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## Professional Standard Regarding Medical Assistance in Dying

This document is a **standard** approved by the Council of the College of Physicians and Surgeons of Nova Scotia.

A **standard** reflects the minimum professional and ethical behaviour, conduct or practice expected by the College of Physicians and Surgeons of Nova Scotia. Physicians licensed with the College are required to be familiar with and comply with the College standards.

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<sup>1</sup> This document reflects the content of Bill C-14, passed by Parliament on June 17, 2016

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## 1. **INTRODUCTION**

- 1.1 On June 17, 2016 new provisions of the Canadian Criminal Code came into force. These amendments to the Criminal Code followed the Supreme Court of Canada decision in *Carter v Canada (Attorney General)*<sup>2</sup>, which struck down the previous prohibitions against medical assistance in dying. The effect of the *Carter* decision, combined with the subsequent changes to the Criminal Code is that it is now legal for a physician or nurse practitioner to assist an adult patient to die if specified criteria have been met.
- 1.2 The College of Physicians and Surgeons of Nova Scotia (CPSNS) has established this Standard for the following purposes:
  - 1.2.1 to provide information that will assist physicians and the public in understanding the criteria and procedural requirements that must be met regarding medical assistance in dying<sup>3</sup>; and
  - 1.2.2 to outline the specific legal requirements for medical assistance in dying, and the procedures to be followed by Nova Scotia licensed physicians who are involved with its provision.
- 1.3 This Standard needs to be read in conjunction with other College standards including the [Professional Standards Regarding Transfer of Care](#) and the [Professional Standard and Guidelines Regarding Informed Patient Consent to Treatment](#).
- 1.4 Physicians are encouraged to consult with the Canadian Medical Protective Association (CMPA) or other authorities if concerns arise regarding medical assistance in dying.

## 2. **INTERPRETATION**

- 2.1 This Standard is to be interpreted in a manner that:
  - 2.1.1 respects the autonomy of patients, such that capable adults are free to make decisions about medical assistance in dying within the criteria established in this Standard;
  - 2.1.2 maintains the dignity of patients and treats with respect patients, their family members and others involved in end of life decisions;
  - 2.1.3 promotes equitable access to medical assistance in dying;
  - 2.1.4 recognizes an appropriate balance between the physician's freedom of conscience and religion and the patient's right to life, liberty and security of the person;

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<sup>2</sup> *Carter v. Canada (Attorney General)*, 2015 SCC 5; <https://www.canlii.org/en/ca/scc/doc/2015/2015scc5/2015scc5.html?resultIndex=1>

<sup>3</sup> See definition of "medical assistance in dying" in Article 9

2.1.5 is consistent with the Criminal Code of Canada.

### **3. SCOPE OF STANDARD**

- 3.1 This Standard relates only to situations where in response to a patient's request for medical assistance in dying, a physician either prescribes medication or administers medication<sup>4</sup> to a patient who meets the criteria in this Standard.
- 3.2 This Standard is not about palliative care<sup>5</sup>. It is not intended to affect the ongoing provision of palliative care, or to provide a substitute for it.

### **4. RESPONSIBILITY OF PHYSICIANS UNABLE OR UNWILLING TO PARTICIPATE IN MEDICAL ASSISTANCE IN DYING**

- 4.1 Physicians may be unable to participate in medical assistance in dying for various practical reasons such as lack of availability or lack of expertise. Some physicians may be unwilling to participate for reasons of conscience. No physician can be compelled to prescribe or administer medication for the purpose of medical assistance in dying.
- 4.2 The physician unable or unwilling to participate **must complete an effective transfer of care**<sup>6</sup> for any patient requesting medical assistance in dying.
- 4.3 In addition to completing an effective transfer of care, a physician unable or unwilling to provide medical assistance in dying for a patient must, at the earliest opportunity:
  - 4.3.1 advise the patient that he or she is not able or willing to provide medical assistance in dying;
  - 4.3.2 provide the patient with a copy of this Standard;
  - 4.3.3 provide all relevant patient medical records to the physician providing services related to medical assistance in dying;
  - 4.3.4 continue to provide medical services unrelated to medical assistance in dying unless the patient requests otherwise or until alternative care is in place.

### **5. ELIGIBILITY CRITERIA FOR PATIENTS TO ACCESS MEDICAL ASSISTANCE IN DYING**

- 5.1 Physicians cannot act on a request for medical assistance in dying set out in a Personal Directive or similar document.
- 5.2 Physicians cannot act on a request for medical assistance in dying on the direction of anyone other than the patient. If the patient has difficulty communicating, physicians

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<sup>4</sup> See definition of "medication" in Article 9

<sup>5</sup> See definition of "palliative care" in Article 9

<sup>6</sup> See definition of "effective transfer of care" in Article 9

must take all necessary measures to provide a reliable means by which the patient may understand the information that is provided and communicate his or her decision.

5.3 Physicians may provide medical assistance in dying only where all the following eligibility criteria are met:

- 5.3.1 The patient is eligible, or, but for any applicable minimum period of residence or waiting period, would be eligible for health services funded by the Province of Nova Scotia;
- 5.3.2 The patient is at least 18 years of age and capable of making decisions with respect to their health;<sup>7</sup>
- 5.3.3 The patient's request for medical assistance in dying is a voluntary one, made freely, without coercion, undue influence, or any form of external pressure;<sup>8</sup>
- 5.3.4 The patient must have a grievous and irremediable medical condition. This criteria is met only where the physician is of the opinion that the patient meets all of the following criteria:
  - (a) the patient has a serious and incurable illness, disease or disability;
  - (b) the patient is in an advanced state of irreversible decline in capability;
  - (c) the illness, disease or disability or that state of decline causes the patient enduring physical or psychological suffering that is intolerable to the patient and cannot be relieved under conditions that the patient considers acceptable; and
  - (d) the patient's natural death has become reasonably foreseeable<sup>9</sup>, taking into account all of the patient's medical circumstances, without a prognosis necessarily having been made as to the specific length of time that the patient has remaining;

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<sup>7</sup> See [Professional Standard and Guidelines Regarding Informed Patient Consent to Treatment](#)

<sup>8</sup> See [Professional Standard and Guidelines Regarding Informed Patient Consent to Treatment](#)

<sup>9</sup> The only court decision to date addressing "reasonably foreseeable" states that:

natural death need not be imminent and that what is a reasonably foreseeable death is a person-specific medical question to be made without necessarily making, but not necessarily precluding, a prognosis of the remaining lifespan.

In formulating an opinion, the physician need not opine about the specific length of time that the person requesting medical assistance in dying has remaining in his or her lifetime. ([AB v. Canada 2017 ONSC 3759, para 79-80](#))

Therefore, natural death will be reasonably foreseeable if a medical or nurse practitioner is of the opinion that a patient's natural death will be sufficiently soon or that the patient's cause of natural death has become predictable

5.3.5 The patient gives informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care.<sup>10</sup>

5.4 A patient with a mental illness is eligible for medical assistance in dying as long as the patient meets all the criteria set out in Article 5.3.<sup>11</sup>

## 6. DUTIES OF FIRST AND SECOND PHYSICIANS

### A. GENERAL

6.1 The Criminal Code requires that at least two physicians<sup>12</sup> are involved in the assessment of eligibility of a patient requesting medical assistance in dying. This Standard refers to these roles as the First and Second Physician.

6.2 Physicians who take on the role of First or Second Physician must:

6.2.1 thoroughly familiarize themselves with this Standard;

6.2.2 be independent from each other;<sup>13</sup>

6.2.3 provide medical assistance in dying with reasonable knowledge, care and skill and in accordance with this Standard and any other applicable law.

6.3 Physicians are expected to remain current with the guidance provided by the Nova Scotia College of Pharmacists and the Nova Scotia Health Authority regarding all aspects of medical assistance in dying including the prescription, use, storage and return of medications.

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<sup>10</sup> See [Professional Standard and Guidelines Regarding Informed Patient Consent to Treatment](#)

<sup>11</sup> Since one of the criteria for eligibility requires a patient to be **capable of making decisions**, particular caution should be paid to this eligibility criterion in the context of a patient with a mental illness. Caution is also advised in general when addressing patients with mental illnesses seeking medical assistance in dying, as the federal government is in the process of reviewing the issue of such requests where mental illness is the sole underlying medical condition. It is uncertain what the outcome of this review may be, and while it is underway some confusion has arisen as to the eligibility of patients where mental illness is the sole underlying medical condition. While the eligibility criteria do not exclude such patients, the fact such review is underway warrants further caution. Physicians are encouraged to seek advice from CMPA or other counsel before dealing with such cases.

<sup>12</sup> Medical assistance in dying may be provided by a medical practitioner or a nurse practitioner. This Standard applies only to medical practitioners, but it is possible for one or both of the persons referred to as the “First” or “Second” Physician in this Standard to be a nurse practitioner. This Standard should be read with that in mind, and in keeping with the definitions of “medical practitioner” and “nurse practitioner” set out in Article 9.

<sup>13</sup> The two practitioners are independent from each other if they:

- (i) are not a mentor to the other practitioner or responsible for supervising their work;
- (ii) do not know or believe that they are a beneficiary under the will of the person making the request, or a recipient, in any other way, of a financial or other material benefit resulting from that person’s death, other than standard compensation for their services relating to the request; or
- (iii) do not know or believe that they are connected to the other practitioner or to the person making the request in any other way that would affect their objectivity.

## B. DUTIES OF FIRST PHYSICIAN

### 6.4 The First Physician must:

- 6.4.1 act as the patient navigator, by keeping the patient informed throughout the process about all relevant information. In fulfilling this role, the First Physician must:
- (a) engage in a discussion of the patient's diagnosis, prognosis and treatment options;
  - (b) engage in a discussion of the availability of palliative care for terminally ill patients; and
  - (c) give the patient a copy of this Standard;
- 6.4.2 expeditiously assess the patient in person to determine whether the patient meets the eligibility criteria:
- (a) In order to determine that a patient meets the eligibility criteria, the First Physician, prior to referral to the Second Physician, must rely either:
    - (i) on their assessment of the patient alone; or
    - (ii) on their assessment of the patient in combination with the opinions of one or more other Regulated Health Professionals (not including the Second Physician for that patient).
- 6.4.3 receive from the patient a signed<sup>14</sup>, written and dated request for medical assistance in dying AFTER the patient is informed by a medical practitioner of the grievous and irremediable medical condition. The written request must be witnessed by two independent witnesses<sup>15</sup> who must also sign and date the request;

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<sup>14</sup> If the person requesting medical assistance in dying is unable to sign and date the request, another person who is at least 18 years of age and who understands the nature of the request for medical assistance in dying, and who does not know or believe that they are a beneficiary under the will of the person making the request, or a recipient, in any other way, of a financial or other material benefit resulting from that person's death, may do so in the person's presence, on the person's behalf and under the person's express direction.

<sup>15</sup> Any person who is at least 18 years of age and who understand the nature of the request for medical assistance in dying may act as an independent witness, except if they

- (a) know or believe that they are a beneficiary under the will of the person making the request, or a recipient, in any other way, of a financial or other material benefit resulting from that person's death;
- (b) are an owner or operator of any health care facility at which the person making the request is being treated or any facility in which that person resides;
- (c) are directly involved in providing health care services to the person making the request; or
- (d) directly provide personal care to the person making the request.

- 6.4.4 ensure the patient has been informed that they may, at any time, and in any manner, withdraw their request;
- 6.4.5 upon being satisfied the patient meets the eligibility criteria:
  - (a) expeditiously arrange for a Second Physician to assess the patient;
  - (b) inform the patient whether the First Physician will be able to prescribe or administer the medication;
  - (c) if unable to prescribe or administer the medication, refer the patient to a Second Physician who is known to be able to prescribe or administer the medication if the eligibility criteria are met.
- 6.4.6 before prescribing or administering the medication (if taking on that role):
  - (a) review all documentation provided by the Second Physician. Specifically, the First Physician must ensure that the Second Physician has provided a written opinion that the eligibility criteria are met;
  - (b) ensure that there are at least 10 clear days between the day on which the request was signed by or on behalf the patient (which must be after the date the patient was informed of the grievous and irremediable medical condition) and the day on which the medical assistance in dying is provided, or, if the First Physician and the Second Physician are both of the opinion that the patient's death, or the loss of their capacity to provide informed consent, is imminent, any shorter period of time that the First Physician considers appropriate in the circumstances;
  - (c) immediately before providing the medical assistance in dying, give the patient an opportunity to withdraw their request and ensure that the patient gives express consent to receive medical assistance in dying. If the patient rescinds the request for medical assistance in dying and subsequently makes another request for it, the First Physician must re-start the process and execute all the duties of the First Physician as if the process had not been previously commenced;
  - (d) comply with the obligations regarding medication in accordance with Article 7;
  - (e) complete the documentation requirements of this Standard in accordance with Article 8;
- 6.4.7 if unable to complete the role, make an effective transfer of care to another physician to take on the role of the First Physician. In this circumstance, if the Second Physician has already determined the patient meets the eligibility criteria, the Second Physician is not required to reassess the patient and provide new confirmation of eligibility.

## C. Duties of Second Physician

6.5 The Second Physician must:

6.5.1 upon receipt of a request from the First Physician, expeditiously assess the patient in person to determine whether the patient meets the eligibility criteria:

- (a) in order to be satisfied that the patient meets the eligibility criteria, the Second Physician must rely either
  - (i) on their assessment of the patient alone; or
  - (ii) on their own assessment of the patient in combination with the opinions of one or more other Regulated Health Professionals (not including the First Physician for that patient);
- (b) where arrangements have been made for the First Physician to prescribe or administer the medication, then after the Second Physician has assessed the patient, the Second Physician must send the required written documentation to the First Physician confirming whether the patient meets the eligibility criteria.

6.5.2 before prescribing or administering the medication (if taking on that role):

- (a) review the documentation provided by the First Physician, and be satisfied that the First Physician is of the opinion that the eligibility criteria are met;
- (b) ensure that there are at least 10 clear days between the day on which the request was signed by or on behalf the patient (which must be after the date the patient was informed of the grievous and irremediable medical condition) and the day on which the medical assistance in dying is provided, or, if the First Physician and the Second Physician are both of the opinion that the patient's death, or the loss of their capacity to provide informed consent, is imminent, any shorter period of time that the Second Physician considers appropriate in the circumstances;
- (c) immediately before providing the medical assistance in dying, give the patient an opportunity to withdraw their request and ensure that the patient gives express consent to receive medical assistance in dying. If the patient rescinds the request for medical assistance in dying and subsequently makes another request for it, the Second Physician must re-start the process and execute all the duties of the Second Physician as if the process had not been previously commenced;
- (d) comply with the obligations regarding the medication in accordance with Article 7;

- (e) complete the documentation requirements of this Standard in accordance with Article 8;

6.5.3 if unable to complete the role, make an effective transfer of care to another physician to take on the role of the Second Physician. In this circumstance, if the First Physician has already determined the patient meets the eligibility criteria, the First Physician is not required to reassess the patient and provide new confirmation of eligibility.

## **7. PRESCRIBING OR ADMINISTERING MEDICATION**

- 7.1 The medication may be prescribed or administered by either the First or Second Physician at the patient's request.
- 7.2 The First or Second Physician who, in providing medical assistance in dying, prescribes or obtains medication for that purpose must, before any pharmacist dispenses the medication, confirm in writing to the pharmacist that:
  - (a) the medication is for a specified patient;
  - (b) the medication is intended for medical assistance in dying for that specified patient; and
  - (c) the specified patient meets the eligibility criteria.
- 7.3 A physician must provide a pharmacist reasonable notice that a prescription for the medication for the specified patient will be requested.

## **8. DOCUMENTATION**

- 8.1 Physicians must document in the patient's chart that all steps in this Standard have been met.
- 8.2 Unless exempted by regulations made by the federal Minister of Health, physicians who receive a written request for medical assistance in dying must comply with all documentation and reporting requirements set out in [regulations](#) made by the federal Minister of Health.
- 8.3 Physicians must comply with [Guidelines for Death Certificates](#) established by the federal Minister of Health respecting information to be included on death certificates in cases where medical assistance in dying has been provided.

## 9. DEFINITIONS

- 9.1 For purposes of this Standard: “**capacity**” has the same meaning as set out in the [\*Professional Standard and Guidelines Regarding Informed Patient Consent to Treatment\*](#)<sup>16</sup>;
- 9.1.1 “**effective transfer of care**” means a transfer made by one practitioner<sup>17</sup> in good faith to another practitioner who is available to accept the transfer, who is accessible to the patient, and willing to provide medical assistance in dying to the patient if the eligibility criteria are met;
- 9.1.2 “**eligibility criteria**” means the criteria set out in Article 5 of this Standard which must be met by a patient in order to access medical assistance in dying, and “eligible” and “eligibility” have similar meaning as the context requires;
- 9.1.3 “**First Physician**” means the physician who agrees to perform the functions of a First Physician set out in Article 6 and elsewhere in this Standard;
- 9.1.4 “**medical assistance in dying**” means
- (a) the administering by a medical practitioner or nurse practitioner of a substance to a person, at their request, that causes their death; or
  - (b) the prescribing or providing by a medical practitioner or nurse practitioner of a substance to a person, at their request, so that they may self-administer the substance and in doing so cause their own death;
- 9.1.6 “**medical practitioner**” means a person licensed to practice medicine by the College of Physicians and Surgeons of Nova Scotia;
- 9.1.7 “**medication**” means the substance prescribed by or administered by the First Physician or Second Physician for the purposes of medical assistance in dying;
- 9.1.8 “**nurse practitioner**” means a person licensed to practice as a nurse practitioner by the College of Registered Nurses of Nova Scotia;
- 9.1.9 “**palliative care**” means care provided to people of all ages who have a life-limiting illness, with little or no prospect of cure, and for whom the primary treatment goal is quality of life. The treatment is aimed at alleviating suffering – physical, emotional, psychological, or spiritual – rather than curing. It aims neither to hasten nor to postpone death, but affirms life and regards dying as a

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<sup>16</sup> See [\*Professional Standard and Guidelines Regarding Informed Patient Consent to Treatment\*](#)

<sup>17</sup> “practitioner” includes both medical practitioners and nurse practitioners

normal process. It recognizes the special needs of patients and families at the end of life, and offers a support system to help them cope;<sup>18</sup>

- 9.1.10 “**patient**” means the person seeking medical assistance in dying;
- 9.1.11 “**pharmacist**” means a person who is licensed as a pharmacist by the Nova Scotia College of Pharmacists;
- 9.1.12 “**Regulated Health Professional**” means a currently licensed member of a regulated health profession, as that term is defined in the *Regulated Health Professions Network Act*, SNS 2012, s. 48;
- 9.1.13 “**Second Physician**” means the physician who agrees to assess the patient at the request of the First Physician to determine whether the patient meets the eligibility criteria for physician-assisted death and who performs the functions of a Second Physician as set out in Article 6 and elsewhere in this Standard.

## 10. DOCUMENT HISTORY

- 10.1 Amended and approved by the Executive Committee of the College of Physicians and Surgeons of Nova Scotia: **February 8, 2018**
- 10.2 First approved by the Council of the College of Physicians and Surgeons of Nova Scotia: Date: **June 22, 2016**
- 10.3 Approximate date of next review: **2019**

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<sup>18</sup> From paragraph 41 of *Carter* Trial Decision.