CNPS | SPIIC

VIA EMAIL

November 9, 2020

Marc-Olivier Girard
Clerk of the Committee
Standing Committee on Justice and Human Rights
JUST@parl.gc.ca

Dear Sir,

Re: Canadian Nurses Protective Society Submission on Bill C-7,
A Bill to Amend the Criminal Code (and other Acts) regarding Medical Assistance in Dying

The Canadian Nurses Protective Society (CNPS) is a not-for-profit corporation that provides professional liability protection, legal assistance and risk management services to over 140,000 nurses of all professional designations (registered nurses, nurse practitioners, registered psychiatric nurses and licensed/registered practical nurses) across Canada. As a provider of legal services familiar with the regulatory framework, the legal obligations and the practice environment of nurses, the CNPS appreciates the opportunity to provide observations and recommendations about Bill C-7.

The CNPS wishes to acknowledge the extensive consultations, research and the depth of the analysis undertaken by the federal Minister of Health and his team in connection with the adoption of Bill C-7. Those consultations reflect, without a doubt, the importance that this government has placed on the rights of Canadian at the end of their lives. The CNPS also wishes to convey its gratitude to the Canadian Nurses Association (CNA) for the opportunity to participate in the series of consultations held by the CNA to better understand the nursing perspective on these issues, both before and after the introduction of Bill C-7. We will not refer specifically to the outcome of these consultations, other than to indicate that they informed the content of this submission, along with our legal review of the legislation and the information and concerns reported by nurses and nurse practitioners since MAID first became legal.

From these consultations within the nursing community, a number of barriers to MAID in the existing framework were identified. Bill C-7 redresses some of these barriers while maintaining safeguards against vulnerability, namely:

- Removal of the 10 day reflection period
- The number of independent witnesses to be one rather than two
- When death is reasonably foreseeable, permitting waiver of final consent by entering into a specific written agreement

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The CNPS looks forward to engaging in future stakeholder consultations with the federal government as the law relating to the provision of MAID continues to evolve, namely with regard to access by citizens whose sole underlying medical condition is a mental illness, access by minors, and advance requests for MAID.

Recommendations

The CNPS presents four recommendations:

> 1. That MAID continue to be recognized in the *Criminal Code* as an exception to the offence of assisted suicide, but that its legislative framework be removed from the *Criminal Code* and contained in dedicated legislation, in recognition of its integration into the legitimate provision of care.
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> 2. That subsection 241(5.1) of the *Criminal Code* be amended to stipulate that this exemption applies notwithstanding that the health care professional may have initiated the discussion about the lawful provision of MAID.
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> 3. That paragraph 241.31(1.1) be removed, or that its adoption be postponed unless and until consultation with the province, territories, and affected health care providers takes place and results in consensus from the implicated health care providers that reporting of such data is warranted and that "preliminary assessment" is clearly defined.
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> 4. That Bill C-7 be revised to clarify to what extent the requirements to obtain the patient's informed consent vary depending on whether death is reasonably foreseeable or not, having regard to the wording of paragraphs 241.2(1)(e), 241.2(3.1) (g) and 241.2(3.1)(h).

The underlying rationale and potential means to implement those recommendations are set out in the following sections of this submission.

RECOMMENDATION 1: That MAID continue to be recognized in the *Criminal Code* as an exception to the offence of assisted suicide, but that its legislative framework be removed from the *Criminal Code* and contained in dedicated legislation, in recognition of its integration into the legitimate provision of care.

This is important because despite their very best efforts, humans, including health care providers, sometime fail to meet the high standards that society sets for them. Only a substantial and meaningful departure from the standards should form the basis of criminal conduct.

We submit that this could be accomplished, for instance, by amending paragraph 241.2(2) to read

> 241(2) No medical practitioner or nurse practitioner commits an offence under paragraph (1)(b) if they provide a person with medical assistance in dying, within the meaning of [Name of new MAID legislation].

The court would then determine if the departure from the legislation is of such significance that it warrants being characterized as criminal, much as it does in the context of criminal negligence.

The new, dedicated MAID legislation could still contemplate appropriate sanctions, where appropriate.

RECOMMENDATION 2: That subsection 241(5.1) of the Criminal Code be amended to stipulate that this exemption applies notwithstanding that the health care professional may have initiated the discussion about the lawful provision of MAID.

Professionals have at times been cautioned about raising MAID with a patient who has not previously presented a request, out of concern that this could be used as a basis to assert that the professional was contravening section 241(1)(a) of the Criminal Code, understanding fully that "counselling" within the meaning of s.241(1)(a) is not used in the clinical sense but rather in the sense of "inciting, encouraging…" and notwithstanding the reassurance found at subsection 241(5). At the same time, some groups have asserted that professionals have a "legal obligation" to raise MAID for patients who meet the criteria. Health care professionals have reported cases of patients who were very upset that MAID had been suggested to them as a potential avenue, and circumstances where family members, having witnessed their loved one suffer, were upset that it had not been raised because the patient was unaware of the option.

In a patient-centred approach, raising MAID should first and foremost be driven by the needs of the patient as they can reasonably be ascertained, both physically and psychologically, taking into account that values of the patient and the relief or distress that it might bring to raise it as an option for any one particular patient. Raising MAID as an option too early when a patient may not have yet fully processed the implications of a diagnosis could be devastating. Failing to raise it when the patient has clearly identified that suffering has become intolerable simply because it was not expressly requested may be unnecessarily prolonging the intolerable suffering. We submit that this can best be achieved when health care professionals are not driven by fear of prosecution or imposition of a legal obligation but rather empowered by the mandate to do what they understand to be in the very best interest of their patient, taking into account all of the circumstances.

The legal challenges to assessments by nurse practitioners and medical practitioners regarding an individual's eligibility for MAID (see, for instance, *A.B. v. Canada (Attorney General)*, 2017 ONSC 3759; *Y. v. Swinemar*, 2020 NSCA 56) and the delay that these legal proceedings entailed for the individuals seeking MAID demonstrate the importance that the law set out clearly the circumstances in which professionals are enabled to act in reference to the provision of MAID. This includes being empowered to use their professional judgment about the appropriateness of *initiating* a discussion about the legal provision of MAID without the threat that simply doing so may have serious criminal consequences.

The revised provision could read as follows:

> (5.1) For greater certainty, no social worker, psychologist, psychiatrist, therapist, medical practitioner, nurse practitioner or other health care professional commits an offence if they provide information to a person on the lawful provision of medical assistance in dying, **whether or not the health care professional initiates the discussion.**

RECOMMENDATION 3: The formal, written request for MAID is a reasonable and certain point at which to start collecting data about MAID. Consequently, we recommend that paragraph 241.31(1.1) be deleted or that its adoption be postponed unless and until consultation with the province, territories, and affected health care providers takes place and results in consensus from the implicated health care providers that reporting of such data is warranted and that "preliminary assessment" is clearly defined.

Pursuant to paragraph 241.31(1.1), Bill C-7 proposes to require reporting of preliminary assessments prior to a person's written request for MAID, which is reaching back earlier in the chronology of care than the current data collection requires. We submit that the formal, written request is a natural point at which to start tracking the progress and result of the MAID request.

By seeking data that pre-dates that point, other considerations arise. Stakeholder feedback to the CNPS on this proposed amendment consistently expressed concern about:

a) the lack of definition of "preliminary assessment' (i.e. prior to a person's written request for MAID or a verbal request from a patient to a regulated health professional or a regulated health professional proposing such an assessment to the patient) and consequently, the definition of "person who has the responsibility to carry out preliminary assessments of whether a person meets the criteria set out in subsection 241.2(1)":

> Under paragraph 231.31(4), failure to report the necessary information by a "person who has the responsibility to carry out preliminary assessments" could result in criminal sanctions. Language which is capable of different interpretations should not form the basis of a criminal sanction.[1]

b) the risk of confusion as to who would be accountable to undertake the preliminary assessment and submit the reporting data;

c) the increased administrative burden on the practitioners.

> The federal government observes that some jurisdictions have MAID coordination services i.e. a central infrastructure dedicated to MAID triage and services. However, that is not the case across Canada. For those practitioners who do not have the advantage of a MAID coordination service, increased reporting simply adds to their administrative burden when a patient's verbal request MAID may never result in a formal, written request for MAID.
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> This is a significant consideration if we take into account that, as noted at page 28 of Health Canada's *First Annual Report on Medical Assistance in Dying in Canada 2019* (July 2020), that some doctors and nurse practitioners are not being paid for MAID services:

[1] We are mindful that under paragraph 231.31(4), only individuals who "knowingly" fail to meet the requirement to report the prescribed information in reference to a preliminary assessment are subject to the criminal sanctions under the Act. Since knowledge is usually established by inference, there remains a lot of room for argument (and therefore prosecution) that a health care professional failed to meet the reporting requirements of paragraph 231.31(1.1.).

> While several healthcare practitioners have reported anecdotally that providing MAID can be a very professionally rewarding experience, some challenges remain that could impact the number of willing MAID providers in Canada. For example, many provinces do not have a specific fee schedule for physician remuneration for MAID and some nurse practitioners (often paid by salary) have reported providing MAID outside of their regular office hours without compensation.

We submit that a patient's written request for MAID is a clear signal to health care professionals that they are now dealing with the stringent Criminal Code provisions that require strict adherence. If this amendment is enacted, the CNPS urges that the phrase "preliminary assessment" be clearly defined. Practitioners must be able to ascertain what kind of assessment triggers which reporting obligations, and not be at risk of being told after the fact they erred by not reporting that which they did not consider to be a preliminary assessment of MAID.

RECOMMENDATION 4: That Bill C-7 be revised to clarify to what extent the requirements to obtain the patient's informed consent vary depending on whether death is reasonably foreseeable or not, having regard to the wording of paragraphs 241.2(1)(e), 241.2(3.1) (g) and 241.2(3.1)(h).

There should be no doubt, in any legislative instrument, that the same language means the same thing.

Paragraph 241.2(1)(e) provides as follows:

> **241.2 (1)** A person may receive medical assistance in dying only if they meet all of the following criteria:
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> […]**(e)** they give 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.

This provision sets out the requirements applicable where death *is* reasonably foreseeable, and where death *is not* reasonably foreseeable. Yet, where death *is not* reasonably foreseeable, the legislation contains two additional provisions referencing the same requirement, using similar, but more expansive language:

> **241.2(3.1)** Before a medical practitioner or nurse practitioner provides medical assistance in dying to a person whose natural death is not reasonably foreseeable, taking into account all of their medical circumstances, the medical practitioner or nurse practitioner must
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> […]
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> **(g)** 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;

> **(h)** ensure that they and the medical practitioner or nurse practitioner referred to in paragraph (e) have discussed with the person the reasonable and available means to relieve the person's suffering and they and the medical practitioner or nurse practitioner referred to in paragraph (e) agree with the person that the person has given serious consideration to those means;

The fact that paragraphs 241.2(3.1)(g) and (h) expand on the requirements of paragraph 241.2(1) where death is *not* reasonably foreseeable suggest that a different level of "informed consent" applies where death is not reasonably foreseeable. It allows the inference, for instance, that where death *is* reasonably foreseeable, it may not be necessary for the assessors to expressly discuss the available means to relieve the person's suffering with the person seeking MAID or expressly agree (ascertain?) that they have given serious consideration to those means; the assessor could instead, for instance, rely on the informed consent obtained by another health care professional. If this is the case, it should be mentioned explicitly. Finally, it is not clear if the words "where appropriate" in paragraph (g), also apply to the requirement to offer consultations.

In the circumstances, we submit that the requirements of paragraph (g) should be subsumed in paragraph 241.2 (1)(e); the resulting paragraph may read as follows.

> 241.2(1)(e) they give informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including, <u>where appropriate,</u> palliative care, counselling services, mental health and disability support services <u>and</u> community services ~~and palliative care~~ and, <u>where it could be useful to inform their decision,</u> have been offered consultations with relevant professionals who provide those services or that care.

The concept of informed consent is one that has been defined and refined by courts over several decades. It is now entrenched in health care practice and it is one that health care professionals know well. We submit that the this concept is sufficient, but if paragraph (h) remains, we suggest that the word "agree" be replaced with the word "ascertain", which seems more consistent with the notion of patient autonomy protected by section 7 of the *Canadian Charter of Rights and Freedom.*

All of which is respectfully submitted.

CANADIAN NURSES PROTECTIVE SOCIETY

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