February 3, 2016

Via Mail & E-Mail: PDAM@parl.gc.ca

Ms Cynara Corbin
Special Joint Committee on Physician-Assisted Dying
Joint Clerk of the Committee
Sixth Floor, 131 Queen Street
Ottawa ON K1P 0A1

Ms Shaila Anwar
Joint Clerk of the Committee
40 Elgin Street
Chambers Building
The Senate of Canada
Ottawa ON K1A 0A4

Dear Ms Corbin and Ms Anwar:

Re: Special Joint Committee Consultations on Physician-Assisted Dying

The Canadian Medical Protective Association ("CMPA") welcomes the opportunity to participate in the consultation process recently initiated by the Special Joint Committee on Physician-Assisted Dying. We thank the Committee for the invitation to make oral submissions and look forward to meeting with the Committee on February 4, 2016.

The CMPA is a not-for-profit mutual defence organization and is the principal provider of medical-legal assistance to Canadian physicians. The most obvious expression of the CMPA's assistance to its members is the provision of legal representation in medical-legal matters related to the practice of medicine. It is equally significant that the CMPA provides broader advisory services to its members on a multitude of medical-legal issues, including issues related to end-of-life care. Consequently, the federal legislative response to *Carter v. Canada (Attorney General)* will have important implications for the CMPA's more than 93,000 members and their patients.

The interaction between a physician and patient on end of life care, including palliative care and physician-assisted death, is inherently intimate. Members have already called the CMPA for guidance in interpreting the *Carter* decision and to find out what they can and should do for their patients who are seeking physician-assisted death. As a physician advisor, the CMPA sits at the intersection of law and medicine and will be asked to assist physicians in the many unique clinical contexts in which physician-assisted death may arise. The CMPA will be asked to guide physicians as they are called upon by patients in individual cases involving physician-assisted death in the context of end of life care. With that perspective, the CMPA and its members wish to see a legislative response to *Carter* that provides a consistent framework for physicians to follow in the best interests of their patients.

The CMPA is pleased to provide the Joint Committee with our recommendations regarding the implementation of federal legislation to address physician-assisted dying. The CMPA submits a legislative response is required to amend the *Criminal Code* and establish a clear and consistent framework that **provides equal access to physician-assisted dying for patients and includes eligibilty requirements and safeguards to ensure equal protection of the law for patients and their physicians**. This Committee can play a critical role in achieving each of these objectives and with respect, should do so.

Overview

The CMPA makes the following recommendations for consideration by the Committee:

- Federal legislation should be implemented to ensure consistent access to physician-assisted dying for all Canadian patients. If considered the most appropriate mechanism to address the issues of shared federal-provincial jurisdiction, the CMPA supports the inclusion of a provision allowing that federal legislation will not supplant provincial-territorial legislation that has been deemed substantially similar or effectively equivalent on the eligibility/safeguard elements of physician-assisted death.
- Eligibility criteria and safeguards should be defined in federal legislation in a clear and concise manner to promote equality of access and to protect patients, while minimizing the medical-legal risks for physicians.
- Federal legislation should support a patient's constitutional right to seek physician-assisted death while balancing the physician's right on moral or religious grounds not to be compelled to assist a patient to die
- In recognition of the unique role played by physicians for their patients, physicians who act in good faith in accordance with the requirements established by law for physician-assisted dying should benefit from legislated protection against criminal charges and civil liability.

Consistent Legislative and Regulatory Approach

Patients and their physicians will benefit from a uniform and consistent legislative and regulatory response to the Supreme Court of Canada's decision in *Carter*. Inconsistent eligibility criteria and safeguards across Canada will result in unequal access to physician-assisted dying for patients, thereby limiting their consistutional rights. Inconsistency is also likely to inhibit equal protection of the law, particularly for vulnerable patients. In the absence of a consistent legislated framework, we remain concerned that physicians willing to participate in physician-assisted dying are at increased risk of medical-legal difficulty in the absence of a consistent framework.

At present (and until June 6, 2016), Canadians who wish to seek physician-assisted dying in accordance with the criteria set out in the *Carter* decision may apply to the court of their jurisdiction for an order allowing them to seek and receive a physician's assistance in dying. We anticipate the Courts may be challenged to issue consistent decisions, in the absence of a legislative framework that addresses the specific parameters of physician-assisted dying. We are aware that the Ontario Superior Court has published a practice advisory to guide applicants on the requirements for court ordered physician-assisted dying and we expect other courts will likely do the same. In the practice advisory, the Court has set out a detailed substantive and procedural framework for patients.

In the absence of legislation, the Court has sought to provide clarity on the eligibility requirements and safeguards. The CMPA submits that comprehensive federal legislation is necessary to facilitate a principles-based approach to physician-assisted dying that is consistent across Canada. In particular, federal legislation is required to make amendments to the *Criminal Code of Canada*. However, the CMPA also recognizes the shared federal-provincial jurisdiction over this matter. If considered the most appropriate mechanism, the CMPA supports the inclusion of a provision allowing that federal legislation will not supplant substantially similar or effectively equivalent legislation in the provincial/territorial jurisdiction. Such an approach is not without precedent in Canadian law.

In the absence of federal legislation, the existing patchwork of eligibility criteria and safeguards for physician-assisted dying is likely to continue. Québec's *An Act Respecting End of Life Care*, for example, requires that patients must be at the "end of life" to be eligible for medical aid in dying, and restricts the provision of medical aid in dying to situations where the physician administers the drug (*i.e.*, physicians cannot prescribe to patients to self-administer). The *Carter* decision does not limit physician-assisted dying to patients suffering from a terminal illness or who are at the end of life and does not limit the method of physician-assisted dying to the administration of the lethal substance by the physician.

The critical aspects of patient access to physician-assisted dying should be aligned based upon the fact that the principles in *Carter* are derived from constitutional rights guaranteed for all Canadians. It is our hope that efforts by the Special Joint Committee will result in a clear and consistent approach across Canada, and that there will be relative uniformity in the legislative and regulatory response to this issue. Parliament and the legislatures have an opportunity to address the existing legislative and social policy gap. In the absence of legislation, there is no clarity on how physician-assisted death should be delivered.

The CMPA applauds efforts by the medical regulatory authorities (Colleges) to address this challenging issue. However, the primary role of the Colleges is generally to create and enforce professional standards, not to address a legislative and social policy vacuum. Not all Colleges have

yet implemented guidance for the profession, and the guidance that has been published is inconsistent.[1] For ease of reference, the divergent approaches taken by the Colleges on key aspects of physician-assisted dying regulation are summarized in the attached chart (Appendix "A").

Eligibility Criteria and Safeguards

In the absence of a comprehensive legislated response, jurisdictions and organizations have considered the questions of eligibility and safeguards and have made important recommendations that should be considered.

The CMPA submits that federal legislation should carefully define eligibility criteria and outline safeguards. Clear delineation of eligibility and safeguards is essential for the protection of patients, including vulnerable individuals. The CMPA's position is that at a minimum, the following issues **must** be addressed by federal legislation:

- The federal legislation should include amendments to the *Criminal Code* to confirm that physicians providing a patient with aid in dying are not in violation of the general prohibition on assisted suicide.
- The legislation must also address:
    - what constitutes an "adult" and whether that term includes "mature minors"
    - what form physician-assisted dying should take (voluntary euthanasia and/or assisted suicide)
    - what is meant by "grievous and irremediable medical condition"
    - whether physician-assisted death could be requested by way of advance medical directives
    - who makes the decision on patient eligibility
    - and what safeguards physicians must comply with before providing physician-assisted dying.

In this regard, the CMPA emphasizes efforts to provide legislated clarity and consistency in the law.

Although physicians' risk management practices already include, among other things, considerations related to informed consent, record-keeping, and assessment of capacity, the CMPA wishes to emphasize the need to adapt these safeguards to the context of physician-

[1] To date, the Colleges of Physicians and Surgeons in British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, New Brunswick and Québec have approved their own guidance materials for their respective members. The Colleges of Physicians and Surgeons of Nova Scotia and Newfoundland and Labrador are also currently conducting consultations on draft guidelines. The government of the Northwest Territories is currently holding consultations on a legislative framework on physician-assisted death.

assisted dying. For example, legislation should address the need to ensure a patient consents free of undue influence and should contemplate that consent may change over time.

Age Requirement

At present, there are inconsistent interpretations of the Supreme Court's decision in *Carter* and proposals across the country suggest varying access to physician-assisted dying. Clarifying the eligibility requirements in federal legislation will specifcally answer questions about patients' constitutional right to physician-assisted dying and help to address medical-legal risk for physicians.

The CMPA is particularly concerned with the disparate interpretations of the term "competent adult" used in the *Carter* decision and submits that a clear definition of the age requirement is essential to remove any uncertainty. Legislation should specify eligibility based on either age of majority or competence of a mature minor.

Other than Québec there has not yet been a comprehenisve legislative response to defining a compenent adult. As a result, several Colleges have taken different approaches to this issue in their interim guidance. Saskatchewan, Manitoba, and Nova Scotia have stated that the Supreme Court of Canada decision in *Carter* limits physician-assisted dying to individuals deemed to be adults under the province's age of majority legislation and excluding mature minors. Québec's legislation also restricts the provision of medical aid in dying to persons over the age of 18, which is the age of majority in Québec.

However, the College of Physicians and Surgeons of Alberta, in their *Advice to the Profession* on physician-assisted dying, suggests mature minors may be eligible for physician-assisted dying. The College of Physicians and Surgeons of New Brunswick states that physician-assisted death "could theoretically be available to any patient who can legally consent, which is the age of sixteen in New Brunswick." The Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying recommends that the federal government make it clear in the legislation that eligibility for physician-assisted dying is to be based on competence rather than age.

Generally there are two approches to this issue: one is age-based and the other is based on an assessment of compentency. If the latter approach is adopted, it will be necessary to address how patient competence will be assessed in the context of physician-assisted dying. The test to determine whether a minor is competent is inherently subjective and may be particularly difficult to implement in the context of physician-assisted dying. At this time it is preferable to set a clear requirment based on age.

Form of Phsysican-Assisted Dying: Administering/Prescribing

Clarity with respect to the process for administering physician-assisted dying is also required. Members of the CMPA have already enquired with the Association about accepted methods of providing physician-assisted dying if a patient obtains a case-specific exemption from a Court before the criminal prohibition on physician-assisted dying falls on June 6, 2016.

The Supreme Court did not expressly rule in *Carter* on the form physician-assisted dying should take. Under Québec's end-of-life legislation, which clearly sets out regulations and guidelines, medical aid in dying can only be administered by physicians; physicians are not permitted to prescribe the lethal medication to a patient to self-administer. In its document "Interim Guidance on Physician-Assisted Death", the College of Physicians and Surgeons of Ontario contemplates that patients may wish to self-administer the fatal dose of medication at home. Patients and physicians in other provinces and territories remain in a state of uncertainty. Other than in Québec, there is no comprehensive legislated direction on this issue. The CMPA's position is that the legislation should outline the acceptable methods of physician-assisted dying, thereby ensuring appropriate protection for patients.

Grievous and Irremediable Medical Condition

What constitutes a "grievous and irremediable" medical condition was not fully defined in *Carter*. The CMPA agrees with the concern raised by regulatory authorities to the External Panel on Options for Legislative Response to *Carter v Canada* that a rigid definition of these terms may not benefit patients and physicians, since it would remove the flexibility to take into acount an individual patient's circumstances. That said, the development of some guiding principles on this issue would be beneficial to both the public and the medical community, to the extent that it will assist their understanding of these terms.

Advance Directives

The CMPA submits that legislation on physician-assisted dying should clearly state whether assisted dying may be requested by way of advance medical directives.

It is unclear from the decision in *Carter* whether the Supreme Court sought to exclude the possibility of requesting physician-assisted dying by way of advance medical directives. The Court merely states that the patient must be a "competent" adult to be eligible for physician-assisted dying, but does not specify if the patient must be competent at the time the request is made, or at the time physician-assisted dying is provided.

To date and in the absence of legislated direction (with the exception of Québec), all regulatory authorities in Canada that have developed guidance on this issue propose that physician-assisted dying cannot be requested by way of advance medical directive. The Québec legislation expressly excludes the option of requesting medical aid in dying by way of advance medical directives.

That said, most provinces and territories have legislation governing the use of advance directives, which generally provide important information to physicians on patient's wishes, especially in the context of end-of-life care. To ensure a consistent approach and equal access to physician-assisted dying and equal protection of the law, the CMPA's position is that any comprehensive legislative response to *Carter* should carefully consider whether and when such directives must be respected.

Decision-Making Process

The CMPA is aware that organizations have made recommendations for the creation of federal boards or other bodies to act as decision makers in determining a patient's eligibility for physician-assisted death. The CMPA takes no position on who should make the eligibility decision. However, to the extent that physicians are involved in the decision making process, their role and obligations should be clearly delineated in federal legislation. The CMPA also supports a decision making process that will be easily accessible to patients, respects patient privacy, and will not impose undue administrative challenges for patients or their physicians.

Roles and Regulation of Healthcare Practitioners

Rights of Conscience

Effective and empathetic end of life care requires a strong bond of trust between a patient and his/her physician. In the context of physician-assisted dying and in support of this trust, the CMPA submits that the legislative response to *Carter* should address a physician's right on moral or religious grounds not to be compelled to assist a patient to die. The Supreme Court of Canada clearly stated in *Carter* that its ruling was not intended to compel physicians to provide assistance in dying. As such, we urge Parliament to ensure that physicians' freedom of conscience is protected when considering the legislation in response to *Carter*.

With a view to ensuring patient access to care, an appropriate approach to consider is the one adopted under Québec's *An Act Respecting End of Life Care*. In Québec, a physician who refuses a request for medical aid in dying for reasons of conscience, must notify the designated authority who will then take the necessary steps to find another physician willing to consider the request.

Discipline and Penalties

With a view to providing appropriate patient access, the CMPA submits that in order for physicians to provide the optimal support to patients faced with phsycian assisted dying, they need assurances that if they comply with the requirements established by law for physician-assisted dying and believe in good faith that their patient met the criteria, they should benefit from protection against criminal charges. The CMPA is aware that the American state of Vermont, in their end of life legislation, has adopted a provision to the effect that "[a] physician shall be immune from any civil or criminal liability or professional disciplinary action for actions performed in good faith compliance".[2] To recognize the unique role being played by physicians for their patients, a similar provision should be considered for Canada.

The CMPA recognizes a role for the existing medical regulatory authorities (Colleges) in the development of more detailed policies to complement the legislative response, as already seen in Québec.

Conclusion

We trust that these comments will be of assistance to the Joint Committee and we look forward to continuing to participate in the development of a response to the decision in *Carter*. If the CMPA's experience with medical-legal issues in the end-of-life context might be of further value to the Committee, we would be pleased to provide any other information or input as may be required.

Yours sincerely,

Hartley S. Stern, MD, FRCSC, FACS
Executive Director/Chief Executive Officer

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[2] *Patient Choice at End of Life*, Sec. 1, 18 VSA c 113, §5290.

Appendix "A"

Overview of Regulatory Guidance for Physicians on Physician-Assisted Death in Canada (current to February 1, 2016)

	Quebec[1]	CPSBC	CPSA	CPSS	CPSM	CPSO	CPSNB	CPSNS (under consultation)	CMA
Age Requirement	18 years old.	Competent adult, no further clarification.	Competent adult includes mature minors.	18 years old.	18 years old.	Competent adult, no further clarification.	Any patient who can legally consent, which is the age of 16 in NB.	19 years old.	Competent adult, no further clarification.
Duty to Refer/ Conscientious Objection	Objecting physician must notify designated health authority who will find another physician to consider the request.	Objecting physician is required to provide an effective transfer of care by advising the patient that other physicians may be available to see them, or by suggesting the patient visit an alternate physician or service.	Objecting physician must arrange timely access to another physician or resource that will provide accurate information about all available medical options.	Objecting physician is expected to arrange timely access to another physician or resources, or offer the patient information and advice about all the medical options available.	Objecting physician must provide the patient with timely access to a resource that will provide accurate information about PAD.	Objecting physician must make an effective referral to another health-care provider. Effective referral means a referral made in good faith, to a non-objecting, available, and accessible physician or agency.	Even if the physician is reluctant to provide an active referral, they remain obligated to provide information to the patient regarding resources which may be directly accessible.	Objecting physician must make an effective referral to a central organization or, if not willing to do so, provide the patient with contact information for that organization who will maintain a list of physicians willing to consider the request.	Objecting physician is expected to advise the patient on how to access any separate central information, counseling and referral service.

[1] Based upon provisions of Quebec's *An Act Respecting End of Life Care*.

	Quebec[1]	CPSBC	CPSA	CPSS	CPSM	CPSO	CPSNB	CPSNS (under consultation)	CMA
Grievous and Irremediable Medical Condition	Patient must be at the end of life, suffer from a serious and incurable illness, be in an advanced state of irreversible decline in capability, and experience constant and unbearable physical or psychological suffering which cannot be relieved in a manner the person deems tolerable. The CMQ Practice Guide provides guidance on these requirements.	No guidance.	No guidance, but states that chronic depression or other mental illness may itself represent a grievous and irremediable condition.	It is not possible to provide a practice guideline or treatment pathway which provides a detailed description of what a physician should do to ensure that those criteria are met. Patients will respond very differently to a grievous medical condition and will differ in the treatments which they are willing to accept. What is intolerable to a patient is subjective to the patient and what is intolerable suffering will significantly	Grievous, in that it is very serious and the current or impending associated symptoms are enduring and cause severe physical or psychological pain or suffering; and irremediable in that there are no medical treatments to cure the condition or alleviate the associated symptoms which make it grievous; or the medical treatments which are available to cure the condition or alleviate the associated symptoms which make it grievous are	'Grievous' is a legal term that applies to serious, non-trivial conditions that have a significant impact on the patient's well-being. 'Irremediable' is a broad term capturing both terminal and non-terminal conditions. 'Irremediable' does not require the patient to undertake treatments that are not acceptable to the individual. The criterion that an individual experience intolerable suffering is subjective, meaning that it is assessed	The patient must have an illness for which there is no cure, nor reasonable amelioration. The illness will eventually cause the patient's death, but this need not be within any predictable time. The patient must be suffering and this must be considered in the broadest sense. Suffering is by nature subjective and it is a challenge for physicians to directly assess such. There can be a possibility of assisting a patient with unresponsive depression if suffering	No guidance, but states that if the grievous and irremediable medical condition is primarily a mental illness, then either the first or second physician must be a psychiatrist or their assessment of eligibility of the patient must be informed by a psychiatric opinion.	It is grievous in that it is serious or severe and the current or impending associated symptoms or prognosis are constant or enduring and cause severe physical or psychological suffering that is intolerable to the patient. What constitutes enduring and intolerable suffering is based on the patient's subjective interpretation. It is irremediable in that it is not able to be cured or made right to alleviate the symptoms which make it

	Quebec[1]	CPSBC	CPSA	CPSS	CPSM	CPSO	CPSNB	CPSNS (under consultation)	CMA
				differ from one patient to another.	not acceptable to the patient. Where the grievous and irremediable medical condition is of a psychiatric nature, the determination must be performed after an independent psychiatric assessment.	from the individual's perspective.	appears truly severe and there is truly no likelihood of a cure, but in those situations, physicians must only proceed with extraordinary caution.		grievous, or it is not amenable to further treatments or interventions that are acceptable to the patient, or it is not remediable by other means acceptable to the patient. A patient is not required to have tried all available standard of care interventions or possible therapies offered to them for this definition to apply.
Advance Medical Directives	Not possible to request medical aid in dying by way of advance medical	PAD cannot be provided to patients who are not able to give consent including when consent is	PAD cannot be provided to patients who lack the capacity to make the decision,	Attending physician must be satisfied that the patient is mentally capable of	If at any time the patient loses his/her medical decision making capacity, PAD	During this time of regulatory uncertainty, requests for PAD must be made by the	Any consent must be from the patient himself/herself, no substitute decision-maker could request	Physicians cannot act on a request for PAD set out in a Personal Directive or similar	Not directly discussed, but appears to indicate advance directives are

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	directives.	given by an alternate or substitute decision-maker, or through a personal advance directive.	including when consent can only be provided by a substitute decision-maker, is known by patient wishes or is provided through a personal directive.	making an informed decision at the time of the request and throughout the process, until the time of PAD.	can no longer be provided to the patient.	patient, and not through an advance directive, or the patient's substitute decision-maker.	PAD, nor could PAD be requested by way of advanced directives.	document.	not permitted. The patient is mentally capable of making an informed decision at the time of the request(s). Before undertaking assisted dying, the attending physician must wait no longer than 48 hours, or as soon as is practicable, after the written request is received, and must hen assess the patient for capacity and voluntariness.
Oversight	Physicians who provide medical aid in dying in an institution must notify the institution's	The medical certificate of death should indicate PAD arising out of the underlying grievous and	A provincial multi-disciplinary committee should receive and review all PADs. Pending	The *Coroner's Act, 1999* requires certain deaths to be reported to a coroner. A physician-	Physicians must ensure that the requirements of physicians set out in *The Fatality*	Supports the establishment of a formal oversight and reporting mechanism that would	No oversight committee or authority. Such creates a high risk of invading the patient's and physician's	Recommends that the government of NS appoint an oversight body to perform a monitoring	There should be a formal oversight body and reporting mechanism that collects data from the

	Quebec[1]	CPSBC	CPSA	CPSS	CPSM	CPSO	CPSNB	CPSNS (under consultation)	CMA
	Council of physicians, dentists and pharmacists (CPDP) within 10 days of administering aid in dying. Physicians practicing in a private health facility must inform the CMQ within the same timeframe. The CPDP or the CMQ will then assess the quality of the care provided. In addition, the physician must give notice to the Commission on End of Life Care within 10 days of administering the aid and send the Commission certain prescribed	irremediable medical condition.	the establishment of such a committee in Alberta, physicians are required to notify the CPSA when a death involves the assistance of a regulated member, and to provide all documents identified in the guidelines. The collection of this information will ensure appropriate procedures and documentation, to enhance the provision of professional services.	assisted death is a reportable death and a physician participating in a physician-assisted death must comply with the requirements of that Act.	*Inquiries Act*, and *The Vital Statistics Act* in respect to reporting and/or registering the cause and manner of the patient's death, including completing all required forms specified by the legislation or regulations, are met in a timely fashion.	collect data on PAD, and advocates that a data collection mechanism form part of the federal and/or provincial legislative framework. Where PAD is provided, physicians are advised to consult the Ontario government for guidance on the completion of death certificates and any mandatory reporting obligations associated with PAD.	privacy, especially in a smaller jurisdiction. This does not preclude the collection of anonymized data. Regarding oversight for potential abuse or malpractice, death is always reviewable to the coroner. In addition it could be open to a family member to complain to the College regarding the approach a physician took with the matter.	function with respect to PAD. Also recommends that cause of death be the grievous and irremediable medical condition that qualified the patient to be eligible for PAD, PAD will be noted as the mechanism utilized. This reporting on the death certificate, in combination with other reporting requirements that may be established, will ensure that incidents of PAD can be readily captured and available to the Medical Examiner and the oversight	attending physician. The oversight body would review the documentation for compliance. Prov/Terr should ensure that legislation and/or regulations are in place to support investigations related to assisted dying by existing prov/terr systems. Pan-Canadian guidelines should be developed to clarify how to classify the cause on the death certificate.

	Quebec[1]	CPSBC	CPSA	CPSS	CPSM	CPSO	CPSNB	CPSNS (under consultation)	CMA
	information.							body.	

Regulatory Authorities	Documents on PAD
College of Physicians and Surgeons of British Columbia ("CPSBC")	Interim Guidance, *Physician-Assisted Dying*, approved January 22, 2016, https://www.cpsbc.ca/files/pdf/IG-Physician-assisted-Dying.pdf
College of Physicians and Surgeons of Alberta ("CPSA")	Advise to the Profession, *Physician-Assisted Death*, published December 2015, http://www.cpsa.ca/standardspractice/advice-to-the-profession/pad/
College of Physicians and Surgeons of Saskatchewan ("CPSS")	Policy, *Physician-Assisted Dying*, approved November 2015, https://www.cps.sk.ca/Documents/Legislation/Policies/POLICY%20-%20Physician-Assisted%20Dying.pdf
College of Physicians and Surgeons of Manitoba ("CPSM")	Schedule M attached to and forming part of By-Law No. 11 of the College, *Physician Assisted Death*, December 2015, http://cpsm.mb.ca/cjj39alckF30a/wp-content/uploads/PAD/PADSchM.pdf
College of Physicians and Surgeons of Ontario ("CPSO")	*Interim Guidance on Physician-Assisted Death*, approved January 26, 2016, http://www.cpso.on.ca/CPSO/media/documents/Council/Council-Materials_Jan2016.pdf
College of Physicians and Surgeons of New Brunswick ("CPSNB")	Guidelines, *Assistance in Dying*, December 2015, http://www.cpsnb.org/english/Guidelines/AssistanceinDying.htm
College of Physicians and Surgeons of Nova Scotia ("CPSNS")	*Standard of Practice: Physician-Assisted Death*, January 13, 2016 (under consultation – not approved), http://www.cpsns.ns.ca/Portals/0/PDFpoliciesguidelines/DRAFT%20Standard%20of%20Practice%20-%20Physician-Assisted%20Death.pdf
Canadian Medical Association ("CMA")	Principles-Based Recommendations for a Canadian Approach to Assisted Dying, January 22, 2016, https://www.cma.ca/Assets/assets-library/document/en/advocacy/cma-framework_assisted-dying_final-jan2016.pdf
* Note that the government of the Northwest Territories is currently holding consultations on a legislative framework on PAD; the College of Physicians and Surgeons of Newfoundland and Labrador has prepared a draft standard of care on PAD and anticipates to have it finalized in March 2016	