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April 26, 2021[1]

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.

[1] This document reflects the content of amendments to the Criminal Code of Canada, through Bill C-14, which came into force on June 17, 2016 and Bill C-7, which came into force March 17, 2021.

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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)*[2], 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, was that medical assistance in dying became legal.

1.2 On March 17, 2021, in response to the Superior Court of Quebec's decision in *Truchon c. Procureur general du Canada*, Bill C-7 received royal assent, further changing the provisions of the Criminal Code. (*2019 QCCS 3792 "Truchon"*). These changes include:

1.2.1 a pathway to eligibility for medical assistance in dying for patients whose natural death is not reasonably foreseeable, and

1.2.2 a mechanism for patients whose death is reasonably foreseeable to receive medical assistance in dying on their preferred date, despite having lost capacity to consent at the time the medication is to be administered. This mechanism is discussed in Article 10, Advance Requests[3].

1.3 Building on these legal developments, The College of Physicians and Surgeons of Nova Scotia (CPSNS) has established this Standard for the following purposes:

1.3.1 to provide information that will assist physicians and the public in understanding the eligibility criteria and procedural requirements that must be met regarding medical assistance in dying[4]; and

1.3.2 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.

1.4 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*.

1.5 Physicians are encouraged to consult with the Canadian Medical Protective Association (CMPA) and to consult with resources generated by the Canadian Association of MAID Assessors and Providers (CAMAP) or other authorities if concerns arise regarding medical assistance in dying.

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

[3] The amendment allowing for waiver of final consent is often known as "Audrey's Amendment", in honor of the concerns raised by Audrey Parker of Nova Scotia who chose to receive MAiD earlier than she wanted out of fear of losing decision-making capacity before her preferred date.

[4] See definition of "medical assistance in dying" in Article 9.

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, the patient's freedom of conscience and religion, and the patient's right to life, liberty and security of the person and equality; and

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[5] to a patient who meets the criteria in this Standard.

3.2 This Standard is not about palliative care[6]. 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 No physician can be compelled to prescribe or administer medication for the purpose of medical assistance in dying.

4.2 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 or religion.

4.3 The physician unable or unwilling to participate or to continue to participate in medical assistance in dying **must complete an effective transfer of care**[7] for any patient requesting or eligible to receive medical assistance in dying.

[5] See definition of "medication" in Article 9.
[6] See definition of "palliative care" in Article 9.
[7] See definition of "effective transfer of care" in Article 9.

4.4 In addition to completing an effective transfer of care, a physician unable or unwilling to assess for or provide medical assistance in dying to a patient must, at the earliest opportunity:

4.4.1 advise the patient that he or she is not able or willing to provide medical assistance in dying;

4.4.2 provide the patient with a copy of this Standard;

4.4.3 provide all relevant patient medical records to the physician or nurse practitioner providing services related to medical assistance in dying; and

4.4.4 continue to provide medical services unrelated to medical assistance in dying unless the patient requests otherwise or until alternative care is in place.

5. GENERAL ELIGIBILITY CRITERIA FOR MEDICAL ASSISTANCE IN DYING

5.1 Physicians cannot act on a request for medical assistance in dying set out in an advance directive (known in Nova Scotia as personal directives and known colloquially as living wills), except as permitted by this Standard's provisions relating to Advance Request (set out in Article 10, or Advance Consent - failure of self-administered medical assistance in dying).

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 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;[8]

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;[9]

5.3.4 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;

[8] See *Professional Standard and Guidelines Regarding Informed Patient Consent to Treatment*
[9] See *Professional Standard and Guidelines Regarding Informed Patient Consent to Treatment*

5.3.5 The patient has a grievous and irremediable medical condition. These criteria are met only where the physician is of the opinion:

(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; and

(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.

5.3.6 Mental illness[10] is not considered to be an illness, disease or disability for the purpose of determining eligibility for medical assistance in dying.

6. DUTIES OF FIRST AND SECOND PHYSICIANS

A. GENERAL

6.1 The Criminal Code requires that at least two practitioners[11] are involved in the assessment of eligibility of a patient requesting medical assistance in dying. This Standard generally 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;[12] and

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 Nova Scotia Health regarding all aspects of medical assistance in dying including the prescription use, storage and return of medications.

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[10] Mental Illness has not been defined in this legislation nor has its meaning in this legislation been considered in the courts. For present purposes, it appears clear that "mental illness" does not encompass all diagnoses within the DSM5. For example, disorders such as neuro-cognitive disorders or dementias would not be considered mental illnesses.

[11] 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, or the "Physician" or "practitioner" 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 13.

[12] 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; and

(c) give the patient a copy of this Standard.

6.4.2 In order to determine that a patient meets the eligibility criteria, the First Physician, prior to referral to the Second Physician, must expeditiously assess the patient, relying 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[13], written and dated request for medical assistance in dying AFTER the patient is informed by a physician of the grievous and irremediable medical condition. The written request must be witnessed by one independent witness[14].

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:

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[13] 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 on the person's behalf and under the person's express direction.

[14] 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.

The duty of the witness is solely to attest to the signature of the party or parties. By witnessing the written request for medical assistance in dying, the witness is not affirming, supporting, or in any way speaking to the decisions of the parties set out in the document. [or to any aspect of their eligibility for MAiD]

(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; and

(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) except where the provisions of an Advance Request apply as set out in Article 10, immediately before administering the medication give the patient an opportunity to withdraw their request and ensure that the patient gives express consent to receive medical assistance in dying;

(c) if the patient withdraws or 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 obligations regarding medication in accordance with Article 7;

(e) comply with all safeguards set out in Article 8 or 9, whichever is applicable; and

(f) complete the documentation requirements of this Standard in accordance with Article 12.

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) except where the provisions of an Advance Request apply as set out in Article 10, immediately before immediately before administering the medication give the patient an opportunity to withdraw or rescind their request and ensure that the patient gives express consent to receive medical assistance in dying;

(c) If the patient withdraws or 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) comply with all safeguards set out in Article 8 or 9, whichever is applicable, and

(f) complete the documentation requirements of this Standard in accordance with Article12.

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. GENERAL SAFEGUARDS WHEN NATURAL DEATH IS REASONABLY FORESEEABLE[15]

8.1 This article applies to all physicians involved in any aspect of medical assistance in dying for patients where natural death is foreseeable.

8.2 When caring for a patient requesting medical assistance in dying whose natural death is reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time they have remaining, physicians must:

(a) be of the opinion that the person meets all of the criteria set out in Article 5;

(b) ensure that the person's request for medical assistance in dying was:

(i) made in writing and signed and dated by the person or by another person as set out in footnote 13;

(ii) signed and dated after the person was informed by a medical practitioner or nurse practitioner that the person has a grievous and irremediable medical condition;

(c) be satisfied that the request was signed and dated by the person, or by another person as set out in footnote 13, before an independent witness who then also signed and dated the request;

(d) ensure that the person has been informed that they may, at any time and in any manner, withdraw their request;

[15] The key 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)*

(e) ensure that another medical practitioner or nurse practitioner has provided a written opinion confirming that the person meets all of the criteria set out in Article 5;

(f) be satisfied that they and the other medical practitioner or nurse practitioner referred to in clause (e) are independent[16];

(g) if the person has difficulty communicating, take all necessary measures to provide a reliable means by which the person may understand the information that is provided to them and communicate their decision; and

(h) except where the provisions of an Advance Request apply as set out in Article 10, immediately before administering the medication, give the person an opportunity to withdraw their request and ensure that the person gives express consent to receive medical assistance in dying.

9. ADDITIONAL SAFEGUARDS WHEN NATURAL DEATH IS NOT REASONABLY FORESEEABLE

9.1 This article applies to all physicians involved in any aspect of medical assistance in dying for patients where natural death is not reasonably foreseeable.

9.2 When caring for a patient requesting medical assistance in dying whose natural death is not reasonably foreseeable, taking into account all of their medical circumstances, physicians must, **in addition to complying with all the requirements of Article 8:**

(a) if neither they nor the other practitioner who has provided an opinion on eligibility has expertise in the condition that is causing the person's suffering, ensure that they or the other practitioner consults with a practitioner who has that expertise and share the results of that consultation with the other practitioner;

(b) ensure that the person has been informed of the means available to relieve their suffering, including, where appropriate, counselling services, mental health and disability support services, community services and palliative care and has been offered consultations with relevant professionals who provide those services or that care;

(c) ensure that they and the other practitioner who has provided an opinion on eligibility have discussed with the person the reasonable and available means to relieve the person's suffering and they and the other practitioner agree with the person that the person has given serious consideration to those means;

[16] See footnote 12.

(d) ensure that there are at least 90 clear days between the day on which the first assessment of whether the person meets the eligibility criteria begins and the day on which medical assistance in dying is provided to them or, if the assessments have been completed and the two practitioners who provided opinions on eligibility are both of the opinion that the loss of the person's capacity to provide consent to receive medical assistance in dying is imminent, any shorter period that the first practitioner considers appropriate in the circumstances.

10. ADVANCE REQUEST

10.1 For the patient found to be eligible for medical assistance in dying **whose natural death is reasonably foreseeable**, an Advance Request is permitted.

10.2 An Advance Request permits a patient whose death is reasonably foreseeable to waive the requirement that they give express consent immediately prior to receiving the medication used for medical assistance in dying.

10.3 The Advance Request containing the patient's consent must be documented in writing with agreement that a physician would administer a medication to cause their death on a specified day. The patient must have been informed that they are at risk of losing capacity.

10.4 If the patient who has provided an Advance Request still has capacity on the day of the scheduled procedure, they must be provided an opportunity to withdraw their request.

10.5 The Advance Request is invalidated if the patient demonstrates by word, sound or gestures, refusal or resistance to the administration of medical assistance in dying at the time of the procedure.

10.6 When caring for a patient whose death is reasonably foreseeable who has provided an Advance Request for medical assistance in dying, physicians must comply with the following legal safeguards as established by Parliament:

10.6.1 The physician must be satisfied that before the person loses the capacity to consent to receiving medical assistance in dying,

(a) they met all of the criteria and all other safeguards set out in this Standard;

(b) they entered into an arrangement in writing with the medical practitioner that the practitioner would administer a medication to cause their death on a specified day;

(c) they were informed by the medical practitioner of the risk of losing the capacity to consent to receiving medical assistance in dying prior to the day specified in the arrangement; and

(d) in the written arrangement, they consented to the administration by the medical practitioner of a medication to cause their death on or before the day specified in the arrangement if they lost their capacity to consent to receive medical assistance in dying prior to that day.

10.6.2 The physician must be satisfied that:

(a) the person has lost the capacity to consent to receive medical assistance in dying;

(b) the person does not demonstrate, by words, sounds or gestures, refusal to have the medication administered or resistance to its administration; and

(c) the medication is administered to the person in accordance with the terms of the arrangement.

10.6.3 For greater certainty, *involuntary* words, sounds or gestures made in response to contact do not constitute a demonstration of refusal or resistance for the purposes of Article 8.6.2(e).

10.7 Once a person demonstrates, by words, sounds or gestures, in accordance with this Standard, refusal to have the medication administered or resistance to its administration, medical assistance in dying can no longer be provided to them on the basis of the Advance Request given by them.

11. ADVANCE CONSENT

11.1 For the person found to be eligible for medical assistance in dying, who has elected to receive medical assistance in dying through self-administration of medications, Advance Consent is permitted.

11.2 Advance Consent permits a practitioner to administer medication to a person who loses the capacity to consent to receiving medical assistance in dying after self-administering medication.

11.3 In the case of a person who loses the capacity to consent to receiving medical assistance in dying after self-administering a medication provided to them under this standard to cause their own death, a practitioner may administer medication if:

(a) before the person loses the capacity to consent to receiving medical assistance in dying, they and the practitioner entered into an arrangement in writing providing that the practitioner would:

(i) be present at the time the person self-administered the first medication; and

(ii) administer a second medication to cause the person's death if, after self-administering the first medication, the person lost the

capacity to consent to receiving medical assistance in dying and did not die within a specified period.

(b) the person self-administers the first medication, does not die within the period specified in the arrangement and loses the capacity to consent to receiving medical assistance in dying; and

(c) the second medication is administered to the person in accordance with the terms of the arrangement.

12. DOCUMENTATION

Physicians must document in the patient's chart that all steps in this Standard have been met.

12.1 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.

12.2 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.

13. DEFINITIONS

13.1 "**capacity**" has the same meaning as set out in the *Professional Standard and Guidelines Regarding Informed Patient Consent to Treatment*[17];

13.2 "**effective transfer of care**" means a transfer made by one practitioner[18] 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;

13.3 "**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;

13.4 "**First Physician**" means the physician who agrees to perform the functions of a First Physician set out in Article 1 and elsewhere in this Standard;

13.5 "**medical assistance in dying**" means:

(a) the administering by a medical practitioner or a nurse practitioner of a medication to a person, at their request, that causes their death; or

[17] See *Professional Standard and Guidelines Regarding Informed Patient Consent to Treatment*
[18] "practitioner" includes both medical practitioners and nurse practitioners.

(b) the prescribing or providing by a medical practitioner or a nurse practitioner of a medication to a person, at their request, so that they may self-administer the medication and in doing so cause their own death;

13.6 "**medical practitioner**" means a person licensed to practice medicine by the College of Physicians and Surgeons of Nova Scotia;

13.7 "**medication**" means the substance prescribed by or administered by the First Physician or Second Physician for the purposes of medical assistance in dying;

13.8 "**nurse practitioner**" means a person licensed to practice as a nurse practitioner by the College of Registered Nurses of Nova Scotia;

13.9 "**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 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;[19]

13.10 **"patient**" means the person seeking medical assistance in dying;

13.11 **"pharmacist"** means a person who is licensed as a pharmacist by the Nova Scotia College of Pharmacists**;**

13.12 **"practitioner"** means either a medical practitioner or a nurse practitioner;

13.13 "**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;

13.14 "**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.

13.15 "**Reasonably Foreseeable**" means that:

(a) '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'.

(b) 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)*

[19] From paragraph 41 of *Carter* Trial Decision.

14. RESOURCES

- College of Physicians and Surgeons of Nova Scotia's *Professional Standards Regarding the Provision of Telemedicine Services*
- Nova Scotia Health MAiD Care Coordinator Office

15. DOCUMENT HISTORY

15.1 First approved by the Council of the College of Physicians and Surgeons of Nova Scotia: Date: **June 22, 2016**

15.2 Amended and approved by the Council of the College and Physicians and Surgeons of Nova Scotia: **October 17, 2017**

15.3 Amended and approved by the Executive Committee of the College of Physicians and Surgeons of Nova Scotia: **February 8, 2018**

15.4 Amended and approved by the Council of the College of Physicians and Surgeons of Nova Scotia: **December 14, 2018**

15.5 Temporary amendment to Standard approved by the Council of the College of Physicians and Surgeons of Nova Scotia: **March 27, 2020**

15.6 Amended and approved by the Executive Committee of the College of Physicians and Surgeons of Nova Scotia: **September 18, 2020**

15.7 Approved by the Executive Committee of the College of Physicians and Surgeons of Nova Scotia: **April 26, 2021**

15.8 Approximate date of next review: **2023**