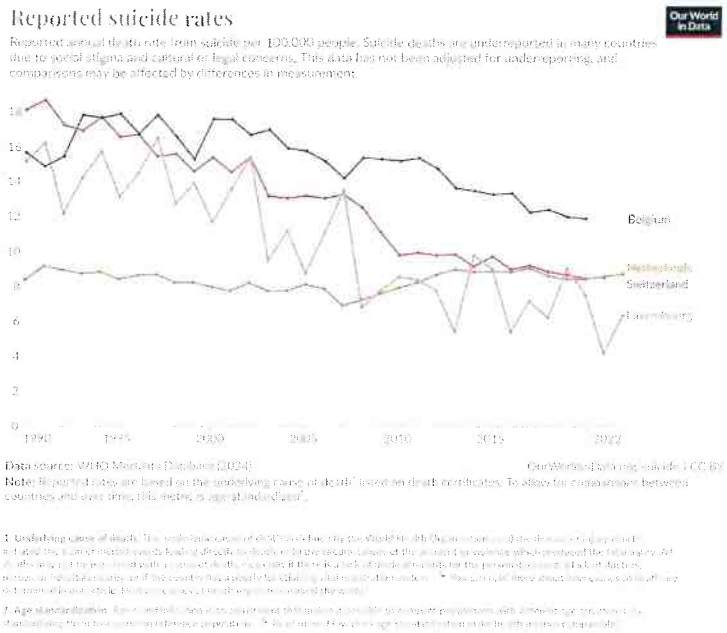
[54] Supra note 30.

[55] Supra note 48.

DCT

18.1. Another argument against legalizing MAID is a slopist concern that this would lead to an increasing incidence of suicide, either because of "suicide contagion" caused by MAID or because the legalization of MAID would undermine suicide prevention. This is challenging to study, because "unassisted" suicide is affected by a variety of known socioeconomic factors that fluctuate over time, so there may be changes in suicide rates that are unrelated to legalization of MAID. That said, the available data show that when MAID is legalized or MAID rates increase, suicide rates generally fall or they follow the trend of similar jurisdictions that have not legalized MAID.

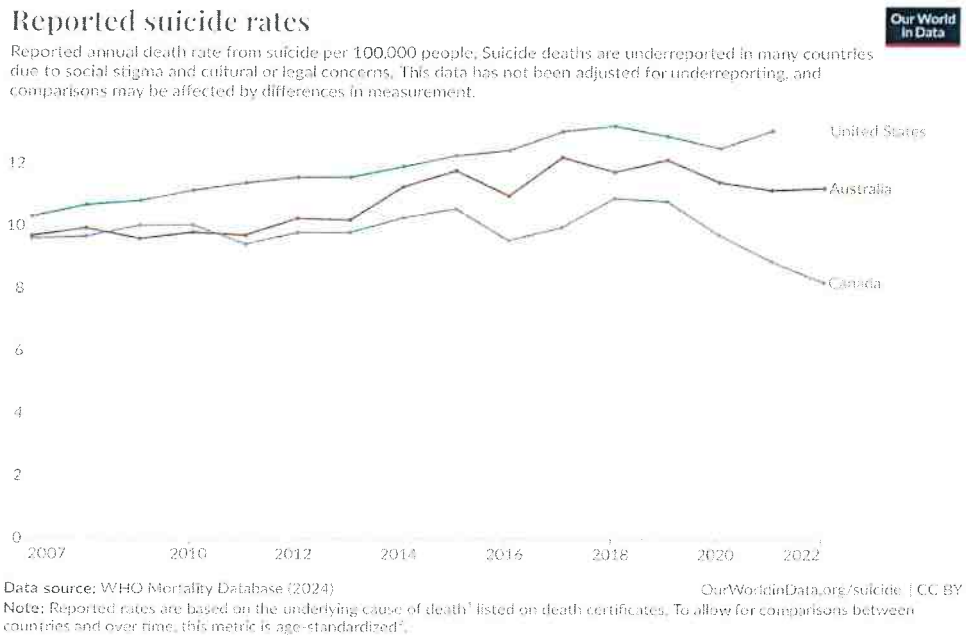
18.2. First, for the European jurisdictions where MAID has been legal for more than 20 years (Belgium, Netherlands, Luxembourg and Switzerland), the use of MAID has been increasing consistently in all over in the past decade. Meanwhile, suicide rates have fallen consistently and dramatically over that time. The one exception is the Netherlands, where suicide rates were lowest, and they have remained roughly at their baseline.



https://ourworldindata.org/grapher/suicide-rate-whomdb?time=1990..latest&country=BEL~LUX~NLD~CHE

NKI

18.3. We can also look at suicide rates for jurisdictions that have legalized more recently (Canada, Australia and the US states (which mostly legalized since 2015)). In this case, we see that prior to 2018 there was a consistent trend towards increasing suicide rates (see figure below). That has since halted or reversed in all three, particularly as MAID rates began to increase substantially. While Canada's MAID numbers have grown annually, our suicide rate in 2022 fell to the lowest rate since the 1960s (when suicides were heavily underreported for social reasons).



https://ourworldindata.org/grapher/suicide-rate-who-mdb?time=2007..latest&country=CAN~AUS~USA

18.4. Three published studies have looked at suicide rates before and after legalization of MAID. Jones and Paton looked at suicide rates in several US

WRA

DFT

states where MAID was legalized, correcting for socioeconomic factors, and found that while unassisted suicide rates increased overall, the change was no different from what was seen in states that did not legalize MAID.[56] Nanner conducted a similar study of Belgian suicides before and after legalization of MAID, and found that suicide rates in Belgium followed the trend of European Union members that had not legalized MAID.[57] More recently, Jones published a study of Victoria, Australia, showing that age-adjusted suicide rates fell after MAID was legalized there, but the decrease mirrored decreases in other Australian states that did not legalize MAID.[58] Given what we have seen from the data we have, there is absolutely no reason to be concerned that legalizing MAID leads to an increase in suicides, or undermines suicide prevention.

19. Erosion of palliative care services or funding

19.1. A common concern among palliative care providers is that MAID will become a low-cost, simple alternative to high quality palliative care, and that palliative care service delivery and funding will erode as a result. This question may be challenging to study, as palliative care funding and service delivery has been steadily increasing in most countries in the past few decades, and not every jurisdiction has a clearly defined budget for palliative care (as opposed to a pool of funding for multiple healthcare services). Multiple studies and reports have documented the growth of palliative care practices (e.g. palliative care home visits, or "intensification of symptom management" or "palliative sedation" at end of life) in jurisdictions that legalized MAID.[59] In all cases, the

---

[56] Jones and Paton. South Med J 2015 Oct;108(10):599-604.

[57] Nanner H. J Public Health Policy 2021; 42(1): 86–97.

[58] Jones D. J Ethics Mental Health. Open Volume 11 (2022). https://jemh.ca/issues/open/documents/JEMH%20article%20EAS%20and%20suicide%20rates%20in%20Europe%20-%20copy-edited%20final.pdf Accessed Feb 5, 2024

[59] *Access to Palliative Care in Canada.* Canadian Institutes for Health Information, 2023.

growth of these palliative care practices in absolute terms was much greater than the increases in the use of MAID.

19.2. Canada does not have a defined palliative care budget, and palliative care spending is challenging to measure because health spending is a shared provincial and federal responsibility. Our federal government invested $5 billion in palliative and home care in 2016, much of which went to palliative care services.[60] There has been a large growth in funding and salaried positions for Palliative Care physicians in many provinces; for example, the division I lead in Ottawa has almost doubled in size (to >40 physicians) in the past 5 years. There has also been a large growth in the number of funded community hospice beds in Canada, mirroring the rapid growth seen in the Benelux countries following MAiD legalization there.[61] In Ontario, for example, the number of funded hospice beds almost doubled (to 750) between 2016 and 2024.[62]

19.3. Palliative care utilization has also increased substantially in Canada since MAID was legalized. A report from the Canadian Institutes of Health Information showed a large increase the proportion of Canadians receiving palliative care between 2016 and 2022.[63] There was a particularly large growth in the proportion who received palliative home care (15% to 24%), and who were able to die at home with the help of palliative care (7% to 16%). Of course, Canada (like all countries) would benefit from ongoing investments in training, research, and clinical services devoted to palliative care. But there

---

Onwuteaka et al. Lancet 2012;380:908-15.

Chambaere et al. NEJM 2015;372:1179-81.

60 https://www.canada.ca/en/department-finance/news/2016/12/federal-proposal-to-strengthen-health-care-for-canadians.html

61 Supra note 1.

62 Supra note 2.

63 Supra note 48.

DLI

can be little doubt that the past 8 years have seen the greatest investment and growth in palliative care in Canadian history.

20. *MAID becoming more common – is this even a slippery slope?*

20.1. After MAID is legalized, there is almost invariably an increase in the reported use of MAID as a proportion of all deaths. The notable exceptions to this would be Belgium and the Netherlands, where MAID was fairly common prior to legalization and actually became less frequent in the first decade after legalization.[64] There has also been a dramatic increase in the use of MAID in most jurisdictions since the start of the COVID-19 pandemic, including jurisdictions where MAID rates were stable for many years (e.g. Oregon, Netherlands). As mentioned above, the growth in MAID has been overshadowed by the growth in palliative care service utilization and practices wherever this data is available, which is reassuring to those concerned that MAID would be seen as preferable to palliative care. But what about the growing incidence of MAID itself, independent of any other data?

20.2. In order for this to be considered a slippery slope, we would need to agree that there is a given incidence of MAID cases that would be acceptable, and a higher incidence that would not. Clearly, there could be no empirical justification for any given threshold; it would be arbitrary. But this misses the broader problem with this slippery slope claim: the fact that legalizing MAID is not aimed at providing MAID but providing choice. The success or failure of a MAID regime is determined by the number of people who are able to make an informed choice about their care at the end of life, rather than the number of people who make one choice or another. If a jurisdiction recognizes a right to MAID, similar to the right to withdraw life-sustaining

---

[64] Onwuteaka et al. Lancet 2012;380:908-15.
Chambaere et al. NEJM 2015;372:1179-81.

PKI

measures (that would be expected to result in death), this does not imply that this right should only be exercised by a certain number of people per year (more about this below). The fact that the incidence of legal, rule-conforming MAID is increasing is only a bad thing if we believe that legal MAID itself is a bad thing.

20.3. To underscore this point, we can look at how other types of end-of-life decision-making have evolved in different countries after legal decisions. The withdrawal of life support in the intensive care unit (ICU) was considered to be homicide (even with surrogate consent) by the New Jersey Superior Court in the case of Karen Ann Quinlan in 1975, and only allowed after a landmark appeal.[65] Yet an observational study of 131 ICUs in the United States of America conducted 20 years later found that 38% of all ICU deaths were preceded by a withdrawal of life support.[66]

20.4. In Canada, consensual withdrawal of life support was only determined to be legal following the case of Nancy B in 1992.[67] Again, a study published 10 years later found that 46% of all ICU deaths in Canada were preceded by a withdrawal of mechanical ventilation.[68] We do not have reliable baseline data for either the United States or Canada prior to these legal decisions; but even if extra-legal withdrawal of life support was performed, the subsequent increase in withdrawal of life support must have been much more dramatic than any reported changes in the use of MAID after legalization anywhere in the world. This profound and rapid change in attitudes and practice is not considered to be a "slippery slope" in any academic discussion, because

---

[65] In re Quinlan.

[66] Prendergast TJ, et al. Am J Respir Crit Care Med 1998;158:1163–1167.

[67] Nancy B. v. Hôtel Dieu de Québec (1992), 86 D.L.R. (4th) 385 (Que. S.C.)

[68] Cook et al. N Engl J Med 2003;349:1123-32.

pr I

measures (that would be expected to result in death), this does not imply that this right should only be exercised by a certain number of people per year (more about this below). The fact that the incidence of legal, rule-conforming MAID is increasing is only a bad thing if we believe that legal MAID itself is a bad thing.

20.3. To underscore this point, we can look at how other types of end-of-life decision-making have evolved in different countries after legal decisions. The withdrawal of life support in the intensive care unit (ICU) was considered to be homicide (even with surrogate consent) by the New Jersey Superior Court in the case of Karen Ann Quinlan in 1975, and only allowed after a landmark appeal.[65] Yet an observational study of 131 ICUs in the United States of America conducted 20 years later found that 38% of all ICU deaths were preceded by a withdrawal of life support.[66]

20.4. In Canada, consensual withdrawal of life support was only determined to be legal following the case of Nancy B in 1992.[67] Again, a study published 10 years later found that 46% of all ICU deaths in Canada were preceded by a withdrawal of mechanical ventilation.[68] We do not have reliable baseline data for either the United States or Canada prior to these legal decisions; but even if extra-legal withdrawal of life support was performed, the subsequent increase in withdrawal of life support must have been much more dramatic than any reported changes in the use of MAID after legalization anywhere in the world. This profound and rapid change in attitudes and practice is not considered to be a "slippery slope" in any academic discussion, because

---

[65] In re Quinlan.

[66] Prendergast TJ, et al. Am J Respir Crit Care Med 1998;158:1163–1167.

[67] Nancy B. v. Hôtel Dieu de Québec (1992), 86 D.L.R. (4th) 385 (Que. S.C.)

[68] Cook et al. N Engl J Med 2003;349:1123-32.

DFI

withdrawal of life support is now accepted (and even preferred) as an end-of-life option for most people in high-income countries.

20.5. And we must also appreciate how rapidly end-of-life practices can evolve even in jurisdictions where there has been no legal change. The ETHICUS-2 study looked at evolutions in ICU end-of-life practices across Europe over a 16-year period.[69] Although there were regional variations, the withdrawal of life support increased from 25% to 39% of all deaths, and the use of ineffective cardiopulmonary resuscitation fell from 22% to only 6%. Once again, without any legal changes, the end-of-life practices in ICUs across Europe have changed more dramatically on average than the growth in MAID in any jurisdiction over the same period, or at any time in history.

20.6. In this context, changes in the use of legal MAID may be best understood not as a slippery slope, but as just one aspect of a broad, international shift in attitudes and practice towards prioritizing comfort over lifespan when confronted by a serious and incurable condition.

[69] Sprung et al. JAMA. 2019;322(17):1692-1704.

PKI

2. The factors that lead to patients requesting medical assistance in dying.

(In this regard, please address, based on your experience, expertise and research:)

21. *What drives patients to request medical assistance in dying? Put differently, what does the data reveal are the most common associations in requests for assistance in dying? And what, if any, incorrect theories are disproved by the data?*

21.1. There is no universal rationale for MAID requests in the terminally ill. As explained above, the data strongly refute the idea that MAID requests are driven by factors external to patients, such as socioeconomic factors, the availability of social supports or palliative care, or the attitudes of healthcare providers or caregivers. On the contrary, the data suggest that the practice of MAID is principally focused on disproportionately privileged and competent people who are approaching the end of life. Moreover, since we see dramatic differences in the incidence of MAID depending on the underlying disease, and the degree of difference appears consistent around the world and over time, we can hypothesize that disease-related factors are central to a MAID request.

21.2. People who request MAID often cite a combination of factors[70], but as mentioned above, the most common rationale involves the loss of the ability to perform acts that they find meaningful, or that gave them purpose throughout life. This suggests that functional decline is an important factor, but it would not explain why conditions with greater and longer-term functional impairments (e.g. organ failure) have a relatively low incidence of MAID, while people with conditions that have better-preserved function until they are close to death (e.g. ALS and cancer, which follow a "terminal illness" trajectory[71])

---

[70] *Second Annual Report on Medical Assistance in Dying in Canada 2020.* 2021.

[71] Lunney JR, Lynn J and Hogan C. Profiles of older medicare decedents. *J Am Geriatr Soc* 2002; 50: 1108-1112.

PKT

have *the highest* incidence of MAID. Indeed, one of the few points of commonality between cancer and ALS is their trajectory; they are otherwise quite different in terms of physical symptoms. Another important similarity is the degree of impairment in self-perceived dignity. Studies looking at the Patient Dignity Inventory (a validated metric of dignity-related distress) have shown that people dying of cancer and ALS have the highest degree of dignity-related distress compared with other illnesses[72].

21.3. Taken together, this data suggests that MAID requests in the terminally ill may be largely driven by the trajectory itself- a rapid, progressive, and apparently irreversible decline in the ability to perform acts that people consider to be important to their identity and role. The distress of this rapid decline may be more keenly felt by those with a higher "baseline" of function, socioeconomic status and family supports, explaining the higher incidence in these groups. It may be tempting to conclude that this is a form of ableism- a stigmatizing self-perception based on dependence, or an indication that support services are inadequate. But if any of these explanations were true, we would expect to see higher rates of MAID among those with greater and longer-term dependence (e.g. organ failure and frailty) and those with fewer socioeconomic resources to support them. The distress apparently does not come from the dependence or the inadequacy of the support provided, but the fact that a person has seen a *rapid* decline and no realistic hope of an improvement.

22. *Can requests for medical assistance in dying be said to be the result of, or linked to, structural or socioeconomic vulnerability or inadequate supportive resources for*

---

[72] Chochinov HM, Johnston W, McClement SE, et al. Dignity and Distress towards the End of Life across Four Non-Cancer Populations. *PLoS One* 2016; 11: e0147607. 2016/01/26. DOI: 10.1371/journal.pone.0147607; Chochinov HM, Hassard T, McClement S, et al. The landscape of distress in the terminally ill. *J Pain Symptom Manage* 2009; 38: 641-649. 2009/08/29. DOI: 10.1016/j.jpainsymman.2009.04.021.

DFI

people with disabilities? In other words, do patients request medical assistance in dying because of poverty, neglect or an inability to access supportive services?

23. *Would better access to timely, high-quality palliative care prevent requests for medical assistance in dying?*

23.1. I have answered these questions above.

24. *How, practically, does **medical assistance in dying work in practice**? In this regard, please explain the practical process from start to finish, including the requests for assistance in dying to the administering of the lethal medical, and any effects on a patient's suffering, body and mind.*

24.1. I have outlined the process of making the request above, and the procedural safeguards required. This generally takes some time even for Track 1- days or weeks to complete the process. In some cases, the person is found eligible but chooses not to proceed with MAID and dies naturally. In other cases, the person wants to delay the procedure to try another form of treatment for the underlying disease or the suffering, or perhaps to accomplish a life goal or complete a legacy project. Otherwise, if the person requests to proceed with MAID as soon as possible, they will schedule a time that is mutually convenient for the patient (and sometimes family) and the provider.

24.2. The patient often has a preference of where they would like to receive MAID- either they strongly prefer to be at home in a favourite location, or they strongly prefer not to be at home so that remaining family members do not have the memory of the person dying in their residence. According to our most recent federal report, most people receive MAID in a private residence (38%), followed by a hospital (33%) or a palliative care facility (22%). Many hospitals or other facilities have specific rooms for MAID; these rooms are generally separate from other clinical areas, and designed to resemble a

DKI

pleasant, home-like setting rather than a hospital. Some facilities have institutional policies that forbid the performance of MAID on site, often for religious reasons. These policies are currently the subject of a legal challenge, which is beyond the scope of this report. Nevertheless, in such a situation, the person would need to be transferred elsewhere to receive MAID.

24.3. In Canada, both self-administered and clinician-administered MAID are permitted (except in Quebec, where it must be clinician-administered), but almost every procedure is clinician-administered intravenously. The provider orders the required medication and supplies from the pharmacy in advance, and generally brings a second "kit" in case additional medications are required or there is a problem with the first kit. Intravenous access is generally obtained in advance because people who have received chemotherapy may have poor venous access; making multiple attempts to obtain intravenous access with a needle at the time of the procedure can be distressing to patients and family alike.

24.4. Patients and family members may have ceremonies or activities planned, or they may want to play their favourite music before or during the procedure. While patients and families are appropriately emotional, MAID procedures are often not sombre affairs. Many patients tell stories or jokes, and the atmosphere is generally more similar to a "celebration of life" than what I generally see at the time of a natural death in acute hospitals and palliative care units.

24.5. I will not name the medications or the doses as this is a public document, but when the procedure starts, we administer a sedative to help the person to relax or sleep. We then administer a large dose of an intravenous anesthetic, which is generally sufficient to stop the person from breathing and eventually stops their heart or lowers their blood pressure to the point that the person is

DKT

no longer conscious. If this doesn't occur with the dose given, we can administer a second dose from the second "kit", but this is rarely required. Some providers may use a medication or potassium specifically to stop the heart at this point, but many do not. We also administer a muscle paralytic in order to suppress involuntary reflexes (e.g. vomiting, or diaphragmatic spasm) that would be unpleasant for the family and undignified for the patient. Once we are certain that the person's heart has stopped and will not restart, we pronounce the person dead. We remain with the family to support them for as long as required (and many providers follow-up in the days after the death) to ensure that they are coping with the loss. We then complete documentation and fulfill the reporting requirements mandated by law (which may involve a phone call to the oversight body, depending on the province).

24.6. The protocol used in Canada is straightforward, and complications are very rare. In one Canadian study of 3557 MAID cases,[73] only 1.2% reported difficulty with intravenous access or the need to administer an additional dose of anesthetic (which is not really a complication). In two cases, the patient experienced some pain on injection of the anesthetic (which is known to irritate the vein).

[73] Stukalin I, Olaiya OR, Naik V, et al. Medications and dosages used in medical assistance in dying: a cross-sectional study. *CMAJ Open* 2022; 10: E19-E26. 2022/01/20. DOI: 10.9778/cmajo.20200268.

PKI

3. The interaction between palliative care and medical assistance in dying.

(In this regard, please address at least the following, based on your experience, expertise and research in both palliative care and assisted dying:)

25. What does palliative care entail? Specifically:

25.1. *What kinds of medications are administered and what is the effect of these – from a medical perspective – on a patient's body, mind and quality of life?*

25.1.1. The World Health Organization defines Palliative Care as:[74]

25.1.2. *"...an approach that improves the quality of life of patients (adults and children) and their families who are facing problems associated with life-threatening illness. It prevents and relieves suffering through the early identification, correct assessment and treatment of pain and other problems, whether physical, psychosocial or spiritual."*

25.1.3. The term "Palliative Care" was coined in 1974 by Dr Balfour Mount in Canada, but Palliative Care has been provided in different settings through much of history. Hospices – institutions that care for the sick and dying – have existed for centuries. In the 19th century, Dr Edward Trudeau, who founded a tuberculosis sanitarium in New York State, famously explained that the role of the physician was "to cure sometimes, to relieve often, to comfort always."[75] The modern hospice movement was founded by Dame Cicely Saunders in the 1960s in England, and has grown from there to become an

[74] https://www.who.int/news-room/fact-sheets/detail/palliative-care

[75] https://medicine.yale.edu/news-article/to-comfort-always/

DKI

international initiative, and a recognized specialty or subspecialty of medical practice in many countries.

25.1.4. A palliative approach to care can have many elements, but it often aims to improve quality of life through (1) a focus on relief of physical, psychological and existential symptoms; (2) developing a comprehensive care plan that is focused on patient-centred goals; and (3) supporting family through the trajectory of illness, including end-of-life and bereavement. PC ideally involves an interdisciplinary approach, and can be provided in any setting – hospital, home, or outpatient. Although Palliative Care is often provided to people who are at or near the end of their life, it can be provided at any point in an illness trajectory, even when curative options are being pursued.

25.1.5. One cornerstone of high quality palliative care is the treatment of physical symptoms and suffering, which is frequently achieved with opioids and sedatives. For this reason, there is a common perception linking palliative care, opioids and death, with the result that many people believe that opioids routinely hasten death by suppressing respiratory drive and impairing consciousness. This perception drives a fear of opioids, a phenomenon sometimes called "opiophobia" (or "palliphobia", more broadly). It can be challenging to scientifically refute the perception that opioids hasten death, but there are some observational studies that are helpful here.

25.1.5.1. Multiple studies have looked at opioid doses in palliative populations, and found that higher

PKI

opioid doses were associated with a longer survival[76].

25.1.5.2. One ICU study found that when a hospital adopted a new end-of-life symptom management protocol with higher doses of opioids and sedatives than were previously used, there was no effect on the survival duration of their patients[77].

25.1.5.3. A large population study from Norway found that the proportion of the population receiving opioids or benzodiazepines increased significantly towards the end of life, but was different in different age groups. The authors concluded that the association of opioid and sedative use and death was likely due to confounding and not causation[78].

---

[76] Az Azoulay D, Hammerman-Rozenberg R, Cialic R, et al. Increasing opioid therapy and survival in a hospice. *J Am Geriatr Soc* 2008; 56: 360-361. 2008/02/07. DOI: JGS1536 [pii] 10.1111/j.1532-5415.2007.01536.x. ; Portenoy RK, Sibirceva U, Smout R, et al. Opioid use and survival at the end of life: a survey of a hospice population. *J Pain Symptom Manage* 2006; 32: 532-540. 2006/12/13. DOI: S0885-3924(06)00547-1 [pii] 10.1016/j.jpainsymman.2006.08.003 ; Thorns A and Sykes N. Opioid use in last week of life and implications for end-of-life decision-making. *Lancet* 2000; 356: 398-399. 2000/09/06. DOI: S0140-6736(00)02534-4 [pii]

[77] Chan JD, Treece PD, Engelberg RA, et al. Narcotic and benzodiazepine use after withdrawal of life support: association with time to death? *Chest* 2004; 126: 286-293. 2004/07/14. DOI: 10.1378/chest.126.1.286 126/1/286 [pii].

[78] Neutel CI and Johansen HL. Association between hypnotics use and increased mortality: causation or confounding? *Eur J Clin Pharmacol* 2015; 71: 637-642. DOI: 10.1007/s00228-015-1841-z.

PKI

25.1.5.4. Multiple prospective studies of opioids in patients with chronic lung disease (including randomized controlled trials) have shown improved symptoms with no evidence of increased mortality or other harms[79].

25.1.5.5. Multiple studies in patients with advanced lung disease have shown how symptom-targeted opioids do not suppress respiratory drive, but actually improve respiratory efficiency while improving symptoms[80].

---

[79] Currow DC, McDonald C, Oaten S, et al. Once-Daily Opioids for Chronic Dyspnea: A Dose Increment and Pharmacovigilance Study. *Journal of Pain and Symptom Management* 2011; 42: 388-399. DOI: 10.1016/j.jpainsymman.2010.11.021 ; Rocker G, Simpson C, Young J, et al. Opioid therapy for refractory dyspnea in patients with advanced chronic obstructive pulmonary disease: patients' experiences and outcomes. *CMAJ Open 2013DOI:109778/cmajo20120031* 2013 ; Currow D, Louw S, McCloud P, et al. Regular, sustained-release morphine for chronic breathlessness: a multicentre, double-blind, randomised, placebo-controlled trial. *Thorax* 2020; 75: 50-56. 2019/09/29. DOI: 10.1136/thoraxjnl-2019-213681 ; Verberkt CA, van den Beuken-van Everdingen MHJ, Schols J, et al. Effect of Sustained-Release Morphine for Refractory Breathlessness in Chronic Obstructive Pulmonary Disease on Health Status: A Randomized Clinical Trial. *JAMA Intern Med* 2020; 180: 1306-1314. 2020/08/18. DOI: 10.1001/jamainternmed.2020.3134.

[80] Abdallah SJ, Wilkinson-Maitland C, Saad N, et al. Effect of morphine on breathlessness and exercise endurance in advanced COPD: a randomised crossover trial. *Eur Respir J* 2017; 50. DOI: 10.1183/13993003.01235-2017 ; Hallenbeck J. Pathophysiologies of dyspnea explained: why might opioids relieve dyspnea and not hasten death? *J Palliat Med* 2012; 15: 848-853. 2012/05/19. DOI: 10.1089/jpm.2011.0167 ; Clemens KE and Klaschik E. Symptomatic therapy of dyspnea with strong opioids and its effect on ventilation in palliative care patients. *J Pain Symptom Manage* 2007; 33: 473-481. 2007/04/03. DOI: S0885-3924(06)00725-1 [pii] 10.1016/j.jpainsymman.2006.09.015 ; Estfan B, Mahmoud F, Shaheen P, et al. Respiratory function during parenteral opioid titration for cancer pain. *Palliat Med* 2007; 21: 81-86. 2007/03/09. DOI: 21/2/81 [pii] 10.1177/0269216307077328.

DKI

25.1.6. A detailed review of the limitations of observational studies is beyond the scope of this report, but it is important to understand that there is no evidence to support the idea that symptom-targeted opioids hasten death, or that reducing opioid doses in symptomatic patients nearing the end of life would prolong survival. On the contrary, multiple studies suggest the opposite- that when higher doses of symptom-targeted opioids are used, if anything, survival duration might actually increase.

25.2. *What is palliative sedation?*

25.2.1. Briefly, palliative sedation is an approach generally used in palliative care to manage suffering (e.g. pain) that is refractory to treatment. In that situation, it is considered an acceptable option (with patient or surrogate consent) to relieve the suffering by giving medications to reduce the consciousness of the person in a deliberate way to the point that they are no longer apparently suffering. Palliative sedation has important ethical and legal considerations because lowering a person's level of consciousness can shorten their life (e.g., if they vomit and aspirate their vomit, they could asphyxiate), but it is broadly considered acceptable to use palliative sedation to treat refractory symptoms in people with life-limiting disease so long as the intent is to relieve suffering and not to shorten life.

25.2.2. Palliative sedation is distinct from MAID, and ethically justified on the basis of the Doctrine of Double Effect (DDE). The DDE is a vital concept in end-of-life care ethics, recognizing that an action can have both a positive effect that is intended and desirable (e.g. relief of symptoms) and a negative effect that is foreseen but unintended (e.g. the potential for shortening life). The DDE holds that it is acceptable to perform an act that has this "double" effect. Lo and

DKI

Rubenfeld[81] identify four key considerations when invoking the DDE:

25.2.2.1. The act itself (e.g. giving opioids and sedatives) must be inherently morally acceptable.

25.2.2.2. The unintended effect (e.g. hastening death) must not be the means of achieving the intended effect (e.g relief of symptoms)- in other words, the DDE does not justify MAID.

25.2.2.3. The intended effect must be proportional to the unintended effect- in other words, a risk of death can only be justified if there is a substantial benefit at stake (e.g. relief of suffering in a dying person).

25.2.2.4. There must be no less harmful means of achieving the desired goal- in other words, the desire to achieve a good outcome does not justify the use of literally any medication at any dose.

25.2.3. In Canada, palliative sedation and MAID are both in common use for people approaching the end of life. Typically, palliative sedation would be used more for physical suffering in people who are days or short weeks away from a natural death, when the concern is that people might not maintain decisional capacity through the MAID assessment process, and are asking for more acute relief of distress. MAID, on the other hand, is used more for people with existential or psychological distress who are weeks or short months

[81] Lo B and Rubenfeld G. Palliative sedation in dying patients: "we turn to it when everything else hasn't worked". *JAMA* 2005; 294: 1810-1816. 2005/10/13. DOI: 10.1001/jama.294.14.1810.

DKI

from a natural death, when the concern is that their natural life expectancy is long enough that continuously sedating them would actually shorten life (due to a lack of nutrition and hydration). North American guidelines for palliative sedation generally indicate that it should only be used in the final days or short weeks of life, and only for existential distress in exceptional cases.[82]

25.2.4. I am providing these generalizations in order to explain how MAID and palliative sedation are used alongside one another in practice, and why the availability of palliative sedation does not address the suffering that prompts MAID requests. Some have argued that palliative sedation could be used earlier, and for existential distress. The European Association of Palliative Care recently published updated clinical and ethical guidelines on this,[83] which considered existential distress to be a valid indication for palliative sedation, and did not include any specific timeframe for the use of palliative sedation. They did recommend starting with light sedation and allowing the patient to awaken periodically to assess for symptom improvement or to eat or drink, but if the distress persisted, deep and continuous sedation would be indicated.

25.2.5. With great respect to those who developed these guidelines, I think it is clear that if you initiate deep, continuous sedation in someone

---

[82] de Graeff A and Dean M. Palliative sedation therapy in the last weeks of life: a literature review and recommendations for standards. *J Palliat Med* 2007; 10: 67-85. 2007/02/15. DOI: 10.1089/jpm.2006.0139 ; Dean MM, Cellarius V, Henry B, et al. Framework for continuous palliative sedation therapy in Canada. *J Palliat Med* 2012; 15: 870-879. 2012/07/04. DOI: 10.1089/jpm.2011.0498.

[83] Surges SM, Brunsch H, Jaspers B, et al. Revised European Association for Palliative Care (EAPC) recommended framework on palliative sedation: An international Delphi study. *Palliat Med* 2024; 38: 213-228. 2024/02/01. DOI: 10.1177/02692163231220225.

OKI

who has many months to live, and you do not provide hydration or nutrition, you cannot argue that this doesn't shorten life. In that context, palliative sedation would simply be a slow, protracted form of MAID, conducted without the usual procedural safeguards and oversight. It was this concern that drove Quebec to develop mandatory reporting for palliative sedation as well as MAID, although we do not yet have published data from this dataset.

25.3. *What are the limits of palliative care? Is control of pain to the satisfaction of a patient always possible?*

25.3.1. We know from multiple studies that palliative care consultation can significantly improve symptoms and quality of life in people with serious and advanced illness. But there is an important difference between improving symptoms and relieving them enough to forestall a MAID request. Meta-analyses (studies that combine the results of many studies) indicate that the effect of specialist palliative care consultation is significant but small for both physical symptoms and quality of life, and there is essentially no effect on mood symptoms.[84] Palliative Care is more effective when delivered as a multi-disciplinary intervention for many months, but even when this happens, a large proportion of patients do not experience a meaningful benefit in terms of either symptoms or quality of life.[85]

25.3.2. In fairness, published studies likely underestimate the effect of palliative care consultation for a variety of reasons that I will not

---

[84] Hui D, Heung Y and Bruera E. Timely Palliative Care: Personalizing the Process of Referral. *Cancers (Basel)* 2022; 14 2022/02/26. DOI: 10.3390/cancers14041047.

[85] Johnson MJ, Rutterford L, Sunny A, et al. Benefits of specialist palliative care by identifying active ingredients of service composition, structure, and delivery model: A systematic review with meta-analysis and meta-regression. *PLoS Med* 2024; 21: e1004436. 2024/08/02. DOI: 10.1371/journal.pmed.1004436.

DKI

review here. However, studies of patients enrolled in world-leading inpatient and outpatient palliative care programs show that despite receiving the best palliative care available, at least half experience moderate or severe physical or psychological suffering in the final days of life[86]. Thus, palliative care can *reduce* suffering, but sometimes not enough to deter them from requesting MAID. This may partly explain why roughly 20% of MAID procedures in Canada take place in a palliative care facility[87].

25.3.3. We also know that relatively few people request MAID for uncontrolled physical symptoms[88]. The most common reason for requesting MAID is existential distress, which can be variously defined but often relates to people being unable to perform activities that they consider meaningful or a loss of independence (which is what they indicate in our federal reports).[89] Severe existential

---

[86] Hui D, dos Santos R, Chisholm GB, et al. Symptom Expression in the Last Seven Days of Life Among Cancer Patients Admitted to Acute Palliative Care Units. *J Pain Symptom Manage* 2015; 50: 488-494. DOI: 10.1016/j.jpainsymman.2014.09.003 ; Pidgeon T, Johnson CE, Currow D, et al. A survey of patients' experience of pain and other symptoms while receiving care from palliative care services. *BMJ Support Palliat Care* 2016; 6: 315-322. 2015/03/07. DOI: 10.1136/bmjspcare-2014-000748 ; Clark K, Connolly A, Clapham S, et al. Physical Symptoms at the Time of Dying Was Diagnosed: A Consecutive Cohort Study To Describe the Prevalence and Intensity of Problems Experienced by Imminently Dying Palliative Care Patients by Diagnosis and Place of Care. *J Palliat Med* 2016; 19: 1288-1295. 2016/09/08. DOI: 10.1089/jpm.2016.0219.

[87] *Second Annual Report on Medical Assistance in Dying in Canada 2020.* 2021.

[88] Loggers ET, Starks H, Shannon-Dudley M, et al. Implementing a Death with Dignity program at a comprehensive cancer center. *The New England journal of medicine* 2013; 368: 1417-1424. 2013/04/12. DOI: 10.1056/NEJMsa1213398 ; supra note 87.

[89] Emanuel EJ, Onwuteaka-Philipsen BD, Urwin JW, et al. Attitudes and Practices of Euthanasia and Physician-Assisted Suicide in the United States, Canada, and Europe. *JAMA* 2016; 316: 79-90. DOI: 10.1001/jama.2016.8499; Loggers ET, Starks H, Shannon-Dudley M, et al. Implementing a Death with Dignity program at a comprehensive cancer center. *The New England journal of medicine* 2013; 368: 1417-1424. 2013/04/12. DOI: 10.1056/NEJMsa1213398 ; Ganzini L, Goy ER and Dobscha SK. Why Oregon

DFI

suffering can be found in up to 38% of people as they approach death[90], and we have little or nothing to adequately address it. A meta-analysis of psychotherapeutic interventions delivered for existential distress found that none of the main symptoms studied were improved by the interventions, and the long-term outcomes even suggested moderate harm to spiritual well-being, although this was only one study[91]. Some of the secondary symptoms studied showed small or moderate benefits immediately post-treatment, these findings were questionable.[92] More importantly, none of the benefits were still evident at short-term follow-up (3 months)[93].

25.3.4. I do not want to suggest that specialist palliative care and existential interventions are ineffective- they do work. And even a small improvement can be very meaningful when amplified over a large population, which justifies ongoing efforts to make such interventions available to all. But these studies explain why so many people request MAID despite receiving apparently high-quality and timely palliative services, and why we should not expect further increases in the availability of palliative services to substantially affect the incidence of MAID requests in countries where this data was collected.[94] Simply put, high quality palliative care (including

---

patients request assisted death: family members' views. J Gen Intern Med 2008; 23: 154-157. 2007/12/18. DOI: 10.1007/s11606-007-0476-x ; Third Annual Report on Medical Assistance in Dying in Canada 2021. 2022. Health Canada.

[90] Lo C, Panday T, Zeppieri J, et al. Preliminary psychometrics of the Existential Distress Scale in patients with advanced cancer. *Eur J Cancer Care (Engl)* 2017; 26 2016/10/26. DOI: 10.1111/ecc.12597.

[91] Bauereiss N, Obermaier S, Ozunal SE, et al. Effects of existential interventions on spiritual, psychological, and physical well-being in adult patients with cancer: Systematic review and meta-analysis of randomized controlled trials. Psychooncology 2018; 27: 2531-2545. 2018/06/30. DOI: 10.1002/pon.4829.

[92] Supra note 91.

[93] Ibid.

[94] Downar et al. CMAJ 2023 October 16;195:E1385-7. doi: 10.1503/cmaj.230259

DKI

psychosocial interventions) is not always sufficient to address the severe suffering that prompts requests for AD, and requests for AD should not be interpreted as a deficiency in the PC provided.

25.4. *Is there an inherent conflict between palliative care and assisted dying? Alternatively, do they share any characteristics or conceptual similarities?*

25.4.1. Palliative Care's focus on comfort and patient-defined goals, even at the expense of lifespan, would appear on the surface to be entirely compatible with MAID. Yet PC and AD have often had an antagonistic relationship, with many leaders in the field of PC expressing strong opposition to the legalization of AD for various reasons. In some countries where AD is legal, PC providers have come to accept and provide AD, or even take a leading role in developing policies around AD.[95] In others, PC providers remain steadfastly opposed to the legalization and provision of AD.[96]

25.4.2. Notably, the history of the hospice movement and of Palliative Care practice in general is one of patient-driven changes in practice and law, often without the support (and sometimes with the active resistance) of medical practitioners and organizations. For better or worse, patients and families have embraced the idea that quality of life is sometimes more important than quantity of life. Generally, this is not a dichotomy, and patients can pursue quality without compromising quantity. But when this cannot be achieved, Palliative Care providers work with the person to help them choose when and how they may wish to prioritize quality over quantity. This is the core ethos of Palliative Care, to the degree that Dr. Harvey Chochinov

---

[95] Gerson et al. J Pain Symptom Manage 2020;59:1287-1303 e1

[96] Ibid.

DKI

recently described it as a "Platinum Rule"[97] ("doing unto patients as they would want done unto themselves"). It is also the core ethos of MAID. The goal of the MAID provider, similar to the PC professional, is not to hasten death. The goal of each is to support choice.

25.4.3. MAID opponents in Palliative Care often perceive that some patients or family members resist a palliative approach to care (e.g. limiting life-sustaining measures, adding comfort medications) because of concerns that it would compromise survival. From this observation, they might assume that excluding MAID from Palliative Care settings and practice will make Palliative Care more acceptable to patients and family members. But while people may fear *unintentional* shortening of life when they are pursuing a cure or prolongation of life, they are deeply supportive of the right to request an *intentional* shortening of life when this is no longer realistic[98]. Fear of Palliative Care is not driven by a fear of legal MAID.

25.4.4. MAID and Palliative Care are not mutually exclusive options, as we have already seen. Studies of MAID recipients worldwide have routinely shown very high rates of PC involvement (70-90%)[99]. In the

---

[97] Chochinov HM. The Platinum Rule: A New Standard for Person-Centered Care. J Palliat Med 2022; 25: 854-856. 2022/03/02. DOI: 10.1089/jpm.2022.0075.

[98] 2022 poll: Support for medically assisted dying in Canada, https://www.dyingwithdignity.ca/wp-content/uploads/2022/05/DWDC_Ipsos_2022-Final-Report.pdf (2022, accessed February 27 2023); 7 in 10 Britons support assisted dying in latest Ipsos poll, https://www.ipsos.com/en-uk/7-10-britons-support-assisted-dying-latest-ipsos-poll (2022, accessed February 27 2023).

[99] Loggers ET, Starks H, Shannon-Dudley M, et al. Implementing a Death with Dignity program at a comprehensive cancer center. *The New England journal of medicine* 2013; 368: 1417-1424. 2013/04/12. DOI: 10.1056/NEJMsa1213398; Downar J, Fowler RA, Halko R, et al. Early experience with medical assistance in dying in Ontario, Canada: a cohort study. *CMAJ* 2020; 192: E173-E181. 2020/02/14. DOI: 10.1503/cmaj.200016 *Third Annual Report on Medical Assistance in Dying in Canada 2021*. 2022. Health Canada ; Dierickx S, Deliens L, Cohen J, et al. Involvement of palliative care in euthanasia practice in a

OKI

Netherlands, Palliative Care professionals are also the MAID assessors or providers in 60% of MAID cases. In Canada, Palliative Care teams have successfully integrated MAID into their practice,[100] and roughly 1 in 5 MAID procedures take place in a palliative care unit or hospice. This can be reassuring for those concerned that MAID might be driven by poor access to PC services. But it is notable that PC involvement generally precedes the MAID request by many weeks or months[101]. This suggests that PC is not merely being consulted by a medical team as a procedural step prior to performing MAID, but that the patients themselves are driving both. People who request or agree to involvement of the Palliative Care team are likely more accepting of their prognosis, and more willing to self-advocate for prioritizing quality of life over quantity of life. And herein lies a cognitive dissonance for Palliative Care professionals who are opposed to the legalization of MAID. It is well and good to invoke the "Platinum Rule" when people are *not* requesting MAID[102], but then we cannot immediately discard the Platinum Rule when a competent person *is* requesting MAID. A rule is not a rule if it is selectively applied or abandoned in order to achieve the result desired by the provider (i.e. no MAID).

25.5. *What has been the effect of the legalisation of assisted dying on palliative care services in Canada?*

---

context of legalized euthanasia: A population-based mortality follow-back study. *Palliat Med* 2018; 32: 114-122. 2017/08/30. DOI: 10.1177/0269216317727158.

[100] Wales J, Isenberg SR, Wegier P, et al. Providing Medical Assistance in Dying within a Home Palliative Care Program in Toronto, Canada: An Observational Study of the First Year of Experience. *J Palliat Med* 2018; 21: 1573-1579. 2018/08/11. DOI: 10.1089/jpm.2018.0175.

[101] Third Annual Report on Medical Assistance in Dying in Canada 2021. 2022. Health Canada.

[102] Chochinov HM. The Platinum Rule: A New Standard for Person-Centered Care. J Palliat Med 2022; 25: 854-856. 2022/03/02. DOI: 10.1089/jpm.2022.0075.

PKI

25.5.1.I have answered this in the slippery slope section above.

25.6. *How can, or do, palliative care and assisted dying work together in practice? How has assisted dying and palliative care been integrated in palliative care units in Canada?*

25.6.1. There are different ways of integrating MAID into palliative care in practice. Palliative care providers sometimes act as MAID assessors and providers for their own patients. I would estimate that approximately 1/4 of my own division does this, while the majority do not. I know of some groups where virtually all palliative care providers assess and provide MAID for their own patients; conversely, I know of other groups where nobody is an assessor or provider. Over time, many centres or regions have formed specialized MAID teams, which centralize and coordinate the process of assessment and provision. This team provides MAID to any eligible person in the facility or region (including palliative care units and hospices), with team members scheduled in rotation.

25.7. *Do you consider there to be a conflict between your ethical and professional duties as a medical professional and providing medical assistance in dying? Please explain your answer.*

25.7.1. I have never felt any conflict between my ethical and professional duties as a physician and providing MAID. For the reasons mentioned above, I feel that there are clear parallels between MAID and palliative care in terms of allowing patients to choose their threshold for prioritizing quality of life over quantity of life. Moreover, as a critical care physician, I am frequently involved in withdrawing life support as part of a consensual plan for providing comfort to someone with an incurable condition. I believe that the ethical

PEI

distinction between MAID and withdrawal of life support is small enough that I do not believe we can justify allowing one while banning the other. They both involve the performance of an act that we expect to result in death, with the consent of the patient (sometimes through a surrogate in the case of withdrawing life support), in the interest of ending suffering or promoting quality of life.

25.7.2. Conversely, I would have serious concerns about anyone other than a medical professional performing MAID assessment and provision. Clinicians, particularly those involved in critical care and end of life care, have considerable experience assessing capacity and discussing values with someone who is confronted by serious and terminal illness. We are also well-equipped to discuss prognosis and alternatives to MAID, and ensure that people have a realistic understanding of the potential benefits and risks of each option. Moreover, we are also able to provide, even at the last minute, many of these alternatives. We are also experienced with the medications used in MAID. Given our skillset and experience, I think it is highly preferable to have clinicians in this role rather than non-clinicians.

DKI

4. Based on your research, experience and expertise with regard to fears regarding suicide and suicide contagion:

26. *What is your experience of eligibility assessments for medical assistance in dying, and do you think they are sufficient to properly assess vulnerable patients?*

26.1. The term "vulnerable" is used ubiquitously in medicolegal circles and society as a whole, often without understanding the meaning or the consequence. When someone is "vulnerable", we are not saying that they are incapable of making decisions, or that they cannot be trusted to understand their own interests. We are saying that (for various reasons) they are at elevated risk of receiving something that they *don't* want, and they are at elevated risk of *not* receiving something that they *do* want. In such a situation, the correct response is not to restrict their decision-making; this only compounds their vulnerability. The correct response is to spend more time and attention with each person clarifying their values; ensuring that they understand their medical situation, the options available to them and the likely consequences of each one; and ensuring that they are able to communicate a rationale for picking one option over the other(s). In this sense, it is no different from obtaining informed consent for any other plan of treatment. Of course, MAID is more impactful than many other decisions, but we have to obtain informed consent for analogous decisions where the immediate or delayed consequence is death, such as a person who wishes to stop life-sustaining measures such as a ventilator or dialysis, or forego toxic chemotherapy when there may be chance to prolong life.

26.2. In my experience, MAID assessments are performed carefully and with great attention to ensuring that people have a clear understanding of their options. Patients themselves are invariably driving the process, while family members, friends and healthcare providers are often hesitant to

PCI

proceed. Of course, it is possible that some have been pressured to request MAID by others, but this would be very inconsistent with my own experience of seeing families generally opposed to a MAID request. In Canada, part of the assessment involves a physician speaking to the patient without family members present, which allows an opportunity to voice uncertainty. I also believe that MAID assessors and providers are able to identify when a person seems unsure or equivocal about their request, in which case they would pause and explore further.

26.3. I would also note that the standards used to assess capacity and identify coercion in MAID assessment are far higher than in any other aspect of medicine. Specifically, when we are making decisions on behalf of a critically ill person who is receiving life-sustaining measures such as mechanical ventilation, we are almost never able to communicate directly with the patient. Instead, we communicate with their substitute decision-maker (often a family member), who makes decisions on their behalf, ideally using their known values and instructions. If we are comfortable with the idea of life-ending decisions being left entirely in the hands of a family member, without any investigation into ulterior motives or potential gain, then I don't believe we can justify prohibiting MAID because we are worried that the same family member might be subtly coercing a competent patient.

27. *Describe the distinction (if any) between "conventional" suicidal thinking and the reasoning process involved in a rational decision to seek medical assistance in dying, including, from your clinical experience, differences in the behaviour of patients requesting medical assistance in dying compared with those who are suicidal.*

27.1. Medical assistance in dying (MAID) and unassisted suicide should be considered separate concepts. In terms of demographics, MAID typically involves both men and women equally, principally among the elderly (85%

PKI

are >65 years old), with very few cases among younger adults (~1% are under age 45). MAID recipients are relatively affluent or privileged members of the majority (Caucasian) culture, with higher education and social capital, who are usually in the final weeks or months of life, dying from cancer or neurodegenerative disease[6]. In contrast, unassisted suicide in Canada affects men more than three times as often as women, and is three times as common among indigenous people than non-indigenous people.[103] Unassisted suicide is also more common among adults under age 65, with relatively high rates seen among adults under age 50.[104] Most are affected by a combination of mental illness, substance use disorder, chronic pain or illness, trauma, marital breakdown, financial hardship, a major personal loss, and relatively reduced social/medical support[105]. People who seek MAID are typically well engaged in the healthcare system, and are more likely that the general population to be receiving palliative care before they die[106]. People who attempt suicide are more likely to be unconnected to healthcare and unwilling to seek help because of the stigma attached to mental illness[107].

27.2. Since MAID and suicide are so different in terms of demographics and circumstances, it is hard to draw a parallel between the risk of suicide and

---

[103] https://www150.statcan.gc.ca/n1/pub/99-011-x/99-011-x2019001-eng.htm#:~:text=The%20rate%20among%20First%20Nations,among%20those%20living%20off%20reserve.

[104] https://www.canada.ca/en/public-health/services/publications/healthy-living/suicide-canada-key-statistics-infographic.html

[105] Suicide: risks and prevention., https://www.canada.ca/en/public-health/services/suicide-prevention/suicide-risks-prevention.html (accessed May 5 2018).

[106] Emanuel EJ, Onwuteaka-Philipsen BD, Urwin JW, et al. Attitudes and Practices of Euthanasia and Physician-Assisted Suicide in the United States, Canada, and Europe. JAMA 2016; 316: 79-90. DOI: 10.1001/jama.2016.8499.

[107] Suicide: Risk and protective factors., https://www.cdc.gov/violenceprevention/suicide/riskprotectivefactors.html (accessed May 5 2018).

PKI

the desire for MAID. Efforts to prevent suicide typically focus on reducing risk factors for suicide, restricting the access to means of committing suicide impulsively (e.g. bridges, firearms, etc.), and treatment and counselling for mental illness. These all require specific policies, but none of these are impacted by legalizing MAID.

27.3. From my clinical experience, there are some important differences in the behavior of patients requesting MAID compared with those who are suicidal. Patients who are requesting MAID are often suffering from existential distress, but they are not *anhedonic*. In other words, they retain the ability to experience pleasure or joy- for example, they can fondly recall activities that give them pleasure, they enjoy telling stories about their younger days, and they enjoy the company of their friends and family and look forward to specific activities (e.g. going out to a favourite restaurant). They often seek out friends and family, seeking to deepen their emotional connections during the final period of their life. During an assessment, they will engage with the interviewer and often give long, detailed answers to questions. They demonstrate a good *range of affect*, which means that they will show a range of emotional responses to whatever they are talking about. They will laugh and smile at times, and they will cry at others, as appropriate. When explaining their request, they are able to explain their suffering in detail, usually with a clear rationale for what they value most in life, and why their current state of health was preventing them from experiencing a quality of life that they would want to prolong. Overall, a person who is eligible for MAID will be capable of experiencing a range of emotions and responses to stimuli, but their grievous and irremediable condition has caused them intolerable suffering, which makes their quality of life poor enough that they are requesting MAID. In my experience, they often resist or resent any suggestion that they are "suicidal", because they would typically prefer to live, if only their situation were different. They are looking to end their own life but would like the help of the medical

DKI

establishment and are willing to undergo the assessment process to do so. Their request is well-considered, not impulsive, and generally comes as little surprise to family and friends who know them well.

27.4. In contrast, people who are "conventionally" suicidal have a more pervasive form of suffering that often prevents them from experiencing pleasure (they are generally *anhedonic*)- they usually do not enjoy activities (even things that they previously took pleasure in doing), they usually do not talk about fond memories or reminiscences, and they usually don't have specific events or activities that they look forward to. They rarely seek the company of others, preferring solitude in general. During an interview, they may not engage with the interviewer, and either refuse to answer questions or give short answers with little detail. They often demonstrate a blunted range of affect, which means that their facial expression and tone of voice will change very little regardless of the topic. When explaining their suicidality, they will give short answers with little detail, often without being clear about the rationale behind their desire to end their own life. Overall, unlike patients who request MAID, suicidal patients often display only a limited range of emotions and responses due to distorted thinking brought on by depression, delusional disorders, or psychosis. They cannot see a way that their suffering will ever improve, even if they can't necessarily provide a good explanation for why they think it will never improve. They are looking to end their suffering and often don't want to involve the medical establishment or delay their death in any way. I should note that in some situations, suicidality is a product of anxiety or impulsivity, in which case they may not have the same degree of anhedonia or other features I mention above. In fact, as many as 50% of people who suicide do so without warning anyone or seeking professional help. This is another stark difference from MAID, in which the patient is typically well-engaged with the healthcare system and actively seeking the assistance of physicians with their request for MAID. People who suicide

DICT

with no (or little) warning are difficult to identify for obvious reasons, but they would also be easily distinguishable from those requesting MAID by the impulsivity of the request and the lack of a clear rationale.

27.5. In practice, a very small proportion of people who request MAID have a history of known suicidality or severe mental illness, in which case a psychiatric consultation can be helpful. For example, I was once involved in a case of a person who had swallowed bleach in a suicide attempt three years previously. They did not die and their suicidality had resolved, but as a result of the ingestion, they required multiple operations to repair and remove parts of their stomach and intestine that were damaged by the bleach. After three years, their intestine had never healed, the person continued to develop perforations in their intestine and serious infections as a result, and they had become bedbound and unable to leave hospital. The surgeons no longer felt that there was any surgical option available; the person would continue to receive intravenous antibiotics and nutrition, but was ultimately going to develop a complication (likely painful) that would not respond to treatment and cause them to die in the coming months. This person requested MAID rather than wait for such a complication. In speaking with the patient, it was clear that the circumstances were very different from those of the suicide attempt three years previously. They had regretted their suicide attempt and made a consistent effort to recover, both physically and psychologically. They had requested and undergone multiple operations, and been adherent to antidepressants and counselling to manage their depression. They wanted to live, and they were appropriately sad that they were going to die regardless of their efforts. They were choosing MAID as the more comfortable option compared with a natural death. Based on my assessment, I felt that this was very distinct from suicidality, and that the person was making a competent request for MAID. However, given the circumstances, I requested a psychiatric consultation to ensure that

PKI

someone with more psychiatric expertise agreed with my assessment, which they did.

28. *What is your opinion on whether medical assistance in dying will increase the rate of conventional suicides in the general population (i.e. the concept of suicide contagion)?*

28.1. Suicide contagion refers to the idea that one case of suicide might prompt others to commit suicide. Examples of this notion include the "Werther" effect, whereby a well-publicized suicide is followed by a cluster of suicides among individuals who identify with the grief of the deceased, often using the same methods[108]. The Werther effect is used to justify guidelines for the reporting of suicide cases. Others have suggested that suicide contagion could occur through the widespread use and acceptance of suicide, that "persons socialized in nations with relatively high rates of suicide are more likely to be exposed to suicidal role models, which provide positive definitions of suicide"[109]. This, in turn, would lead to an "increased inclination to suicide in others"[110]. In other words, legalizing assisted suicide would lead to an overall increase in suicide rate, so we should prohibit assisted suicide as a means of reducing or preventing unassisted suicide.

28.2. There are two problems with using suicide contagion as an argument in any discussion of MAID. First, the argument requires some conflation of the practice of MAID with unassisted suicide, since the imagined scenario would

---

[108] Kheriaty A. Social Contagion Effects of Physician-Assisted Suicide: Commentary on "How Does Legalization of Physician-Assisted Suicide Affect Rates of Suicide?". *South Med J* 2015; 108: 605-606. DOI: 10.14423/SMJ.0000000000000346.

[109] S. S and Kposowa AJ. The Association of Suicide Rates with Individual-Level Suicide Attitudes: A Cross-National Analysis. *Soc Sci Q* 2008; 89: 21.

[110] Jones DA and Paton D. How Does Legalization of Physician-Assisted Suicide Affect Rates of Suicide? *South Med J* 2015; 108: 599-604. DOI: 10.14423/SMJ.0000000000000349.

DKI

have to involve a case of legal MAID inspiring subsequent cases of unassisted suicide (presumably involving people who were not eligible for MAID). This scenario would be very unlikely, given what we know about MAID and unassisted suicide. As stated above, there is very little similarity in terms of circumstances or demographics to allow one group to identify with the other. Furthermore, most cases of MAID could not inspire others because they are not publicized, and the use of MAID at the end of life would often be known only to close friends and family members, while others would simply assume that it was a "natural death". The contagion model does not fit any of the typical features of MAID.

28.3. The second problem with the contagion argument is that it has never actually been demonstrated in any jurisdiction following the legalization of MAID, as indicated above. In most jurisdictions where MAID was legalized, suicide rates have actually decreased, and have certainly never increased more than similar jurisdictions that had not legalized MAID. Either way, in jurisdictions with the most notable increase in *use* of MAID (e.g. Canada, Netherlands, Belgium, Australia), suicide rates have either remained unchanged or fallen dramatically. If suicide contagion was a consequence of MAID, we couldn't have possibly seen these changes.

29. *As set out above, the position in South African law is that there are life-ending options (other than medical assistance in dying and other than those options available to the patient on his/her own like suicide) that are presently available to South African patients who are suffering and wish to die: these are the request for a doctor to withdraw or cease life-saving treatment or artificial feeding, or the refusal of life-sustaining treatment or artificial feeding. So too, a patient may choose to starve him/herself. A patient with capacity may choose any of these options.* ***In your opinion, should there be any difference between the assessment of capacity in the above circumstances and the assessment of capacity for purposes of medical assistance in dying? What is the position in practice?***

DKI

29.1. I have already answered this question above, but will expand briefly here. The four key elements of a capacity assessment are the same for any medical decision, and were outlined by Applebaum and Grisso.[111]

29.1.1. Ensuring that the person has the ability to communicate stable choices long enough for them to be implemented.

29.1.2. Ensuring that the person can understand relevant information about a treatment decision, including the potential risks and benefits (and the probability of them occurring).

29.1.3. Ensuring that the person appreciates the situation they are in, and the probable consequences of receiving or refusing a given treatment. Part of this involves ensuring an understanding of the person's values, and how those values inform the decision they are making.

29.1.4. Ensuring that people can "manipulate information rationally", which involves comparing the benefits and risks of different options.

29.2. There are many factors that might impair decisional capacity, which I will not review here. However, clinicians involved in treating people with advanced or incurable illness are often required to assess a person's capacity to consent to decisions or treatments that might result in death (either immediately or delayed), such as stopping chemotherapy; withdrawing life-sustaining measures such as mechanical ventilation or hemodialysis; continuous palliative sedation; or voluntarily stopping eating and drinking. The common concerns that are raised about assessing capacity to request MAID (e.g. depression related to a poor prognosis, impaired cognition due to

---

[111] Appelbaum PS and Grisso T. Assessing patients' capacities to consent to treatment. *N Engl J Med* 1988; 319: 1635-1638. 1988/12/22. DOI: 10.1056/NEJM198812223192504.

PKI

medications, coercion by family members) are equally applicable to these requests. In my experience, MAID assessors spend far more time and attention ensuring decisional capacity than clinicians spend on any other analogous decision, which is reassuring to me. The fact that each assessment is performed in duplicate is even more reassuring.

29.3. Ultimately, capacity assessment is subjective; there is no way to objectively prove that someone has or doesn't have decisional capacity. There are rare occasions where two assessors may disagree about whether a person is capable of requesting MAID, but in most cases, this disagreement can be resolved through discussion or reassessment. This is no different from capacity assessments for the other types of decisions mentioned above. In short, if we accept that clinicians can assess capacity for those decisions, then we cannot justify a double standard for MAID decisional capacity.

30. *In relation to the practice of a patient voluntarily stopping eating and drinking (self-starvation) among patients seeking to end their life:*

30.1. *Describe the practice of the deliberate hastening of death by a patient by stopping eating and drinking. Please describe the effects this in terms of its impact on the body and mind of the patient and the stages and developments by which it leads to a patient's death.*

30.2. *How long would the cessation of eating and drinking usually take before a patient dies?*

30.3. *What factors would shorten or lengthen the period of self-starvation required to achieve a patient's death by these means?*

30.4. *What, if any, sort of pain and other discomfort or distress would such a patient suffer in the course of pursuing self-starvation through to death?*

DKI

30.5. VSED is the act of deliberately and voluntarily stopping eating and drinking in order to achieve suicide. The early symptoms associated with VSED are hunger and thirst. Hunger is unpleasant, but can sometimes be managed with opioid medications (e.g. morphine), which slow or stop the peristaltic motion of the digestive tract and diminish the "pangs" of hunger. Thirst is more challenging to manage - lubricating or moistening the lips and gargling water can reduce the unpleasantness of a dry mouth, but this symptom is often unpleasant enough to end the attempt at VSED.[112]

30.6. Those who are able to follow through on VSED will eventually experience dehydration and possibly electrolyte imbalances such as low potassium, low phosphate and low magnesium.[113] These electrolyte abnormalities are all associated with unpleasant feelings of weakness, headaches and irritability. Dehydration leads to an elevation in serum sodium, which is associated with an intense desire to drink water. Eventually, VSED leads to delirium - a state of confusion and fluctuating level of consciousness during which the person may even request water and food, forgetting their previous conviction to VSED. This can be very distressing for caregivers, who have to choose between giving water to a thirsty person under their care, or respecting previously competent wishes to continue with VSED.[114] In some cases, if we respect their competent request to VSED, it is necessary to sedate people in order to relieve the suffering caused by electrolyte abnormalities and hunger.

---

[112] Quill TE, Ganzini L, Truog RD, et al. Voluntarily Stopping Eating and Drinking Among Patients With Serious Advanced Illness-Clinical, Ethical, and Legal Aspects. *JAMA Intern Med* 2018; 178: 123-127. 2017/11/09. DOI: 10.1001/jamainternmed.2017.6307.

[113] Eichelberger M, Joray ML, Perrig M, et al. Management of patients during hunger strike and refeeding phase. *Nutrition* 2014; 30: 1372-1378. 2014/10/05. DOI: 10.1016/j.nut.2014.04.007.

[114] Supra note 112 ; Gruenewald DA. Voluntarily Stopping Eating and Drinking: A Practical Approach for Long-Term Care Facilities. *J Palliat Med* 2018; 21: 1214-1220. 2018/06/06. DOI: 10.1089/jpm.2018.0100.

PKI

Ultimately, if the person continues with VSED, they will become unconscious and ultimately die.

30.7. It is important to distinguish VSED in patients who are close to a natural death from terminal illness from VSED in those who are still years away from a natural death. People who are close to a natural death are often in poor health, with diminished reserves of fat and muscle to provide the energy to sustain the brain and other vital organs. Reports of successfully managed VSED are largely limited to end of life scenarios[115] and they report a death within a matter of 10-14 days. People with acute illnesses such as infections (which are common among the terminally ill) would likely die sooner after VSED, because these acute illnesses increase the rate at which the fat and muscle reserves are consumed.

30.8. In contrast, people who are years from their natural death (even if they had stable chronic illness) would likely have sufficient reserves of fat and muscle to last much longer, and they would likely have a normal (or near-normal) appetite, leading to much more substantial suffering from hunger "pangs" and thirst. It is difficult to know how long a person in stable health could survive VSED, but it would likely be longer than 10-14 days.

30.9. People have occasionally suggested VSED as an alternative to MAID (in terms of relieving intolerable suffering for people with an advanced illness. In jurisdictions where MAID is illegal, VSED represents an opportunity for those with a grievous and irremediable illness (including intolerable suffering) to relieve their suffering through a deliberate act that hastens their death. In Canada, the role of VSED is harder to see. VSED clearly hastens death, and it is performed for the purpose of relieving suffering (physical, psychological or existential) that was bad enough to make the person not wish to continue

[115] Supra note 114.

PKI

living, in someone who would typically have a grievous and irremediable (but not necessarily terminal) medical condition. In other words, the rationale and ethical underpinning of the decision to VSED is *identical* to that of MAID. The only reason to use VSED instead of MAID would be for reasons of personal preference.

30.10. Moreover, I do not feel that VSED is an ethically superior option to MAID for situations of refractory suffering. All of the potential concerns raised about MAID (e.g. that the person merely has depression related to a poor prognosis, or impaired cognition due to medications, or is being coerced by family members) apply equally to someone seeking to hasten their death through VSED. There is also the additional concern that VSED has fewer safeguards (e.g. no reflection period, no second assessor, and no oversight or reporting) and VSED itself may cause discomfort. If we feel that a person is eligible and capable of consenting to VSED, the same logic would apply to MAID. If we don't think they are eligible and capable of consenting to MAID, then VSED should not be an option either.

31. *How is conscientious objection handled in Canada. In particular, may medical professionals conscientiously object to providing, or assisting in providing, medical assistance in dying and, if so, do they have any referral or other duties.*

31.1. In Canada, providers may choose not to participate in MAID as an assessor or a provider for religious or moral reasons, or simply because they don't have time or they feel that it is outside their area of expertise. At the same time, physicians have an obligation to limit the potential impact that their nonparticipation might have on their patients' right to access treatment that they are eligible for. Professional duties vary by province, but for most provinces there is a professional obligation to assist requesting patients to access MAID.

DKI

31.2. In Ontario, for example, our regulatory college has a policy on "Human Rights in the Provision of Health Services",[116] which indicates that physicians are obliged to provide their patients with information about options available to them, and cannot withhold or impede access to information about a treatment option (e.g. MAID) because it conflicts with their conscience or religious beliefs. Notably, objecting physicians must "...provide the patient with an effective referral in a timely manner to allow patients to access care...."

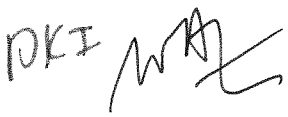
31.3. Many regions and provinces have established MAID coordination services that objecting physicians can refer to if they have no other options available. This helps to alleviate the burden on objecting physicians.

Dated: January 13, 2025

Signed: 

---

116 https://www.cpso.on.ca/en/Physicians/Policies-Guidance/Policies/Human-Rights-in-the-Provision-of-Health-Services



Department/School: Faculty of Medicine

21 March 2025

CURRICULUM VITAE

NAME:

DOWNAR, James, Full Professor

DEGREES AND CREDENTIALS:

Degrees:

2019	Advanced Health Leadership, University of Toronto, Ontario, Canada
2010	M.H.Sc Bioethics, University of Toronto, Ontario, Canada
2002	M.D.(C.M.), McGill University, Quebec, Canada
1998	BSc Biology, McGill University, Quebec, Canada

Credentials:

Certification, Royal College of Physicians and Surgeons of Canada, Ontario, from September 2009
Description: Critical Care Medicine
Certification, Royal College of Physicians and Surgeons of Canada, Ontario, from June 2007
Description: Palliative Care
Certification, Royal College of Physicians and Surgeons of Canada, Ontario, from June 2006
Description: Internal Medicine
Certification, Medical College of Canada, from October 2003

EMPLOYMENT HISTORY:

Academic Work Experience:

2021 –	Professor, Professor, Medicine, University of Ottawa, Ontario, Canada
2018 –	Head, Division of Palliative Care, Department of Medicine, Associate Professor, Medicine, University of Ottawa, Ontario, Canada
2018 – 2021	Associate Professor, Associate Professor, Medicine, University of Ottawa, Ontario, Canada
2016 – 2018	Associate Professor, Associate Professor, Medicine, University of Toronto, Ontario, Canada
2016 – 2018	Program Director, Subspecialty Residency Training Program, Associate Professor, Medicine, University of Toronto, Ontario, Canada
2015 – 2017	Chair, Transitional Palliative Care Committee, Assistant Professor, Family and Community Medicine, University of Toronto, Ontario, Canada
2015 – 2017	Program Coordinator, Conjoint Subspecialty Palliative Care Residency Program, Assistant Professor, Family and Community Medicine, University of Toronto, Ontario, Canada
2012 – 2016	Assistant Professor, Assistant Professor, Medicine, Faculty of, University of Toronto, Ontario, Canada
2012 – 2012	Interim Program Director, Conjoint Subspecialty Palliative Care Residency Program, Lecturer, Family and Community Medicine, University of Toronto, Ontario, Canada

2009 – 2012 Lecturer, Lecturer, Medicine, University of Toronto, Ontario, Canada

Non-academic Work Experience:

2023 –	President, Canadian Critical Care Society
2022 –	Lead, Hospital-Based Models of Care (Adult), Ontario Health
2017 –	Co-Chair and Founder, Pan-Canadian Palliative Care Research Collaborative
2021 – 2023	Treasurer, Canadian Critical Care Society
2019 – 2021	Secretary, Canadian Critical Care Society
2014 – 2016	Faculty, Canadian Foundation for Healthcare Improvement
2013 – 2013	Advisor, LEAP 2 Curriculum, Pallium Canada
2012 – 2013	Palliative Care Advisor, Critical Care Secretariat Long-Term Ventilation Toolkit, Government of Ontario, Ontario, Canada
2012 – 2018	Active Staff, University Health Network/Mount Sinai Hospital
2009 – 2012	Clinical Assistant, Toronto General Hospital, Ontario, Canada
2008 – 2009	Physician Instructor, Canadian Resuscitation Institute
2006 – 2011	Courtesy Staff, Toronto East General Hospital, Ontario, Canada
2006 – 2008	Courtesy Staff, St. Michael's Hospital, Ontario, Canada

HONOURS:

2025	King Charles III Coronation Medal, Recognition of contributions to Palliative Care in Canada, Governor General of Canada
2021	Award of Excellence, Ontario Medical Association - Palliative Care Section
2020	Presidents Award of Excellence, WeRPN
2017	Palliative Care Innovation Award, Canadian Foundation for Healthcare Improvement
2016	Health Professional Award, World Federation of Right to Die Societies
2015	William J. Sibbald Visiting Professorship, Named in honour of a renowned ICU Physician, researcher and mentor. This award includes an invitation to give lectures as part of a visit to the University of Western Ontario, University of Western Ontario, Ontario, Canada
2014	Wightman-Berris Award for Teaching Excellence, Award for teaching at the Postgraduate Level, University of Toronto, Ontario, Canada
2013	Don Wasylenki Award for Social Responsibility, Award given for extensive educational interventions in Kuwait, University of Toronto Department of Psychiatry
2013	Honour your hero 2013, Awarded by patient or family member for care provided, University Health Network, Ontario, Canada
2012	Palliative Medicine Residency Program- Outstanding Teacher Award 2012, Awarded annually to the top 3 teachers in the division of palliative medicine, as voted by the graduating subspecialty residents, University of Toronto, Ontario, Canada
2012	Excellence in Teaching Award - New Faculty, Awarded to newly-appointed staff on the basis of teaching evaluations, University Health Network, Ontario, Canada
2011	Palliative Medicine Residency Program- Outstanding Teacher Award 2011, Awarded annually to the top 3 teachers in the division of palliative medicine, as voted by the graduating subspecialty residents, University of Toronto, Ontario, Canada

PCI

2011	Exceptional Peer Review Letter of Recognition, My review of a submitted manuscript was given their top rating (5/5), Canadian Medical Association Journal
2008	Resident Research Award, Physician's Services Incorporated (PSI)
2008	Best Oral Presentation Award in Clinical Science, Division of Critical Care Medicine Annual Research Day, University of Toronto, Ontario, Canada
2007	Spanier Award for Oral Research Abstract Presentation, Critical Care Canada Forum
2007	Resident Research Award, Physician's Services Incorporated (PSI)
2006	Outstanding Housestaff Award, Mount Sinai Hospital, Ontario, Canada
2005	Anderson Award for Teaching Excellence, Annual award for teaching excellence in the ASCM course, University of Toronto, Ontario, Canada
2005	Sopman Humanitarian Award, Awarded to housestaff on the basis of humanitarian behaviour, University Health Network, Ontario, Canada

SCHOLARLY and PROFESSIONAL ACTIVITIES:

Editorial Activities

2023 –	Section Editor, Current Oncology
2016 –	Editorial Board Member, Palliative Medicine

Expert Witness Activities

2022 –	Expert Witness, Expert witness for the defence of a physician charged with four counts murder over the care he provided to patients during the COVID-19 pandemic. The physician was acquitted but the ruling is being appealed
2020 – 2020	Expert Witness, Gave an expert report and witness testimony for the plaintiff regarding the use of "Reasonably Forseeable Death" as a criterion for eligibility for Medical Assistance in Dying. My testimony was heavily cited in the decision, which found for the plaintiff.doi:https://www.canlii.org/fr/qc/qccs/doc/2019/2019qccs3792/2019qccs3792.html
2019 – 2019	Expert Witness, Gave an expert report for the plaintiff regarding voluntarily stopping eating and drinking (VSED). This case ultimately was dropped by the plaintiff, and did not go to trial

LIFETIME FUNDING:

- Total amount of funding received $73,978,878.00
  As Principal Investigator $13,068,616.00

EXTERNAL RESEARCH FUNDING:

Date(s)	Source	Type	Investigator	Amount
2025/4 - 2026/4	Ottawa Hospital Academic Medical Organization (The) (TOHAMO) Title: The impact of language concordant care on outcomes of long-term care patients with stroke in the emergency department Program:	Type: Grant Purpose: Operating	My Role: Principal Investigator	Funding Total: $96,000

PKI

Date(s)	Source	Type	Investigator	Amount
	Innovation Fund			
2025/4 - 2026/3	Ottawa Hospital Academic Medical Organization (The) (TOHAMO) Title: Patient-centred pain control – using Scrambler Therapy to treat chronic nerve pain during dialysis: a phase 2 proof-of-concept clinical trial. Program: Innovation Fund	Type: Grant Purpose: Operating	My Role: Principal Applicant	Funding Total: $97,950
2025/2 - 2026/6	Canadian Institutes of Health Research (CIHR) Title: PSYCHED-PAL: Psilocybin microdose for psychological distress in patients with advanced illness: A phase 3 double-blind, placebo-controlled, parallel-arm clinical trial Program: Accelerating Clinical Trials (ACT) Initiative	Type: Grant Purpose: Operating	My Role: Principal Investigator Co-applicant: Justin Sanders, Danielle Kain, Craig Goldie, Arnell Baguio, Martin Chasen, Ann Boyle, Claudio Soares, Tim Ramsay Collaborators: Julie Lapenskie	Funding Total: $498,272
2025/1 - 2029/12	Canadian Cancer Society Title: Transforming Palliative Care for People Living with Advanced Cancer: Developing a National Research Platform Program: Breakthrough Team Grant	Type: Grant Purpose: Operating	My Role: Principal Investigator Co-applicant: Julie Lapenskie, Joshua Black, Paul Daeninck, Jonathan Downar, Andrea Feldstain, Bruno Gagnon, Catherine Goldie, Peter Greenstreet, Diane Guay, Philippa Hawley, Paul Hebert, Leonie Herx, Zhimeng Jia, Danielle Kain, Christian La Riviere, Caitlin Lees, John Marshall, Kate Nelson, Stuart Nicholls, Jana Pilkey, Tim Ramsay, Julia Ridley, Justin Sanders, Jessica Simon, Aynharan Sinnarajah, Amol Verma, Dong Vo, Pete Wegier	Funding Total: $5,899,008

DKI

Date(s)	Source	Type	Investigator	Amount
2024/5 - 2027/4	Ministère de la Santé et des Services sociaux (Québec) Title: Better understanding the use of MAID in the Quebec context. Program: Other	Type: Grant Purpose: Operating	My Role: Collaborator Co-applicant: Payot, A, Gaucher, N, Dorval, M, Guay, M, Souliere, M, Hebert, J, Bourgeois-Guerin, V, Lapierre, S, Lavoie, B, Bernier, L, Leclerc-Loiselle, J, Champagne, E, Simard, C, Hebert, M, Dumont, I, Lessard, S, Ummel, D, Dumas, M, Bourque, C, Gupta, M, Guay, D, Bravo, G, Godard-Sebillotte, C, Dupre, N, Vissandjee, B, Sanders, J, Olivier-d'Avignon, M, Allard, E, Chenard, J, Nguyen, O, Gagnon, B, Moreau, M, Crnich-Cote, T, Durivage, P, Lussier, D, Dion, D, Morissette, G, Perron, C, Martisella, M, Richard-Freve, E, Gagne, MA, Petit, E, Smele, S, Lamothe, G, Laperle, P, Rouly, G Collaborators: Marchand, MH, Giroux, M, Bromwich, C, Cote, A, Marcoux, I, Laflamme, J, Dupuis, J, Carmichael, F Principal Investigator: Bouthillier, M-E, Marcoux, I, Perron, C	Funding Total: $920,570
2024/3 - 2027/3	Bruyère Academic Medical Organization (BAMO) Title: Patient-centered pain control-using Scrambler Therapy to treat chronic nerve pain: a phase 2 proof-of-concept clinical trial. Program:	Type: Grant Purpose: Operating	My Role: Co-applicant Co-applicant: Bruni, A, Isenberg, S, Polskaia, N, Lapenskie, J, Davis, J Principal Applicant: Warmels, G, Cohen, L	Funding Total: $99,866

PKI

Date(s)	Source	Type	Investigator	Amount
	Innovation Grant			
2024/1 - 2028/1	Canadian Institutes of Health Research (CIHR) Title: Improving subacute-to-home transitions for patients receiving a palliative approach to care (ACEPATH-Bruyère) Program: CIHR New Investigator Salary Award: Health System Impact Embedded Early Career Researcher Award	Type: Grant Purpose: Operating	My Role: Co-investigator Principal Investigator: Isenberg, SR	Funding Total: $400,000
2023/3 - 2026/2	Canadian Institutes of Health Research (CIHR) Title: Building system capacity for home visits for patients near the end of life: A mixed methods study Program: Project Grant: Fall 2022	Type: Grant Purpose: Operating	My Role: Collaborator Co-applicant: Arya, A, Bennett, C, Buchman, S, Howard, M, Kendall, C, Klinger, C, Lamanna, M, Manuel, D, Marshall, D, Ponka, D, Scott, M, Seow, H, Sinnarajah, A, Tanuseputro, P, Thavorn, K, Webber, C Collaborators: Bryant, D, Cargill, DC, Cooper, D, Drok, R, Lachance, J, Lovell, J, Oikonen, K, Petersen, L, Roberts, B, Spencley, M, Wilkes, K, Yaternick, W Principal Applicant: Isenberg, SR, Hsu, A	Funding Total: $443,701
2023/3 - 2024/2	Canadian Institutes of Health Research (CIHR) Title: Guiding Prospective policy development to increase end-of-life home visits with economic evaluations using real-world data Program:	Type: Grant Purpose: Operating	My Role: Co-knowledge User	Funding Total: $149,981

DKI

Date(s)	Source	Type	Investigator	Amount
	Catalyst Grant: Policy Research for Health System Transformation			
2023/1 - 2026/1	Canadian Institutes of Health Research (CIHR) Title: Accelerating Clinical Trials (ACT) Program: Pan-Canadian Clinical Trials Consortium	Type: Grant Purpose: Operating	My Role: Co-applicant Co-applicant: Clark, W, Garg, A, Fergusson, D, Grimshaw, J, Harvey, V, Hohl, C, Joyes, C, Marlin, S, Nicholis, S, McDonald, E, Pilote, L, Richer, L, Rouleau, G Principal Applicant: Devereaux, P.J.	Funding Total: $38,996,931
2022/9 - 2026/8	Canadian Institutes of Health Research (CIHR) Title: Advancing the Care Experience in Palliative care patient Transitions from hospital to Home (ACE-PATH). Program: Team Grant: Transitions in Care	Type: Grant Purpose: Operating	My Role: Co-applicant Principal Applicant: Sarina Isenberg, Ed Fitzgibbon, Nathalie Gilbert, Michelle Kornberg, Jill Rice	Funding Total: $655,156
2022/8 - 2026/8	Canadian Institutes of Health Research (CIHR) Title: Supporting long term care residents through transitions to acute care hospital and end-of-life care with personalized prognoses and electronic decision support tools. Program: Transitions in Care (TiC)-Phase 2 Team Grant	Type: Grant Purpose: Operating	My Role: Co-applicant Co-applicant: Manuel D, Webber C, Ronksley P, Presseau J, Wegier P, Wilson K, Isenberg SR, Shamon S, Ramsay T Collaborators: Burr T, Durant S Principal Applicant: Kobewka D, Hsu A, Kaasalainen S, Tanuseputro P, Kierulf J, Gaudreau Simard M, Fung C, Robert B Principal Knowledge User: Diedrich K	Funding Total: $959,987

PKI

Date(s)	Source	Type	Investigator	Amount
2022/4 - 2026/3	Canadian Institutes of Health Research (CIHR) Title: Evaluating palliative and end-of-life care for Canadians living with schizophrenia Program: Project Grant	Type: Grant Purpose: Operating	My Role: Co-applicant Co-applicant: Webber C, Mahar A, Isenberg S, Bolton J, Bonares M, Buchman D, Bush S, Chochinov H, Edwards J, Franck C, Hatcher S, Kurdyak P, Lawlor P, Li W, Solmi M, Wellman M Collaborators: Boudreau E, Miller S, Moore V, Summerville C, Thorpe K Principal Applicant: Tanuseputro P, Fiedorowicz J	Funding Total: $428,400
2022/4 - 2026/3	Canadian Institutes of Health Research (CIHR) Title: Continuity of care at the end of life: Describing patterns, experiences and outcomes and finding optimal ways to capture. Program: Project Grant	Type: Grant Purpose: Operating	My Role: Co-applicant Co-applicant: Tanuseputro P, Webber C, Hsu A, Jones A, Gallagher E, Manuel D Principal Applicant: Howard M, Isenberg S	Funding Total: $336,600
2021/8 - 2025/7	Canadian Institutes of Health Research (CIHR) Title: Advancing personalized health decisions for end-of-life through Implementation Science. Program: CIHR Team Grant: Personalized Health	Type: Grant Purpose: Operating	My Role: Collaborator	Funding Total: $1,998,900
2021/7 - 2022/12	The Foundation for Advanced Family Medicine Title: The College of Family Physicians of Canada COVID-19 Pandemic Response	Type: Grant Purpose: Operating	My Role: Co-investigator Co-applicant: Webber C, Isenberg SR, Downar J, Milani C, Qureshi	Funding Total: $219,876

PICI

Date(s)	Source	Type	Investigator	Amount
	& Impact Grant Program Program: (Co-RIG Program Phase II)		D, Kobewka D, Hsu A, Lau J, Seow H, Sinnarajah A, Hannon B, Boyd H, Arya A Principal Applicant: Tanuseputro P	
2021/6 - 2026/3	Health Canada Title: Supporting the Pan-Canadian Palliative Care Research Collaborative (PCPCRC) Program: Special Projects	Type: Grant Purpose: Operating	My Role: Principal Investigator	Funding Total: $3,010,278
2021/4 - 2024/9	Canadian Institutes of Health Research (CIHR) Title: Project Grant Program: Project Grant	Type: Grant Purpose: Operating	My Role: Principal Investigator Co-applicant: Ailon, J, Barwick, M, Bhimji, K, Buchman, S, Caraiscos, V, Cargill, D, Chasen, M, Gratton, V, Gupta, M, Halligan, R, Herx, L, Isenberg, S, Jamieson, T, Kennette, W, Kobewka, D, Lapenskie, J, Lawlor, P, Mersmann, S, Munene, P, Murphy, R, Rowan, D, Tanuseputro, P, Webber, C Collaborators: Blocki, B, Hett, S, Iyengar, A, Schrierer, G, Van Manen, L, Varga, P	Funding Total: $719,101
2021/4 - 2024/3	Canadian Institutes of Health Research (CIHR) Title: Virtual Palliative Care: A Natural Experiment in Models of End of Life Care During the Covid-19 Pandemic Program: Project Grant	Type: Grant Purpose: Operating	My Role: Co-investigator Co-investigator: S Isenberg, P Tanuseputro, S Bhatia, P Kurdyak, K Kyeremanteng, D Lee, N Stall, T Stukel, D Vincent Principal Applicant: C Bell, K Quinn	Funding Total: $510,000

DKI

Date(s)	Source	Type	Investigator	Amount
2021/4 - 2024/3	Ottawa Hospital Academic Medical Organization (The) (TOHAMO) Title: Innovation Grant Program: Innovation Grant	Type: Grant Purpose: Operating	My Role: Principal Investigator Co-applicant: Lawlor, Peter, Bush, Shirley, Vanderspank, Brandi, Cohen, Leila, Kanji, Salmaan, Lascelle, Debi, Doctorow, Roslyn, Lapenskie, Julie, Lelievre, Natasha	Funding Total: $98,081
2021/4 - 2024/3	Bruyère Academic Medical Organization (BAMO) Title: Innovation Grant Program: Innovation Grant	Type: Grant Purpose: Operating	My Role: Principal Investigator Co-applicant: Parsons, Henrique, Bush, Shirley, Vanderspank, Brandi, Cohen, Leila, Wolfe, Amanda, Lascelle, Debi, Doctorow, Roslyn, Lapenskie, Julie, Lelievre, Natasha	Funding Total: $98,412
2021/4 - 2022/3	Canadian Institutes of Health Research (CIHR) Title: Project Grant Program: Project Grant – Priority Announcement, Patient-Oriented Research	Type: Grant Purpose: Operating	My Role: Principal Investigator Co-applicant: Bush, S, Cohen, L, Doctorow, R, Herx, L, Hughes, J, Iqbal, M, Lapenskie, J, Lau, J, Lelievre, N, Simon, J, Sinnarajah, A, Vanderspank, B, Wolfe, A, Zimmermann, C	Funding Total: $100,000
2021/3 - 2024/2	Canadian Institutes of Health Research (CIHR) Title: Palliative care at the end of life among patients with cancer before and during COVID-19 pandemic Program: COVID-19 initiative	Type: Grant Purpose: Operating	My Role: Co-investigator Co-investigator: Booth, C, Fowler, R, Iqbal, J, Herx, L, Krzyzanowska, M, Lau, J, Le, LW, Moineddin, R, Rodin, G, Seow, H, Tanuseputro, P Collaborators: Ailon, J, Bezansen, K, Del Paggio, J, Earle, C, Mackay, H, Samawi, H	Funding Total: $423,045
2020/11	Ontario Research Fund (ORF)	Type:	My Role:	Funding Total:

OKI

Date(s)	Source	Type	Investigator	Amount
- 2023/1	Title: A Translational Platform for Transcranial Magnetic Stimulation in Novel Patient Population Program: JELF-Unaffiliated	Grant Purpose: Operating	Principal Investigator	$191,320
2020/11 - 2021/11	Canadian Institutes of Health Research (CIHR) Title: The Canadian Network of COVID-19 Clinical Trials Network Program: Network Grant	Type: Grant Purpose: Operating	My Role: Co-investigator Co-applicant: Archambault, P, Begin, P, Cuthbertson, B, Dos Santos, C, Gregson, D, Jerath, A, Liaw, P, Mehta, S, Muscedere, J, Pinto, A, Robitaille, N, Samis, S, Verma, A, Arnold, D, Callum, J, Daley, P, Haworth-Brockman, M, Kahn, S, Maslove, D, Mertz, D, Paprica, P, Piquette, D, Rochwerg, B, Schull, M, Schull, M, Wuerz, T, Boyd, J, Cheung, A, De Guise, M, Forgie, S, Henry, B, Lacaze-Masmonteil, T, McGeer, A, Mills, E, Parsons Leigh, J, Razak, F, Rodger, M, Seely, A, Zemek, R, Burns, K, Choong, K, Devine, D, Fralick, M, Herridge, M, Lellouche, F, McGrail, K, Mittmann, N, Patrick, D, Rewa, O, Salvadori, M, Straus, S Principal Applicant: Fowler, R, Binnie, A, Daneman, N, Goligher, E, Lawler, P, McDonald, E, Russell, J, Zarychanski, R, Adhikari, N, Chasse, M, Fiest, K, Kho, M, Lee, T, Menon, K, Tsang, J, Bagshaw, S, Cook, D, Fox-Robichaud, A,	Funding Total: $4,000,000

PKI

Date(s)	Source	Type	Investigator	Amount
			Lamontagne, F, Marshall, J, Murthy, S, Turgeon, A	
2020/8 - 2021/7	The Foundation for Advancing Family Medicine Title: The College of Family Physicians of Canada COVID-19 Pandemic Response & Impact Grant Program Program: Co-Rig Program Phase 1	Type: Grant Purpose: Operating	My Role: Principal Investigator Collaborators: Sauls R, Boissonneault R, Boyd H Principal Investigator: Tanuseputro, P, Isenberg S, Lau J, Hsu A, Kobewka D	Funding Total: $112,752
2020/6 - 2021/6	Hamilton Academic Health Sciences Organization Title: Propranolol as an anxiolytic to reduce the use of sedatives for critically-ill adults receiving mechanical ventilation: an open-label randomized controlled trial (PROACTIVE) Program: AFP Innovation Grant 2020/21 - COVID-19	Type: Grant Purpose: Operating	My Role: Principal Investigator Co-applicant: Lapenskie J Co-investigator: Isenberg S, Bigham B	Funding Total: $74,580
2020/6 - 2021/6	Ottawa Hospital Academic Medical Organization (The) (TOHAMO) Title: Surveillance of Critical Care Outcomes during implementation of Ontario's ICU Triage Recommendations During the COVID-19 Pandemic Program: COVID-19 Innovation Grant	Type: Grant Purpose: Operating	My Role: Principal Investigator Co-applicant: Lapenskie J, Pryzbylak-Brouillard A Co-investigator: Tanuseputro P, Isenberg S, Hsu AT	Funding Total: $98,000
2020/6 - 2021/5	Canadian Institutes of Health Research (CIHR) Title: Canadian COVID-19 Prospective Cohort Study (CanCOV) Program: COVID-19 Rapid Research	Type: Grant Purpose: Operating	My Role: Co-investigator	Funding Total: $2,112,500

DKI

Date(s)	Source	Type	Investigator	Amount
2020/4 - 2021/3	Bruyere Academic Medical Organization Title: Identifying Genetic Factors Impacting Opioid Response in the Palliative Care Population Program: Academic Incentive Fund	Type: Grant Purpose: Operating	My Role: Co-investigator	Funding Total: $20,000
2020/3 - 2025/3	Bruyère Academic Medical Organization (BAMO) Title: Psilocybin for psychological and existential distress in palliative care Program: BAMO	Type: Grant	My Role: Principal Investigator Co-applicant: Jill Rice, Christine Watt, Shirley Bush, Peter Lawlor, Colleen Webber, Julie Lapenskie, Amanda Wolfe	Funding Total: $90,850
2020/3 - 2025/3	Ottawa Hospital Academic Medical Organization (The) (TOHAMO) Title: Psilocybin for Psychological and Existential Distress in Palliative care Program: TOHAMO	Type: Grant	My Role: Principal Investigator Co-applicant: Ed Fitzgibbon, Paula Enright, Henrique Parsons, Colleen Webber, Julie Lapenskie	Funding Total: $98,200
2020/1 - 2020/12	Canadian Institutes of Health Research (CIHR) Title: Planning and Dissemination Grant - Institute Community Support Program: Planning and Dissemination Grant-Institute Community Support	Type: Grant	My Role: Principal Investigator Co-applicant: Deborah Dudgeon, Jenny Lau, Kimberlyn McGrail, Ayn Sinnarajah, Colleen Webber Co-knowledge User: Genevieve Turmel, Christoher Klinger, Julie Lachance, Debi Lascelle	Funding Total: $19,716
2019/11 - 2021/3	Canadian Foundation for Healthcare Improvement Title: Spread and scale of modified Hospital	Type: Grant Purpose: Operating	My Role: Principal Investigator	Funding Total: $115,800

PKI

Date(s)	Source	Type	Investigator	Amount
	One Year Mortality Rate project Program: Bridge Funding			
2019/11 - 2020/10	Centre for Aging and Brain Health (CABHI) Title: Implementing an automated clinical surveillance tool in a rural hospital to screen for unmet palliative need in the final year of life Program: SPARK	Type: Grant Purpose: Operating	My Role: Principal Investigator Co-applicant: Lapenskie J Co-investigator: Wegier P, Rowan D Co-knowledge User: Menard L Principal Knowledge User: Mersmann S	Funding Total: $50,000
2019/9 - 2021/3	Canadian Cancer Society Title: Transcranial Magnetic Stimulation for psychological distress in patients with advanced cancer Program: Innovation Grant	Type: Grant	My Role: Principal Investigator	Funding Total: $187,205
2019/6 - 2021/3	Ottawa Hospital Academic Medical Organization (The) (TOHAMO) Title: ICU BEREAVE: An early bereavement support program for family members of patients who die in the intensive care unit. Ontario Ministry of Health and Long-Term Care Program: Innovation Fund	Type: Grant	My Role: Principal Investigator	Funding Total: $200,000
2019/6 - 2020/12	National Centres of Excellence. Canadian Frailty Network - 2019 Knowledge Translation Grant Title: Use of an automated prospective clinical	Type: Grant	My Role: Principal Investigator	Funding Total: $224,000

PKI

Date(s)	Source	Type	Investigator	Amount
	surveillance tool to drive screening for unmet palliative needs among patients in the final year of life. Program: Knowledge Translation 2019			
2018/10 - 2022/10	Reseau Quebecoise de Recherche en Soins Palliatifs et Fin de Vie Title: Connaissances, attitude et representation de la sedation palliative continue et de l'aide medicale a mourir au Quebec Program: Pilot Grant	Type: Grant Purpose: Operating	My Role: Co-investigator	Funding Total: $20,000
2018/10 - 2019/10	Centre for Aging and Brain Health Innovation Title: MedSafer e-Care Program: Research-Clinician Partnership Program	Type: Grant Purpose: Operating	My Role: Co-investigator	Funding Total: $368,588
2018/8 - 2019/10	Canadian Institutes of Health Research (CIHR) Title: Physician care at the end of life Program: Project Grant	Type: Grant Purpose: Operating	My Role: Co-investigator	Funding Total: $495,000
2018/1 - 2019/6	Canadian Frailty Network Title: Using an automated mortality prediction tool to focus advance care planning efforts for inpatients Program: 2017 Knowledge Translation Grant	Type: Grant Purpose: Operating	My Role: Principal Investigator	Funding Total: $194,395
2016/8 - 2017/10	University of Toronto Title: Death, Dying, and Doctors: A	Type: Grant Purpose:	My Role: Co-investigator Principal Investigator:	Funding Total: $9,998

PKI

Date(s)	Source	Type	Investigator	Amount
	Qualitative Exploration of Physician-Assisted Death to Guide Continuing Professional Development. Program: Education Development Fund	Operating	Kathleen Sheehan	
2016/7 - 2019/6	TVN Title: Better tArgetting, Better outcomes for frail ELderly patients (BABEL) Program: Transformative Grant Program	Type: Grant	My Role: Co-investigator	Funding Total: $2,996,168
2016/7 - 2019/6	TVN Title: Reducing post-discharge adverse drug events among the elderly: a multi-centre electronic deprescribing intervention. Program: Transformative Grant Program	Type: Grant	My Role: Co-investigator	Funding Total: $120,000
2016/7 - 2017/10	Associated Medical Services Inc. (AMS) Title: AMS Phoenix Fellowship Program: Phoenix Project	Type: Fellowship	My Role: Principal Investigator	Funding Total: $50,000
2016/7 - 2017/6	Canadian Institutes of Health Research (CIHR) Title: Reducing post-discharge adverse drug events amongst the elderly: a multi-centre electronic deprescribing intervention Program: Project Grant	Type: Grant Purpose: Operating	My Role: Co-investigator Principal Applicant: Todd Lee Principal Investigator: Emily McDonald	Funding Total: $1,662,789
2016/4 - 2020/3	Canadian Institutes of Health Research (CIHR) Title:	Type: Grant	My Role: Co-investigator	Funding Total: $1,388,754

PIC I

Date(s)	Source	Type	Investigator	Amount
	Development and Evaluation of a Family-Partnered Care Pathway for Critically Ill Older Patients Program: Team Grant - Late Life Issues			
2016/4 - 2017/3	National Centre for Excellence Title: Pilot study of an automated one-year mortality prediction tool to trigger Advance Care Planning. Program: TechValueNet	Type: Grant	My Role: Principal Investigator	Funding Total: $153,000

INTERNAL RESEARCH FUNDING:

Date(s)	Source	Type	Investigator	Amount
2021/11 - 2026/3	Canadian Institutes of Health Research (CIHR) Title: A mixed-methods study to develop a jurisdiction-level resource allocation framework to guide the use of triage and triage-avoidant strategies during an overwhelming surge in demand for critical and acute care Program: Operating Grant	Type: Grant Purpose: Operating	My Role: Principal Applicant Co-applicants: Bagshaw, S, Bouthillier, M, Farrell, C, Gibson, J, Khalifa, A, Opatmy, L, Smith, M, Baker, A, Burns, K, Fowler, R, Godkin, D, Kortbeek, J, Paunovic, B, Valiani, S, Bandrauk, N, Dahine, J, Fox-Robichaud, Huska, M, Kyeremanteng, K, Rashidi, B, Virani, A, Bensimon, C, Downie, J, Frolic, A, Kekewich, M, Oczkowski, S, Schuklenk, U, Warren, M	Funding Total: $499,944
2021/1 - 2021/12	University of Ottawa Title: Effects of dexmedetomidine in patients with delirium in palliative care Program: Pilot Translational Grant	Type: Grant Purpose: Operating	My Role: Principal Investigator Co-applicants: Wolfe, Amanda, Vanderspank, Brandi, Lascelle, Debbie, Doctorow, Roslyn, Cohen, Leila, Lapenskie, Julie, Lelievre, Natasha	Funding Total: $39,800

PKI

Date(s)	Source	Type	Investigator	Amount
2020/12 - 2021/11	University of Ottawa Title: Innovative Grant Program: COVID-19 Pandemic Response Funding Program	Type: Grant Purpose: Operating	My Role: Principal Investigator Co-applicants: Parsons, H, Gratton, V, Cohen, L	Funding Total: $49,712
2020/11 - 2023/1	Canada Foundation for Innovation (CFI) Title: A Translational Platform for Transcranial Magnetic Stimulation in Novel Patient Populations Program: John R. Evans Leaders Fund	Type: Grant Purpose: Operating	My Role: Principal Investigator	Funding Total: $191,320

CONTRIBUTIONS:

Life-time summary count according to the following categories:

Refereed Journal Articles 169
Refereed Chapters In Books 3
Non-Refereed Chapters In Books 3
Non-Refereed Journal Articles 19
Reports 2
Other Contributions 367

PUBLICATIONS:

Refereed Chapters In Books

3. James Downar. (2020, June). The Distinction between Voluntary and Involuntary Euthanasia and the Critical Role of Eugenics. In Sheldon Rubenfeld, Daniel P. Sulmasy (Ed.), *Physician-Assisted Suicide and Euthanasia Before, During, and After the Third Reich* (1 ed.). Lexington Books. *(In Press)*
2. James Downar and Valerie Schulz. (2020, March). Palliative Care in the Intensive Care Unit. In Anne Boyle, Leonie Herx, Susan MacDonald (Eds.), *Palliative Medicine: A Case Based Manual* (4 ed.). New York: Oxford Press. *(In Press)*

Refereed Journal Articles

169. Simon, Jessica E, Bhattarai, Asmita, Apoint-Hao, Zhi-Yun, Roberts, Rhiannon L, Milani, Christina, Webber, Colleen, . . . Sinnarajah, Aynharan. (2025, February). Variations in Prescribing Rates of End-of-Life Medications Among Long-Term Care Residents in Alberta Compared with Ontario-a Retrospective Cohort Study. *Canadian geriatrics journal : CGJ*, 28(1), 31-40.
Impact Factor: 1.6

OKI

168. Hwang, David Y, Oczkowski, Simon J W, Lewis, Kimberley, Birriel, Barbara, Downar, James, Farrier, Christian E, . . . Hopkins, Ramona O. (2025, February). Society of Critical Care Medicine Guidelines on Family-Centered Care for Adult ICUs: 2024. *Critical care medicine*, 53(2), e465-e482.
Impact Factor: 7.7

167. Hwang, David Y, Oczkowski, Simon J W, Lewis, Kimberley, Birriel, Barbara, Downar, James, Farrier, Christian E, . . . Hopkins, Ramona O. (2025, February). Executive Summary: Society of Critical Care Medicine Guidelines on Family-Centered Care for Adult ICUs. *Critical care medicine*, 53(2), e459-e464.
Impact Factor: 7.7

166. Downar, James, Lapenskie, Julie, Kanji, Salmaan, Watpool, Irene, Haines, Jessica, Saeed, Uzma, . . . Fox-Robichaud, Alison. (2025, February). Propranolol As an Anxiolytic to Reduce the Use of Sedatives for Critically Ill Adults Receiving Mechanical Ventilation (PROACTIVE): An Open-Label Randomized Controlled Trial. *Critical care medicine*, 53(2), e257-e268.
Impact Factor: 7.7

165. Lapenskie, Julie, Downar, James, Wolfe, Amanda, Polskaia, Nadia, van den Berg, Kate, Watt, Christine, . . . Lawlor, Peter G. (2025, February). Subcutaneous dexmedetomidine for sedation of agitated delirium in palliative care. *Annals of palliative medicine*, 14(1), 57-66.
Impact Factor: 1.925

164. Downar, James, Sanders, Justin J & Smith, Alexander K. (2025, February). Controlled Trials of "Palliative Care"-Where Do We Go from Here?. *Journal of palliative medicine*, 28(2), 144-146.
Impact Factor: 2.2

163. Quinn, Kieran L, Stukel, Thérèse A, Detsky, Allan, Chung, Hannah, Anwar, Mohammed Rashidul, Bhatia, Sacha, . . . Bell, Chaim M. (2025). Use of virtual care near the end of life before and during the COVID-19 pandemic: A population-based cohort study. *PloS one*, 20(1), e0313766.
Impact Factor: 2.9

162. Bouthillier, Marie-Eve, Farmer, Yanick, Calderon Ramirez, Claudia, Downar, James, Frolic, Andrea, Dahine, Joseph, . . . Orr Gaucher, Nathalie. (2024, December). Public perspectives on COVID-19 triage protocols for access to critical care in extreme pandemic context. *PloS one*, 19(12), e0314460.
Impact Factor: 3.7

161. Courtright, Katherine R & Downar, James. (2024, December). The Struggle Continues: Improving Outcomes for Surrogate Decision-Makers after the Intensive Care Unit. *American journal of respiratory and critical care medicine.*
Impact Factor: 19.3

160. Quinn, Kieran L, Rodin, Rebecca & Downar, James. (2024, December). Rethinking Palliative Interventions in Critical Care-When More Is Not Better. *JAMA internal medicine.*
Impact Factor: 22.3

159. Mroz, Sarah, Daenen, Frederick, Dierickx, Sigrid, Mortier, Freddy, De Panfilis, Ludovica, Downar, James, . . . Deliens, Luc. (2024, December). Associations between physicians' personal preferences for end-of-life decisions and their own clinical practice: PROPEL survey study in Europe, North America, and Australia. *Palliative medicine*, 2692163241300853.
Impact Factor: 3.6

158. Heidinger, Brandon, Webber, Colleen, Chambaere, Kenneth, Close, Eliana, Deliens, Luc, Onwuteaka-Philipsen, Bregje, . . . Downar, James. (2024, December). International Comparison of Underlying Disease Among Recipients of Medical Assistance in Dying. *JAMA internal medicine.*
Impact Factor: 22.3

pg I

157. Akhter, Rabia, Stukel, Thérèse A, Chung, Hannah, Bell, Chaim M, Detsky, Allan S, Downar, James, . . . Quinn, Kieran L. (2024, November). Comparison of physician-delivered models of virtual and home-based in-person care for adults in the last 90 days of life with cancer and terminal noncancer illness during the COVID-19 pandemic. *PloS one*, 19(11), e0301813.
Impact Factor: 3.7

156. Calderon Ramirez, Claudia Lucrecia, Farmer, Yanick, Downar, James, Frolic, Andrea, Opatrny, Lucie, Poirier, Diane, . . . Bouthillier, Marie-Eve. (2024, November). Assessing the Quality of an Online Democratic Deliberation on COVID-19 Pandemic Triage Protocols for Access to Critical Care in an Extreme Pandemic Context: Mixed Methods Study. *Journal of participatory medicine*, 16, e54841.

155. Downar, James, Close, Eliana, Young, Jessica E & White, Ben P. (2024, October). Assisted dying: balancing safety with access. *BMJ (Clinical research ed.)*, 387, q2382.
Impact Factor: 93.7

154. Ghoshal, A, Prince, R, Downar, J, Lapenskie, J, Subramaniam, S, Wegier, P, . . . Hannon, B. (2024, October). Exploring the Utility of the Modified Hospitalized-Patient One-Year Mortality Risk Score to Trigger Referrals to Palliative Care for Inpatients With Cancer. *Cancer medicine*, 13(19), e70292.
Impact Factor: 4.452

153. Roberts, Rhiannon L, Milani, Christina, Webber, Colleen, Bush, Shirley H, Boese, Kaitlyn, Simon, Jessica E, . . . Isenberg, Sarina R. (2024, June). Enablers and Barriers for End-of-Life Symptom Management Medications in Long-Term Care Homes: A Qualitative Study. *Journal of the American Medical Directors Association*, 25(8), 105076.
Impact Factor: 7.6

152. Roberts, Rhiannon L, Milani, Christina, Webber, Colleen, Bush, Shirley H, Boese, Kaitlyn, Simon, Jessica E, . . . Isenberg, Sarina R. (2024, June). Corrigendum: Measuring the Use of End-of-Life Symptom Relief Medications in Long-Term Care Homes-a Qualitative Study. *Canadian geriatrics journal : CGJ*, 27(2), 267.
Impact Factor: 3.9

151. Stiell, Ian G, Madore, Suzanne, Knoll, Greg, Ludwig, Claire, Wooller, Krista, Eagles, Debra, . . . Cheung, Warren J. (2024, May). Decreased patient discharges on weekends part 3: what do the leaders tell us?. *CJEM*.
Impact Factor: 2.4

150. Guité-Verret, Alexandra, Boivin, Jessica, Hanna, Andrew M R, Downar, James, Bush, Shirley H, Marcoux, Isabelle, . . . Gagnon, Bruno. (2024, April). Continuous palliative sedation until death: a qualitative study of palliative care clinicians' experiences. *BMC palliative care*, 23(1), 104.
Impact Factor: 3.1

149. Calderon Ramirez, Claudia, Farmer, Yanick, Frolic, Andrea, Bravo, Gina, Gaucher, Nathalie Orr, Payot, Antoine, . . . Bouthillier, Marie-Eve. (2024, March). What are the views of Quebec and Ontario citizens on the tiebreaker criteria for prioritizing access to adult critical care in the extreme context of a COVID-19 pandemic?. *BMC medical ethics*, 25(1), 31.
Impact Factor: 2.84

148. Downar, James, Lapenskie, Julie, Anderson, Koby, Edwards, Jodi, Watt, Christine, Dionne, Michel, . . . Downar, Jonathan. (2024, March). Accelerated transcranial magnetic stimulation for psychological distress in advanced cancer: A phase 2a feasibility and preliminary efficacy clinical trial. *Palliative medicine*, 2692163241234799.
Impact Factor: 4.4

DKI

147. Lapp, John M, Stukel, Thérèse A, Chung, Hannah, Bell, Chaim M, Bhatia, R Sacha, Detsky, Allan S, . . . Quinn, Kieran L. (2024, March). Association of virtual end-of-life care with healthcare outcomes before and during the COVID-19 pandemic: A population-based study. *PLOS digital health*, 3(3), e0000463.
146. Fremont, Deena, Roberts, Rhiannon L, Webber, Colleen, Clarke, Anna E, Milani, Christina, Isenberg, Sarina R, . . . Tanuseputro, Peter. (2024, March). Changes in End-of-Life Symptom Management Prescribing among Long-Term Care Residents during COVID-19. *Journal of the American Medical Directors Association.*
Impact Factor: 7.6
145. Roberts, Rhiannon L, Milani, Christina, Webber, Colleen, Bush, Shirley H, Boese, Kaitlyn, Simon, Jessica E, . . . Isenberg, Sarina R. (2024, March). Measuring the Use of End-of-Life Symptom Relief Medications in Long-Term Care Homes-a Qualitative Study. *Canadian geriatrics journal : CGJ*, 27(1), 29-46.
Impact Factor: 3.9
144. Tanuseputro, Peter, Webber, Colleen & Downar, James. (2024, March). Illness trajectories in the age of big data. *BMJ (Clinical research ed.)*, 384, q510.
Impact Factor: 107.7
143. Leeies, Murdoch, Landry, Cameron, Blouw, Marcus, Butcher, Joshua, Hrymak, Carmen S, Vazquez-Grande, Gloria, . . . Burns, Karen E A. (2024, March). Canadian Critical Care Society position statement on reconciliation, decolonization, and Indigenous engagement. *Canadian journal of anaesthesia = Journal canadien d'anesthesie*, 71(3), 311-321.
Impact Factor: 4.2
142. Tanuseputro, Peter, Roberts, Rhiannon L, Milani, Christina, Clarke, Anna E, Webber, Colleen, Isenberg, Sarina R, . . . Downar, James. (2024, March). Palliative End-of-Life Medication Prescribing Rates in Long-Term Care: A Retrospective Cohort Study. *Journal of the American Medical Directors Association*, 25(3), 532-538.e8.
Impact Factor: 7.8
141. Iqbal, Javaid, Moineddin, Rahim, Fowler, Robert A, Krzyzanowska, Monika K, Booth, Christopher M, Downar, James, . . . Zimmermann, Camilla. (2024, February). Socioeconomic Status, Palliative Care, and Death at Home Among Patients With Cancer Before and During COVID-19. *JAMA network open*, 7(2), e240503.
Impact Factor: 13.8
140. Honarmand, Kimia, Wax, Randy S, Penoyer, Daleen, Lighthall, Geoffery, Danesh, Valerie, Rochwerg, Bram, . . . Sebat, Frank. (2024, February). Society of Critical Care Medicine Guidelines on Recognizing and Responding to Clinical Deterioration Outside the ICU: 2023. *Critical care medicine*, 52(2), 314-330.
Impact Factor: 8.8
139. Honarmand, Kimia, Wax, Randy S, Penoyer, Daleen, Lighthall, Geoffery, Danesh, Valerie, Rochwerg, Bram, . . . Sebat, Frank. (2024, February). Executive Summary: Society of Critical Care Medicine Guidelines on Recognizing and Responding to Clinical Deterioration Outside the ICU. *Critical care medicine*, 52(2), 307-313.
Impact Factor: 8.8
138. Lapenskie, Julie, Anderson, Koby, Lawlor, Peter G, Kabir, Monisha, Noel, Chelsea, Heidinger, Brandon, . . . Downar, James. (2024, February). Long-term bereavement outcomes in family members of those who died in acute care hospitals before and during the first wave of COVID-19: A cohort study. *Palliative medicine*, 38(2), 264-271.
Impact Factor: 4.4

DKI

137. Hafid, Shuaib, Isenberg, Sarina R, Fernandes, Aleisha, Gallagher, Erin, Webber, Colleen, Joseph, Meera, . . . Howard, Michelle. (2024). End-of-Life Care Among Patients With Kidney Failure on Maintenance Dialysis: A Retrospective Population-Based Study. *Canadian journal of kidney health and disease*, 11, 20543581241280698.
Impact Factor: 1.6
136. Kesecioglu, Jozef, Rusinova, Katerina, Alampi, Daniela, Arabi, Yaseen M, Benbenishty, Julie, Benoit, Dominique, . . . Azoulay, Elie. (2024). European Society of Intensive Care Medicine guidelines on end of life and palliative care in the intensive care unit. *Intensive care medicine.*
Impact Factor: 41.8
135. Downar, James, MacDonald, Susan & Buchman, Sandy. (2023, October). What drives requests for MAiD?. *CMAJ : Canadian Medical Association journal = journal de l'Association medicale canadienne*, 195(40), E1385-E1387.
Impact Factor: 17.4
134. Downar, James, MacDonald, Susan & Buchman, Sandy. (2023, October). Response to Downar J et al., Medical Assistance in Dying, Palliative Care, Safety, and Structural Vulnerability (DOI: 10.1089/jpm.2023.0210). *Journal of palliative medicine.*
133. Wiebe, Kim, Wilson, Lindsay, Lotherington, Ken, Mills, Caitlin, Shemie, Sam & Downar, James. (2023, September). 117.1: Deceased organ and tissue donation after medical assistance in dying and other conscious and competent donors: 2023 updated guidance for policy. *Transplantation*, 107(10S1), 8.
Impact Factor: 6.2
132. Heidinger, Brandon A, Downar, Ariane, Frolic, Andrea, Downar, James & Isenberg, Sarina R. (2023, September). Physician and administrator experience of preparing to implement Ontario's intensive care unit Triage Emergency Standard of Care during the COVID-19 pandemic: a qualitative study. *CMAJ open*, 11(5), E838-E846.
131. Lawlor, Peter, Cohen, Leila, Adeli, Samantha Rose, Besserer, Ella, Gratton, Valérie, Murphy, Rebekah, . . . Parsons, Henrique. (2023, September). Comorbidities, symptoms and end-of-life medication use in hospitalised decedents before and during the COVID-19 pandemic: a retrospective regional cohort study in Ottawa, Canada. *BMJ open*, 13(9), e075518.
Impact Factor: 2.9
130. Howard, Michelle, Hafid, Shuaib, Isenberg, Sarina Roslyn, Webber, Colleen, Downar, James, Gayowsky, Anastasia, . . . Tanuseputro, Peter. (2023, August). Physician continuity of care in the last year of life in community-dwelling adults: retrospective population-based study. *BMJ supportive & palliative care.*
Impact Factor: 2.7
129. Webber, Colleen, Hafid, Shuaib, Gayowsky, Anastasia, Howard, Michelle, Tanuseputro, Peter, Jones, Aaron, . . . Isenberg, Sarina Roslyn. (2023, August). End-of-life interventions in patients with cancer. *BMJ supportive & palliative care.*
Impact Factor: 2.7
128. Downar, James, MacDonald, Susan & Buchman, Sandy. (2023, July). Medical Assistance in Dying and Palliative Care: Shared Trajectories. *Journal of palliative medicine*, 26(7), 896-899.
Impact Factor: 2.94
127. Downar, James, MacDonald, Susan & Buchman, Sandy. (2023, July). Medical Assistance in Dying, Palliative Care, Safety, and Structural Vulnerability. *Journal of palliative medicine.*
Impact Factor: 2.94

PKI

126. Scott, Mary M, Webber, Colleen, Clarke, Anna E, Hafid, Abe, Isenberg, Sarina R, Jones, Aaron, . . . Tanuseputro, Peter. (2023, July). Physician home visits to rostered patients during their last year of life: a retrospective cohort study. *CMAJ open*, 11(4), E597-E606.
Impact Factor: 3.06

125. Sprung, Charles L, Devereaux, Asha V, Ghazipura, Marya, Burry, Lisa D, Hossain, Tanzib, Hamele, Mitchell T, . . . Maves, Ryan C. (2023, July). Critical Care Staffing in Pandemics and Disasters: A Consensus Report From a Subcommittee of the Task Force for Mass Critical Care - Systems Strategies to Sustain the Health Care Workforce. *Chest*, 164(1), 124-136.
Impact Factor: 11.393

124. Wiebe, Kim, Wilson, Lindsay C, Lotherington, Ken, Mills, Caitlin, Shemie, Sam D & Downar, James. (2023, June). Deceased organ and tissue donation after medical assistance in dying: 2023 updated guidance for policy. *CMAJ : Canadian Medical Association journal = journal de l'Association medicale canadienne*, 195(25), E870-E878.
Impact Factor: 17.4

123. Leeies, Murdoch, Valiani, Sabira, Prakash, Varuna, Haddara, Wael M R, Taneja, Ravi, Whittemore, Kathryn G, . . . Burns, Karen E A. (2023, June). Canadian Critical Care Society position statement on Equity, Diversity, Decolonization, and Inclusion. *Canadian journal of anaesthesia = Journal canadien d'anesthesie*, 70(6), 942-949.
Impact Factor: 6.716

122. Michelle, Howard, Abe, Hafid, Colleen, Webber, R, Isenberg Sarina, Ana, Gayowsky, Aaron, Jones, . . . Peter, Tanuseputro. (2022, November). Continuity of physician care over the last year of life for different cause-of-death categories: a retrospective population-based study. *CMAJ open*, 10(4), E971-E980.
Impact Factor: 2.29

121. Abe, Hafid, Michelle, Howard, Colleen, Webber, Ana, Gayowsky, Mary, Scott, Aaron, Jones, . . . R, Isenberg Sarina. (2022, October). Describing settings of care in the last 100 days of life for cancer decedents: a population-based descriptive study. *Cancer medicine*. doi: 10.1002/cam4.5291
Impact Factor: 4.452

120. Bérubé, A, Tapp, D, Dupéré, S, Plaisance, A, Bravo, G, Downar, J & Couture, V. (2022, October). Do Socioeconomic Factors Influence Knowledge, Attitudes, and Representations of End-of-Life Practices? A Cross-Sectional Study. *Journal of palliative care*, 8258597221131658. doi: 10.1177/08258597221131658
Impact Factor: 2.49

119. Nicole, Williams, Kirsten, Hermans, Joachim, Cohen, Anja, Declercq, Ahmed, Jakda, James, Downar, . . . P, Hirdes John. (2022, October). The interRAI CHESS scale is comparable to the palliative performance scale in predicting 90-day mortality in a palliative home care population. *BMC palliative care*, 21(1), 174. doi: 10.1177/08258597221131658
Impact Factor: 3.234

118. Mathieos, Belayneh, Robin, Fainsinger, Cheryl, Nekolaichuk, Viki, Muller, Sylvie, Bouchard, James, Downar, . . . Peter, Lawlor. (2022, October). Edmonton Classification System for Cancer Pain: Comparison of Pain Classification Features and Pain Intensity across Diverse Palliative Care Settings in Canada. *Journal of palliative medicine*. doi: 10.1089/jpm.2022.0187
Impact Factor: 2.49

117. Johannes, Mulder, Hans, Sonneveld, Dirk, Van Raemdonck, James, Downar, Kim, Wiebe, Beatriz, Domínguez-Gil, . . . Gert, Olthuis. (2022, September). Practice and challenges for organ donation after medical assistance in dying: A scoping review including the results of the first international roundtable in

DCI

2021. *American journal of transplantation : official journal of the American Society of Transplantation and the American Society of Transplant Surgeons*. doi: 10.1111/ajt.17198.
Impact Factor: 8.086

116. Downar James, Parsons Henrique A, Cohen Leila, Besserer Ella, Adeli Samantha, Gratton Valérie, Murphy Rebekah, Warmels Grace, Bruni Adrianna, Bhimji Khadija, Dyason Claire, Enright Paula, Desjardins Isabelle, Wooller Krista, Kabir Monisha, Noel Chelsea, Heidinger Brandon, Anderson Koby, Arsenault-Mehta Kyle, Lapenskie Julie, Webber Colleen, Bedard Daniel, Iyengar Akshai, Bush Shirley H, Isenberg Sarina R, Tanuseputro Peter, Vanderspank-Wright Brandi, Lawlor Peter. (2022, July). Bereavement outcomes in family members of those who died in acute care hospitals before and during the first wave of COVID-19: A cohort study. *Palliative medicine*, 2692163221109711. doi:10.1177/02692163221109711
Impact Factor: 5.713

115. Lawlor Peter, Parsons Henrique, Adeli Samantha Rose, Besserer Ella, Cohen Leila, Gratton Valérie, Murphy Rebekah, Warmels Grace, Bruni Adrianna, Kabir Monisha, Noel Chelsea, Heidinger Brandon, Anderson Koby, Arsenault-Mehta Kyle, Wooller Krista, Lapenskie Julie, Webber Colleen, Bedard Daniel, Enright Paula, Desjardins Isabelle, Bhimji Khadija, Dyason Claire, Iyengar Akshai, Bush Shirley H, Isenberg Sarina, Tanuseputro Peter, Vanderspank-Wright Brandi, Downar James. (2022, June). Comparative end-of-life communication and support in hospitalised decedents before and during the COVID-19 pandemic: a retrospective regional cohort study in Ottawa, Canada. *BMJ open*, 12(6), e062937. doi:10.1136/bmjopen-2022-062937
Impact Factor: 3.006, Research Type: Clinical Research

114. Downar James, Boese Kaitlyn, Lalumiere Genevieve, Bercier Ghislain, Leduc Shannon, Rice Jill, Arya Amit, Charbonneau Valerie. (2022, June). A Clinical Response Team Providing Support to Long-Term Care Homes with COVID-19 Outbreaks in Eastern Ontario-a Cohort Study. *Canadian geriatrics journal : CGJ*, 25(2), 171-174. doi:10.5770/cgj.25.561
Impact Factor: 3.1

113. Downar James, Smith Maxwell J, Godkin Dianne, Frolic Andrea, Bean Sally, Bensimon Cecile, Bernard Carrie, Huska Mary, Kekewich Mike, Ondrusek Nancy, Upshur Ross, Zlotnik-Shaul Randi, Gibson Jennifer. (2022, March). A framework for critical care triage during a major surge in critical illness. *Canadian journal of anaesthesia = Journal canadien d'anesthesie*.
Impact Factor: 5.06

112. Wolfe Amanda, Watt Christine L, Downar James, Bush Shirley H. (2022, March). Use and Discontinuation of Milrinone for Advanced Heart Failure in an Academic Palliative Care Unit: A Case Report and Discussion of Recommendations. *Journal of pain & palliative care pharmacotherapy*, 1-10.
Impact Factor: 1.5

111. McDonald Emily G, Wu Peter E, Rashidi Babak, Wilson Marnie Goodwin, Bortolussi-Courval Émilie, Atique Anika, Battu Kiran, Bonnici Andre, Elsayed Sarah, Wilson Allison Goodwin, Papillon-Ferland Louise, Pilote Louise, Porter Sandra, Murphy Johanna, Ross Sydney B, Shiu Jennifer, Tamblyn Robyn, Whitty Rachel, Xu Jieqing, Fabreau Gabriel, Haddad Taleen, Palepu Anita, Khan Nadia, McAlister Finlay A, Downar James, Huang Allen R, MacMillan Thomas E, Cavalcanti Rodrigo B, Lee Todd C. (2022, March). The MedSafer Study-Electronic Decision Support for Deprescribing in Hospitalized Older Adults: A Cluster Randomized Clinical Trial. *JAMA internal medicine*, 182(3), 265-273.
Impact Factor: 21.87

110. Sanders Justin J, Manson Leigh, Constien Deborah, Downar James. (2022, February). Discussing prognosis and what matters most for people with serious illness. *BMJ (Clinical research ed.)*, 376, e067572.
Impact Factor: 39.89

109. Watanabe Tatsuaki, Kawashima Mitsuaki, Kohno Mikihiro, Yeung Jonathan, Downar James, Healey Andrew, Martinu Tereza, Aversa Meghan, Donahoe Laura, Pierre Andrew, de Perrot Marc, Yasufuku Kazuhiro, Waddell Thomas K, Keshavjee Shaf, Cypel Marcelo. (2022, February). Outcomes of lung transplantation from organ donation after medical assistance in dying: First North American experience. *American journal of transplantation : official journal of the American Society of Transplantation and the American Society of Transplant Surgeons.*
Impact Factor: 8.086
108. Downar James, Vanderspank-Wright Brandi. (2022, January). Supporting bereaved family members: three steps in the right direction. *Lancet (London, England)*, 399(10325), 607-609.
Impact Factor: 79.32
107. Webber Colleen, Isenberg Sarina R, Scott Mary, Hafid Abe, Hsu Amy T, Conen Katrin, Jones Aaron, Clarke Anna, Downar James, Kadu Mudathira, Tanuseputro Peter, Howard Michelle. (2022, January). Inpatient Palliative Care Is Associated with the Receipt of Palliative Care in the Community after Hospital Discharge: A Retrospective Cohort Study. *Journal of palliative medicine.*
Impact Factor: 2.947
106. Watt Christine L, Lapenskie Julie, Kabir Monisha, Lalumiere Genevieve, Dionne Michel, Rice Jill, Noël Chelsea, Downar Jonathan, Downar James. (2021, December). Accelerated rTMS for existential distress in palliative care: A report of two cases. *Brain stimulation*, 15(1), 197-200.
Impact Factor: 8.955, Research Type: Clinical Research
105. Kieran Quinn, Sarina Isenberg, James Downar, Amy Hsu, Peter Tanuseputro, Michael Bonares, Kali Barrett, Kwadwo Kyeremanteng, and Konrad Fassbender. (2021, October). Expensive Endings: Reining In the High Cost of End-of-Life Care in Canada. *CD Howe Report*, 608. Retrieved from https://www.cdhowe.org/sites/default/files/2021-10/Commentary_608.pdf
Research Type: Public Health Research
104. Simmons John-Graydon, Reynolds Gavin, Kekewich Michael, Downar James, Isenberg Sarina R, Kobewka Daniel. (2021, September). Enduring Physical or Mental Suffering of People Requesting Medical Assistance in Dying. *Journal of pain and symptom management.*
Impact Factor: 3.249
103. Dichter Jeffrey R, Devereaux Asha V, Sprung Charles L, Mukherjee Vikramjit, Persoff Jason, Baum Karyn D, Ornoff Douglas, Uppal Amit, Hossain Tanzib, Henry Kiersten N, Ghazipura Marya, Bowden Kasey R, Feldman Henry J, Hamele Mitchell T, Burry Lisa D, Martland Anne Marie O, Huffines Meredith, Tosh Pritish K, Downar James, Hick John L, Christian Michael D, Maves Ryan C. (2021, August). Mass Critical Care Surge Response during COVID-19: Implementation of Contingency Strategies A Preliminary Report of findings from the Task Force for Mass Critical Care. *Chest.*
Impact Factor: 9.41
102. Wolfe Amanda, Zhang Jeremy, Lapenskie Julie, Downar James, Kanji Salmaan. (2021, July). Stability of Dexmedetomidine in Polyvinyl Chloride Bags Containing 0.9% Sodium Chloride Intended for Subcutaneous Infusions. *International journal of pharmaceutical compounding*, 25(4), 330-335.
Impact Factor: 0.124
101. Turcotte Luke Andrew, Zalucky Ann Alexandra, Stall Nathan M, Downar James, Rockwood Kenneth, Theou Olga, McArthur Caitlin, Heckman George. (2021, June). Baseline Frailty as a Predictor of Survival after Critical Care: a Retrospective Cohort Study of Older Adults Receiving Home Care in Ontario, Canada. *Chest.*
Impact Factor: 9.41

DKI

100. Chin-Yee Nicolas, Scott Mary, Perelman Iris, Pugliese Michael, Tuna Meltem, Fitzgibbon Edward, Downar James, Tinmouth Alan, Fergusson Dean, Tanuseputro Peter, Saidenberg Elianna. (2021, June). Red blood cell transfusion and associated outcomes in patients referred for palliative care: A retrospective cohort study. *Transfusion.*
Impact Factor: 2.8
99. Howard Michelle, Hafid Abe, Isenberg Sarina R, Hsu Amy T, Scott Mary, Conen Katrin, Webber Colleen, Bronskill Susan E, Downar James, Tanuseputro Peter. (2021, June). Intensity of outpatient physician care in the last year of life: a population-based retrospective descriptive study. *CMAJ open*, 9(2), E613-E622.
98. Wegier Pete, Kurahashi Allison, Saunders Stephanie, Lokuge Bhadra, Steinberg Leah, Myers Jeff, Koo Ellen, van Walraven Carl, Downar James. (2021, April). mHOMR: a prospective observational study of an automated mortality prediction model to identify patients with unmet palliative needs. *BMJ supportive & palliative care.* doi:10.1136/bmjspcare-2020-002870
Impact Factor: 2.681
97. Quinn Kieran L, Hsu Amy T, Meaney Christopher, Qureshi Danial, Tanuseputro Peter, Seow Hsien, Webber Colleen, Fowler Rob, Downar James, Goldman Russell, Chan Raphael, McGrail Kimberlyn, Isenberg Sarina R. (2021, March). Association between high cost user status and end-of-life care in hospitalized patients: A national cohort study of patients who die in hospital. *Palliative medicine*, 2692163211002045. doi:10.1177/02692163211002045
Impact Factor: 4.956
96. Saunders S, Downar J, Subramaniam S, Embuldeniya G, van Walraven C, Wegier P. (2021, February). mHOMR: the acceptability of an automated mortality prediction model for timely identification of patients for palliative care. *BMJ Quality and Safety.* doi: 10.1136/bmjqs-2020-012461
Impact Factor: 7.226, Research Type: Clinical Research
95. Yarnell CJ, Jewell LM, Astell A, Pinto R, Devine LA, Detsky ME, Downar J, Ilan R, Rawal S, Wong N, You JJ, Fowler RA. (2021, February). Observational study of agreement between attending and trainee physicians on the surprise question: "Would you be surprised if this patient died in the next 12 months?. *PLoS One*, 16(2), e0247571. doi: 10.1371/journal.pone.0247571
Impact Factor: 2.74, Research Type: Clinical Research
94. Deschamps Jean, Gilbertson James, Straube Sebastian, Dong Kathryn, MacMaster Frank P, Korownyk Christina, Montgomery Lori, Mahaffey Ryan, Downar James, Clarke Hance, Muscedere John, Rittenbach Katherine, Featherstone Robin, Sebastianski Meghan, Vandermeer Ben, Lynam Deborah, Magnussen Ryan, Bagshaw Sean M, Rewa Oleksa G. (2021, January). Association between supportive interventions and healthcare utilization and outcomes in patients on long-term prescribed opioid therapy presenting to acute healthcare settings: a systematic review and meta-analysis. *BMC emergency medicine*, 21(1), 17.
Impact Factor: 1.48
93. Pereira Jose, Arya Amit, Downar James, Rice Patty, MacDonald Susan, Osborne Ed, Kanji Salmaan, Sauls Robert. (2021, January). Shortages of Palliative Care Medications in Canada during the COVID-19 Pandemic: Gambling with Suffering. *Healthcare quarterly (Toronto, Ont.)*, 23(4), 17-22.
Impact Factor: 0.5
92. Downar James, Kekewich Mike. (2021, January). Improving family access to dying patients during the COVID-19 pandemic. *The Lancet. Respiratory medicine.*
Impact Factor: 25.094
91. Isenberg S., Meaney C., May P., Tanuseputro P., Quinn K., Qureshi D., Saunders S., Webber C., Seow H., Downar J. (2021). The association between varying levels of palliative care involvement on costs during terminal hospitalizations in Canada from 2012 to 2015. *BMC Health Services Research*, 21, 1 - 12.

DKI

90. McGuinty C., Downar J., Slawnych M. (2021). Shared Decision Making and Effective Communication in Heart Failure—Moving from "Code Status" to Decisional Readiness. *Canadian Journal of Cardiology*, 37, 665 - 668.
Impact Factor: 5.234

89. Dodek Peter M, Cheung Elaine O, Burns Karen Ea, Martin Claudio M, Archambault Patrick M, Lauzier Francois, Sarti Aimee J, Mehta Sangeeta, Fox-Robichaud Alison E, Seely Andrew J E, Parshuram Christopher, Garros Daniel, Withington Davinia, Cook Deborah J, Piquette Dominique, Carnevale Franco A, Boyd J Gordon, Downar James, Kutsogiannis D James, Chassé Michael, Fontela Patricia, Fowler Robert A, Bagshaw Sean, Dhanani Sonny, Murthy Srinivas, Gehrke Paige, Fujii Tomoko. (2020, December). Moral Distress and Other Wellness Measures in Canadian Critical Care Physicians. *Annals of the American Thoracic Society*.
Impact Factor: 4.836

88. Healey Andrew, Hartwick Michael, Downar James, Keenan Sean, Lalani Jehan, Mohr Jim, Appleby Amber, Spring Jenna, Delaney Jesse W, Wilson Lindsay C, Shemie Sam. (2020, November). Improving quality of withdrawal of life-sustaining measures in organ donation: a framework and implementation toolkit. *Canadian journal of anaesthesia = Journal canadien d'anesthesie*, 67(11), 1549-1556.
Impact Factor: 3.779

87. Arora Samantha, Shaikh Sameer, Karachi Tim, Vanniyasingam Thuva, Centofanti John, Piquette Dominique, Meade Maureen, Boyle Anne, Woods Anne, Downar James, Cook Deborah. (2020, September). End-of-Life Skills and Professionalism for Critical Care Residents in Training: The ESPRIT Survey. *Journal of intensive care medicine*, 885066620946316.
Impact Factor: 3.142

86. Ross Sydney B, Wilson Marnie Goodwin, Papillon-Ferland Louise, Elsayed Sarah, Wu Peter E, Battu Kiran, Porter Sandra, Rashidi Babak, Tamblyn Robyn, Pilote Louise, Downar James, Bonnici Andre, Huang Allen, Lee Todd C, McDonald Emily G. (2020, August). COVID-SAFER: Deprescribing Guidance for Hydroxychloroquine Drug Interactions in Older Adults. *Journal of the American Geriatrics Society*, 68(8), 1636-1646.
Impact Factor: 4.388

85. Downar J, Sinuff T, Kalocsai C, Przybylak-Brouillard A, Smith O, Cook D, Koo E, Vanderspank-Wright B, des Ordons AR. (2020, June). A qualitative study of bereaved family members with complicated grief following a death in the intensive care unit. *Can J Anaesth*, 67(6), 685-693.
Impact Factor: 3.374

84. Meng H, Dai T, Hanlon JG, Downar J, Alibhai SMH, Clarke H. (2020, June). Cannabis and cannabinoids in cancer pain management. *Curr Opin Support Palliat Care*, 14(2), 87-93.
Impact Factor: 1.916

83. Efstathiou N, Vanderspank B, Vandyk A, Al-Janabi M, Daham Z, Sarti A, Delaney J, Downar J. (2020, May). Terminal withdrawal of mechanical ventilation in adult intensive care units: A systematic review and narrative synthesis of perceptions, experiences, and practices. *Palliative Medicine. (Accepted)*
Impact Factor: 4.956

82. Arya A, Buchman S, Gagnon B, Downar, J. (2020, April). Pandemic palliative care: beyond ventilators and saving lives. *CMAJ*, 192(15), E400-E404.
Impact Factor: 7.7

81. Kalocsai C, des Ordons AR, Sinuff T, Koo E, Smith O, Cook D, Golan E, Hales S, Tomlinson G, Strachan D, MacKinnon CJ, Downar J. (2020, April). Critical care provider's support of families in bereavement: a mixed-methods study. *Can J Anaesth*.

DKI

Impact Factor: 3.374

80. Gagnon B, Boyle A, Jolicoeur F, Labonté M, Taylor K, Downar J. (2020, April). Palliative care clinical rotations among undergraduate and postgraduate medical trainees in Canada: a descriptive study. *CMAJ*, 8(2), E257-E263.
79. Maves RC, Downar J, Dichter J R, Hick J L, Devereaux A, Geiling J A, Kissoon N, Hupert N, Niven A S, King M A, Rubinson L L, Hanfling D, Hodge J G, Marshall M F, Fischkoff K, Evans L E, Tonelli M R, Wax R S, Seda G, Parrish J S, Truog R D, Sprung C L, Christian M D, ACCP Task Force for Mass Critical Care. (2020, April). Triage of Scarce Critical Care Resources in COVID-19 An Implementation Guide for Regional Allocation: An Expert Panel Report of the Task Force for Mass Critical Care and the American College of Chest Physicians. *Chest*. doi:10.1016/j.chest2020.03.063
Impact Factor: 9.657
78. Stevens T, Keller H, Williams N, Downar J, Guthrie DM. (2020, April). Cross-Sectional Nutrition Profile of Palliative Home Care Clients in Ontario and Performance of the interRAI Palliative Care Nutrition Clinical Assessment Protocol. *J Parenter Enteral Nutr*. doi:10.1002/jpen.1827.
Impact Factor: 4.109
77. Downar James, Fowler Robert A, Halko Roxanne, Huyer Larkin Davenport, Hill Andrea D, Gibson Jennifer L. (2020, February 11). Early experience with medical assistance in dying in Ontario, Canada: a cohort study. *CMAJ : Canadian Medical Association journal = journal de l'Association medicale canadienne*, 192(8), E173-E181.
Impact Factor: 7.7
76. Selim S, Kunkel E, Wegier P, Tanuseputro P, Downar J, Isenberg SR, Li A, Kyeremanteng K, Manuel D, Kobewka DM. (2020, February). A systematic review of interventions aiming to improve communication of prognosis to adult patients. *Patient Educ Couns*. doi:10.1016/j.pec.2020.02.029
Impact Factor: 2.232
75. Fernando Shannon M, McIsaac Daniel I, Rochwerg Bram, Cook Deborah J, Bagshaw Sean M, Muscedere John, Munshi Laveena, Nolan Jerry P, Perry Jeffrey J, Downar James, Dave Chintan, Reardon Peter M, Tanuseputro Peter, Kyeremanteng Kwadwo. (2019, November 27). Frailty and associated outcomes and resource utilization following in-hospital cardiac arrest. *Resuscitation*, 146, 138-144.
Impact Factor: 4.572
74. Downar James, Close Eliana, Sibbald Robert. (2019, November 25). Do physicians require consent to withhold CPR that they determine to be nonbeneficial?. *CMAJ : Canadian Medical Association journal = journal de l'Association medicale canadienne*, 191(47), E1289-E1290.
Impact Factor: 7.7
73. Willmott Lindy, White Ben, Ko Danielle, Downar James, Deliens Luc. (2019, August 7). Restricting conversations about voluntary assisted dying: implications for clinical practice. *BMJ supportive & palliative care*, 10(1), 105-110.
Impact Factor: 3.208
72. Wegier Pete, Koo Ellen, Ansari Shahin, Kobewka Daniel, O'Connor Erin, Wu Peter, Steinberg Leah, Bell Chaim, Walton Tara, van Walraven Carl, Embuldeniya Gayathri, Costello Judy, Downar James. (2019, June 28). mHOMR: a feasibility study of an automated system for identifying inpatients having an elevated risk of 1-year mortality. *BMJ quality & safety*, 28(12), 971-979.
Impact Factor: 7.226
71. McDonald Emily G, Wu Peter E, Rashidi Babak, Forster Alan J, Huang Allen, Pilote Louise, Papillon-Ferland Louise, Bonnici André, Tamblyn Robyn, Whitty Rachel, Porter Sandra, Battu Kiran, Downar James, Lee Todd C. (2019, June 27). The MedSafer Study: A Controlled Trial of an Electronic Decision

PLI

Support Tool for Deprescribing in Acute Care. *Journal of the American Geriatrics Society*, 67(9), 1843-1850.
Impact Factor: 4.113

70. James Downar, Sam D Shemie, Clay Gillrie, Marie-Chantal Fortin, Amber Appleby, Daniel Z Buchman, Christen Shoesmith, Aviva Goldberg, Vanessa Gruben, Jehan Lalani, Dirk Ysebaert, Lindsay Wilson, Michael D Sharpe. (2019, June). Deceased organ and tissue donation after medical assistance in dying and other conscious and competent donors: guidance for policy. *Canadian Medical Association Journal*, 191(22), E604-E613.
Impact Factor: 7.7

69. Hill Andrea D, Stukel Therese A, Fu Longdi, Scales Damon C, Laupacis Andreas, Rubenfeld Gordon D, Wunsch Hannah, Downar James, Rockwood Kenneth, Heyland Daren K, Sinha Samir K, Zimmermann Camilla, Gandhi Sonal, Myers Jeff, Ross Heather J, Kozak Jean F, Berry Scott, Dev Shelly P, La Delfa Ignazio, Fowler Robert A. (2019, April 26). Trends in site of death and health care utilization at the end of life: a population-based cohort study. *CMAJ open*, 7(2), E306-E315.

68. Deschamps Jean, Gilbertson James, Straube Sebastian, Dong Kathryn, MacMaster Frank P, Korownyk Christina, Montgomery Lori, Mahaffey Ryan, Downar James, Clarke Hance, Muscedere John, Rittenbach Katherine, Featherstone Robin, Sebastianski Meghan, Vandermeer Ben, Lynam Deborah, Magnussen Ryan, Bagshaw Sean M, Rewa Oleksa G. (2019, April 5). Association between harm reduction strategies and healthcare utilization in patients on long-term prescribed opioid therapy presenting to acute healthcare settings: a protocol for a systematic review and meta-analysis. *Systematic reviews*, 8(1), 88.

67. Chin-Yee Nicolas, Taylor Joshua, Downar James, Tanuseputro Peter, Saidenberg Elianna. (2019, March 21). Red Blood Cell Transfusion in Palliative Care: A Survey of Palliative Care Physicians. *Journal of palliative medicine*, 22(9), 1139-1142.
Impact Factor: 2.477

66. Hawryluck Laura, Kalocsai Csilla, Colangelo Joe, Downar James. (2019, February 10). The perils of medico-legal advocacy in ICU conflicts at the end of life: A qualitative study of what happens when advocacy and best interests collide. *Journal of critical care*, 51, 149-155.
Impact Factor: 2.783

65. Downar James, Green Stefanie, Radhakrishnan Arun, Wales Joshua, Kim George, Seccareccia Dori, Wiebe Kim, Myers Jeff, Kawaguchi Sarah. (2018, December 21). An entrustable professional activity descriptor for medical aid in dying: a mixed-methods study. *CMAJ open*, 6(4), E657-E663.

64. Downar James. (2018, September 15). New Insights into Complicated Grief in Bereaved Family Members Approached for Organ Donation. *American journal of respiratory and critical care medicine*, 198(6), 698-700.
Impact Factor: 16.49

63. Kalocsai Csilla, Amaral Andre, Piquette Dominique, Walter Grace, Dev Shelly P, Taylor Paul, Downar James, Gotlib Conn Lesley. (2018, July 9). It's better to have three brains working instead of one": a qualitative study of building therapeutic alliance with family members of critically ill patients. *BMC health services research*, 18(1), 533.
Impact Factor: 1.932

62. Roze des Ordons Amanda Lee, Cheng Adam, Gaudet Jonathan E, Downar James, Lockyer Jocelyn M. (2018, June). Exploring Faculty Approaches to Feedback in the Simulated Setting: Are They Evidence Informed?. *Simulation in healthcare : journal of the Society for Simulation in Healthcare*, 13(3), 195-200.
Impact Factor: 2.19

PKI

61. Roze des Ordons Amanda, Cheng Adam, Gaudet Jonathan, Downar James, Lockyer Jocelyn. (2018, April). Adapting Feedback to Individual Residents: An Examination of Preceptor Challenges and Approaches. *Journal of graduate medical education*, 10(2), 168-175.
Impact Factor: 1.26
60. Whitty Rachel, Porter Sandra, Battu Kiran, Bhatt Pranjal, Koo Ellen, Kalocsai Csilla, Wu Peter, Delicaet Kendra, Bogoch Isaac I, Wu Robert, Downar James. (2018, February 16). A pilot study of a Medication Rationalization (MERA) intervention. *CMAJ open*, 6(1), E87-E94.
59. Rocker Graeme, Bourbeau Jean, Downar James. (2018, February). The New "Opioid Crisis": Scientific Bias, Media Attention, and Potential Harms for Patients with Refractory Dyspnea. *Journal of palliative medicine*, 21(2), 120-122.
Impact Factor: 2.477
58. Downar J, Moorhouse P, Goldman R, Grossman D, Sinha S, Sussman T, Kaasalainen S, MacDonald S, Moser A, You J J. (2018). Improving End-of-Life Care and Advance Care Planning for Frail Older Adults in Canad. *The Journal of frailty & aging*, 7(4), 240-246.
Impact Factor: 1.76
57. Downar James. (2018, January). Resources for Educating, Training, and Mentoring All Physicians Providing Palliative Care. *Journal of palliative medicine*, 21(S1), S57-S62.
Impact Factor: 2.477
56. Downar James, Koo Ellen, des Ordons Amanda Roze, Smith Orla, Cook Deborah, Golan Eyal, Hales Sarah, Tomlinson George, Kalocsai Csilla, Strachan Derek, MacKinnon Christopher, Sinuff Tasnim. (2017, December 28). Prevalence and predictors of severe grief reactions and desire for support following a death in the intensive care unit: a multicentre observational study. *Intensive care medicine*, 44(4), 521-522.
Impact Factor: 18.967
55. Bandrauk Natalie, Downar James, Paunovic Bojan. (2017, November 17). Withholding and withdrawing life-sustaining treatment: The Canadian Critical Care Society position paper. *Canadian journal of anaesthesia = Journal canadien d'anesthesie*, 65(1), 105-122.
Impact Factor: 3.374
54. Pilkey Jana, Downar James, Dudgeon Deborah, Herx Leonie, Oneschuk Doreen, Schroder Cori, Schulz Valerie. (2017, November 13). Palliative Medicine-Becoming a Subspecialty of the Royal College of Physicians and Surgeons of Canada. *Journal of palliative care*, 32(3-4), 113-120.
Impact Factor: 0.364
53. Heyland Daren K, Dodek Peter, You John J, Sinuff Tasnim, Hiebert Tim, Tayler Carolyn, Jiang Xuran, Simon Jessica, Downar James. (2017, July 31). Validation of quality indicators for end-of-life communication: results of a multicentre survey. *CMAJ : Canadian Medical Association journal = journal de l'Association medicale canadienne*, 189(30), E980-E989.
Impact Factor: 7.7
52. Downar James, Francescutti Louis Hugo. (2017, June 26). Medical assistance in dying: time for physicians to step up to protect themselves and patients. *CMAJ : Canadian Medical Association journal = journal de l'Association medicale canadienne*, 189(25), E849-E850.
Impact Factor: 7.7
51. Farshchi Zarabi Sara, Parotto Matteo, Katznelson Rita, Downar James. (2017, June 13). Massive Ischemic Stroke Due to Pulmonary Barotrauma and Cerebral Artery Air Embolism During Commercial Air Travel. *The American journal of case reports*, 18, 660-664.
Impact Factor: 0.69

DICI

50. Shiotsuka Junji, Steel Andrew, Downar James. (2017, May 4). The Sedative Effect of Propranolol on Critically Ill Patients: A Case Series. *Frontiers in medicine*, 4, 44.
Impact Factor: 3.113
49. Downar James, Goldman Russell, Pinto Ruxandra, Englesakis Marina, Adhikari Neill K J. (2017, April 3). The "surprise question" for predicting death in seriously ill patients: a systematic review and meta-analysis. *CMAJ : Canadian Medical Association journal = journal de l'Association medicale canadienne*, 189(13), E484-E493.
Impact Factor: 7.7
48. Sheehan Kathleen, Gaind K Sonu, Downar James. (2017). Medical assistance in dying: special issues for patients with mental illness. *Current opinion in psychiatry*, 30(1), 26-30.
Impact Factor: 4.483

Non-Refereed Journal Articles

19. Downar, James, Hua, May & Wunsch, Hannah. (2023, July). Palliative Care in the Intensive Care Unit: Past, Present, and Future. *Critical care clinics*, 39(3), 529-539.
Impact Factor: 3.879
18. Turcotte Luke Andrew, Zalucky Ann Alexandra, Stall Nathan M, Downar James, Rockwood Kenneth, Theou Olga, McArthur Caitlin, Heckman George. (2021, December). Response. *Chest*, 160(6), e679-e680.
Impact Factor: 9.657
17. Downar James, Wegier Pete, Tanuseputro Peter. (2019, September 4). Early Identification of People Who Would Benefit From a Palliative Approach-Moving From Surprise to Routine. *JAMA network open*, 2(9), e1911146.
16. Hawryluck Laura, Downar James, Colangelo Joe. (2019, August 2). Legal adjudications at the end of life: The lack of difference between best interest and substantial harm standards in conflict resolution. *Journal of critical care*, 54, 288-289.
Impact Factor: 2.783
15. Kyeremanteng Kwadwo, Downar James. (2019, May 20). Why is it so hard to stop doing things that are unwanted, non-beneficial, or unsustainable?. *The Lancet. Respiratory medicine*, 7(7), 558-560.
Impact Factor: 22.992
14. Bandrauk Natalie, Downar James, Paunovic Bojan. (2018, March 16). In reply: Reappraisal of the Canadian Critical Care Society's position on withholding and withdrawing life-sustaining treatment. *Canadian journal of anaesthesia = Journal canadien d'anesthesie*, 65(7), 845-846.
Impact Factor: 3.374
13. Muscedere John, Kim Perry, Aitken Peter, Gaucher Michael, Osborn Robin, Farrell Barbara, Holroyd-Leduc Jayna, Mallery Laurie, Siu Henry, Downar James, Lee Todd C, McDonald Emily, Burry Lisa. (2017, December 22). Proceedings of the Canadian Frailty Network Summit: Medication Optimization for Frail Older Canadians, Toronto, Monday April 24, 2017. *Canadian geriatrics journal : CGJ*, 20(4), 253-263.
Impact Factor: 1.8
12. Downar James, Goldman Russell, Pinto Ruxandra, Englesakis Marina, Adhikari Neill. (2017, August 21). The authors respond to "The utility and value of the 'surprise question' for patients with serious illness. *CMAJ : Canadian Medical Association journal = journal de l'Association medicale canadienne*, 189(33), E1074.
Impact Factor: 7.7

PCI

11. Downar James, Goldman Russell, Pinto Ruxandra, Englesakis Marina, Adhikari Neill K J. (2017, June 12). Response to: "About the 'surprise question'. *CMAJ : Canadian Medical Association journal = journal de l'Association medicale canadienne*, 189(23), E808.
    Impact Factor: 7.7
10. Downar James, Bakker Jan. (2017, June). The authors reply. *Critical care medicine*, 45(6), e627.
    Impact Factor: 6.971

Expert Opinion

4. (2019, May 21).
   Consulted with Mr. Seymour via teleconference about the Canadian experience with Medical Assistance in Dying, observations about eligibility criteria and safeguards
3. (2019, May 7).
   Invited to consult with Ministerial Expert Panel on Voluntary Assisted Dying in Western Australia on wording of legislation for legalizing Medical Assistance in Dying. Most advice was endorsed by the report and ultimately incorporated into the legislation. Final report available at: https://ww2.health.wa.gov.au/~/media/Files/Corporate/general%20documents/Voluntary%20assisted%20dying/PDF/voluntary-assisted-dying-final-report.pdf

PKI