Canadian Nurses Protective Society
Société de protection des infirmières et infirmiers du Canada

1545 Carling Avenue Suite 510
Ottawa ON K1Z 8P9

Telephone / Téléphone 613 237 2092
Toll free / Sans-frais 1 800 267 3390
Fax / Télécopieur 613 237 6300

VIA EMAIL

27 January 2016

Hon. Kelvin Ogilvie & Hon. Robert Oliphant
Joint Chairs
Special Joint Committee on Physician-Assisted Dying
1 Wellington Street
Ottawa ON K1A 0A6
PDAM@parl.gc.ca

Dear Honourable Sirs,

Re Canadian Nurses Protective Society Submission on Physician-Assisted Death

The Canadian Nurses Protective Society (CNPS) is a not-for-profit organization that provides professional liability protection, legal assistance and risk management services to over 125,000 registered nurses and nurse practitioners in Canada. On October 21, 2015, the CNPS prepared a submission to the External Panel for Options for a Legislative Response to *Carter v. Canada* recommending amendments to *Criminal Code* to exempt legitimate professional activities surrounding physician-assisted death from the application of sections 14 and 241 (a) and (b) of the Code. In light of the *Carter* decision, these provisions, as currently framed, unfairly place at risk of criminal prosecution nurses (and other health care professionals) who, in the normal course of carrying out their duties in accordance with the standards of practice of their profession, provide end-of-life care to patients or engage in discussions with patients about end-of-life options and wishes. A copy of our submission to the External Panel is attached as Appendix B for ease of reference.

Our submission to this Special Joint Committee serves the following purposes. Firstly, we wish to reiterate the need for an exemption and outline the scope of the exemption. The exemption should expressly stipulate that:

a) providing information or advice, in good faith, in relation to physician/practitioner-assisted death;
b) providing physician/practitioner-assisted death, in good faith and within the scope of practice of one's profession; and
c) aiding in the provision of physician/practitioner-assisted death, when doing so in good faith within the scope of practice of one's profession,

do not constitute criminal offences under the *Criminal Code*. The exemption should expressly allow for the possibility that to ensure access to care, policy makers and health regulators may ultimately decide that physician/practitioner-assisted death may have to be provided by health care professionals other than physicians, such as nurse practitioners or registered nurses. We refer you to our submission to the External Panel for additional considerations.

Secondly, we wish to stress that the need for protection from the risk of criminal prosecution for all health care professionals involved in the provision of medically assisted death has been identified by the Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying[1], the Canadian Nurses Association[2], the Federation of Medical Regulatory Authorities of Canada and the College of Physicians and Surgeons of Ontario.[3]

Thirdly, we emphasize that, consistent with the constitutional division of powers and the object of the *Criminal Code*, the exemption should not seek to regulate the provision of medical assistance in dying. Deferring to the provincial and territorial governments in this regard would also provide an opportunity to take into account the specific geographical realities, such as access to health care resources, consider the scopes of practice of health care professionals within those provinces, and consult with the regulatory bodies and professional associations as is normally the case for other decisions that must also closely reflect the standards of the profession. Inter-provincial and territorial collaboration is necessary to ensure that the rights of Canadians and the protections conferred upon them at the end of life are substantially similar in each jurisdiction.

Finally, we wish to provide alternate wording for potential amendments to the *Criminal Code* to simplify the wording that accompanied the initial submission to the External Panel. Two options are presented in Appendix A. While the second option is specific to nursing activities, it could be expanded to other members of the health care team.

---

[1] Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying, *Final Report*, November 30, 2015, Recommendations 7 and 8, pp. 25-26, http://www.health.gov.on.ca/en/news/bulletin/2015/docs/eagreport_20151214_en.pdf

[2] Canadian Nurses Association, *Brief for the Government's External Panel on Options for a Legislative Response to Carter v. Canada¸ October 2015, p. 6,* *https://cna-aiic.ca/~/media/cna/page-content/pdf-en/physician-assisted-death_brief-for-the-government-of-canadas-external-panel-on-options-for-a-legislative-response-to-carter-v-canada.pdf?la=en*

[3] External Panel on Options for a Legislated Response to Carter v. Canada, *Consultations on Physician-Assisted Dying – Summary of Results and Key Findings*¸ December 15, 2015, p. 84., http://www.justice.gc.ca/eng/rp-pr/other-autre/pad-amm/index.html.

All of which is respectfully submitted,

Chantal Léonard
Chief Executive Officer

APPENDIX A

Amendments to Criminal Code, ss. 14 and 241[4] - Option 1

An Act to amend the Criminal Code (practitioner-assisted death)

1. Section 14 of the Criminal Code is replaced with the following:

14. (1) Subject to section 241.1, no person is entitled to consent to have death inflicted on him, and such consent does not affect the criminal responsibility of any person by whom death may be inflicted on the person by whom consent is given.

2. The heading before section 241 of the Act is replaced with the following:

SUICIDE AND PRACTITONER-ASSISTED DEATH

3. Section 241 is amended as follows:

241. Subject to section 241.1, every one who

(a) counsels a person to commit suicide, or

(b) aids or abets a person to commit suicide,

whether suicide ensues or not, is guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years.

4. The Act is amended to include the following after section 241:

241.1(1) The following definitions apply in this section.

"Practitioner-assisted death": The provision of information or means to commit suicide, or the performance of an act with the intent to cause the person's death, with the person's informed consent, in the course of the provision of professional health care services, for the purpose of relieving the person from unbearable suffering;

The proposed language was inspired by the wording of Senate Bill S-225. The CNPS is indebted to the authors of the bill for their insight and analysis. Resulting amendments to the original wording of sections 14 and 241 of the Criminal Code appear as redlined text.

(2) The following do not constitute an offence under this Code:

- (a) providing information, advice or counselling, or otherwise communicating in good faith, in relation to practitioner-assisted death;
- (b) providing practitioner-assisted death, in good faith and within the scope of practice of one's profession; and
- (c) aiding or abetting in the provision of practitioner-assisted death, when doing so in good faith within the scope of practice of one's profession.

Amendments to Criminal Code, ss. 14 and 241[5] - Option 2

An Act to amend the Criminal Code (practitioner-assisted death)

1. Section 14 of the Criminal Code is replaced with the following:

14. (1) Subject to subsections (2) and (3), no person is entitled to consent to have death inflicted on him, and such consent does not affect the criminal responsibility of any person by whom death may be inflicted on the person by whom consent is given.
(2) A person may consent to practitioner-assisted death in accordance with the conditions and requirements set out in section 241.1.
(3) In this section, "practitioner-assisted death" has the same meanings as in section 241.1.

2. The heading before section 241 of the Act is replaced with the following:

SUICIDE AND PRACTITONER-ASSISTED DEATH

3. Section 241 is amended as follows:

241. Subject to section 241.1, every one who

(a) counsels a person to commit suicide, or

(b) aids or abets a person to commit suicide,

whether suicide ensues or not, is guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years.

The proposed language was inspired by the wording of Senate Bill S-225. The CNPS is indebted to the authors of the bill for their insight and analysis. Resulting amendments to the original wording of sections 14 and 241 of the Criminal Code appear as redlined text.

4. The Act is amended to include the following after section 241:

241.1(1) The following definitions apply in this section.

"Practitioner-assisted death": The provision of information or means to commit suicide, or the performance of an act with the intent to cause the person's death, with the person's informed consent, in the course of the provision of professional health care services, for the purpose of relieving the person from unbearable suffering;

"Assisting practitioner": A practitioner who provides or prescribes practitioner-assisted death, whether death ensues or not;

"Consulting physician": A physician who, in the course of providing health care services provides a second opinion to an assisting practitioner in relation to a request for practitioner-assisted death;

"Counsel": The provision of information or advice on practitioner-assisted death in the course of the provision of professional health care services;

"Nurse": A person licensed to practice nursing under the laws of the province or territory in which nursing services are provided. This includes a licensed practical nurse, a registered practical nurse, a registered psychiatric nurse, a registered nurse or a nurse practitioner, or other equivalent designations;

"Practitioner": A physician licensed to practice medicine under the laws of the province or territory in which medical services are provided; or a regulated health care professional licensed to provide professional health care services and authorized to act as an assisting practitioner in the province or territory in which professional health care services are provided;

(2) An assisting practitioner, a consulting physician or a nurse who, in the course of providing professional health care services, provides an opinion or counsels a person about practitioner-assisted death is not guilty of an offence under section 241.

(3) An assisting practitioner who provides practitioner-assisted death to a person, in the course of providing professional health care services to that person, is not guilty of an offence under section 241 if the practitioner or physician acted in good faith to ascertain that the conditions set out in subsection (5) have been met.

(4) When not acting as an assisting practitioner, a nurse is not guilty of an offence under section 241 when aiding or abetting in the provision of providing practitioner-assisted death or, on the order of an assisting practitioner, providing assisted-death to a person in the course of providing professional nursing services to that person.

(5) The person making the request for practitioner-assisted death shall be

(a) eighteen years of age or more, or alternatively, a competent adult as defined in the applicable provincial or territorial legislation;

(b) a Canadian citizen or a permanent resident within the meaning of subsection 2(1) of the *Immigration and Refugee Protection Act* as of the date of the request;

(c) acting voluntarily, free from coercion or undue influence;

(d) diagnosed with a grievous and irremediable medical condition (including an illness, disease or disability) that causes the person to endure physical or psychological suffering that is intolerable to that person in the circumstances of his or her condition;

(e) of sound mind and capable of fully understanding his or her medical prognosis, the consequences of the request for practitioner-assisted death being honoured, the feasible alternative treatments and his or her right to revoke the request at any time;

(f) assessed by a consulting physician who was of the opinion that the conditions set out in paragraphs (5)(a) to (e) were met; and

(g) if he or she received practitioner-assisted death, given the opportunity to revoke his or her request immediately before receiving it.

APPENDIX B

SUBMISSION OF THE CANADIAN NURSES PROTECTIVE SOCIETY ON OPTIONS FOR A LEGISLATIVE RESPONSE TO *CARTER V. CANADA*

1. About the CNPS and its membership

The CNPS is a not-for-profit corporation created in 1988 by territorial and provincial nursing regulators and associations under the auspices of the Canadian Nurses Association. Its mandate is to provide legal advice and risk management services, professional liability protection and legal assistance to eligible registered nurses (RNs) and nurse practitioners (NPs) practising in Canada. The CNPS legal assistance includes assistance with the defence of criminal proceedings arising from the practice of nursing.

The CNPS does not determine the scope of practice of registered nurses and nurse practitioners nor does it set standards of professional conduct. These responsibilities fall within the mandate of the organizations that regulate the practice of registered nursing in Canadian provinces and territories.

The nurses eligible for CNPS protection currently comprise more than 125,000 RNs and NPs practising in all Canadian provinces and territories. These RNs and NPs have access to CNPS services as a benefit of membership in a CNPS member organization[6] or as individual registrants with the CNPS.

As a provider of legal services that understands the regulatory framework, the legal obligations and the practice environment of nurses, the CNPS appreciates the opportunity of presenting its input on the legislative response to the Carter decision.

2. The Carter decision

Our submissions rely primarily on the following excerpt of the Carter decision:

> "The appropriate remedy is therefore a declaration that s. 241(b) and s. 14 of the Criminal Code are void insofar as they prohibit physician-assisted death for a competent adult person who (1) clearly consents to the termination of life; and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her

---

[6] In 2016, the CNPS member organizations will include the provincial Colleges and/or Associations of registered nurses in all provinces and territories, with the exception of the provinces Ontario and Quebec, where registered nurses will access CNPS professional liability protection and services on an individual basis.

condition. "Irremediable", it should be added, does not require the patient to undertake treatments that are not acceptable to the individual." … "[N]othing in the declaration of invalidity which we propose to issue would compel physicians to provide assistance in dying."

3. Nursing professions

There are different nursing professions in Canada:

- Registered Nurses (RN): These are nurses with a broad range of advanced competencies who can provide nursing care to the most complex patients. Unless they have been grandfathered, they must have completed a four year Baccalaureate program in nursing. In their employment setting, registered nurses often oversee teams of nurses or health care providers.

- Nurse Practitioners (NP): These are registered nurses who, after a minimum number of years of practice, completed further postgraduate specialized education and certification and are qualified to independently diagnose medical conditions, order a wide range of diagnostic tests and prescribe most medications.

- Licensed Practical Nurses (LPN), also referred to in some provinces as registered practical nurses: These are nurses with a two or three-year diploma or certificate in nursing who have a broad range of competencies but would normally care for patients who suffer from less complex conditions. They often work under the supervision of a registered nurse.

- Registered Psychiatric Nurses (RPN): Nurses who completed a specialized diploma or baccalaureate program and focus specifically on mental and developmental health and mental illness and addictions. The profession of registered psychiatric nurse is recognized only in Manitoba, Saskatchewan, Alberta and British Columbia.

4. Nurses and the provision of end-of-life care

Although CNPS beneficiaries consist of registered nurses and nurse practitioners, it is important to note that all these nursing professions (referred to collectively as "nurses") play an integral role in providing care to patients and clients at the end of their lives and at any time when they contemplate end-of-life decisions.[7]

[7] Canadian Nurses Association, Canadian Hospice Palliative Care Association and Canadian Hospice Palliative Care Nurses Group Joint Position Statement on the Palliative Approach to Care and the Role of the Nurse, 2015, https://www.cna-aiic.ca/~/media/cna/page-content/pdf-en/the-palliative-approach-to-care-and-the-role-of-the-nurse_e.pdf?la=en, p. 4.

Nurses assess the patients' condition, manage their pain, determine their needs, establish a nursing plan of care, advocate for them, recommend courses of treatment, prepare and administer the treatment. Nurses help patients understand what is happening (or what will happen) to their minds and bodies, listen to them and respond to their fears and concerns. Nurses discuss treatment choices and help patients and families articulate the values and beliefs that will guide end-of-life decisions, and communicate their needs and wishes at the end of life. They do so in a wide variety of settings: hospitals, long-term care facilities, community care centers, medical clinics and the patient's home. They do so as part of a treatment team in which a physician or nurse practitioner is generally designated as the Most Responsible Professional (MRP) and ultimately determines, in consultation with the patient, the overarching treatment plan.

Nurse practitioners, who have the authority to order diagnostic tests and prescribe medications, can also autonomously act as primary care providers.

Nurses will say that they consider it an incredible privilege to be allowed by their patients' to care for them in these very vulnerable and intimate moments.

Despite their central involvement, nurses are seldom referred to in discussions surrounding "physician-assisted death", to which we will refer more generally as "medically assisted death". Given their current responsibilities in the health care system and the level of nursing care required by individuals who experience debilitating and terminal medical conditions, nurses will inevitably be involved in the care of patients who request medically assisted death. In particular, we expect that the following interventions will naturally flow as an integral part or a natural extension of their current nursing responsibilities:

a) nurses will discuss treatment options with patients and will be presented with questions from patients regarding medially assisted death;

b) they will monitor their patient's state of mind and capacity to make decisions;

c) they learn about the values and wishes of the patient and will be expected to monitor the integrity of a patient's request for medically assisted death and the informed consent process;

d) in the normal course of the provision of care, it is part of the nurses' responsibilities to administer medication prescribed by physicians; even if they are not administering the drugs that will be used to induce death at the request of the patient, nurses are likely to be asked to prepare these drugs or otherwise asked to facilitate the process; and

e) even if nurses are not asked to specifically assist in the process, in the normal course of providing care, they are likely to be physically at the patient's side, and support when the assistance in dying is provided.

Studies conducted in countries and states in which patients can request physician-assisted death confirm that nurses are involved in a significant proportion of cases, either as a result of an inquiry by the patient, by engaging in discussions with the physicians regarding aspects of the patient's decision and by administering the lethal dose of medication.[8]

5. The risk of criminal prosecution

a) The nursing role in the context of the prohibition in paragraph 241(a) against counselling a person to commit suicide

Subsection 241(a) of the Criminal Code makes it a criminal offence to counsel a person to commit suicide. While the *Carter* decision focused exclusively on the interpretation and application of paragraph 241(b), we strongly recommend that consideration also be given to the implications of the prohibition in paragraph 241(a) to counsel a person to commit suicide.

Wherever it is found in the Criminal Code, "counsel" is defined in subsection 22(3) of the Criminal Code as including "procur[ing], solicit[ing] or incit[ing]." It has also been the subject of judicial interpretation, which confirmed the requirement for a clear intention, on the part of the accused, to incite a person to commit suicide. For instance, in *Mugesera v. Canada (Minister of Citizenship and Immigration)*[9] the Supreme Court commented as follows:

> "Counsel[ling]" is defined in s. 22(3) of the Criminal Code, which says that its meaning includes "procur[ing]", "solicit[ing]", or "incit[ing]". To incite means to urge, stir up or stimulate: *R. v. Ford* (2000), 2000 CanLII 5701 (ON CA), 145 C.C.C. (3d) 336 (Ont. C.A.), at para. 28.
>
> The offence of counselling requires that the statements, viewed objectively, actively promote, advocate, or encourage the commission of the offence described in them: *R. v. Sharpe*, [2001] 1 S.C.R. 45, 2001 SCC 2 (CanLII), at para. 56. The criminal act will be made out where the statements (1) are likely to incite, and (2) are made with a view to inciting, the commission of the offence: *R. v. Dionne* (1987), 38 C.C.C. (3d) 171 (N.B.C.A.), at p. 180."

---

[8] Bilsen, J.J.R., Vander Stichele R.H., Mortier F. & Deliens L., The role of nurses in physician-assisted death in Belgium, CMAJ, June 15, 2010, vol. 182, no. 9, retrieved at http://www.cmaj.ca/content/182/9/905.full; van Brushem-van de Scheur GG, van der Arend AJ, Abu-Saad, HH, Spreeuwenberg, C, van Wijmen FC, ter Meulen RH, The role of nurses in euthanasia and physician-assisted suicide in The Netherlands, J. Med. Ethics, 2008 Apr. 34(4); 254-8, retrieved from http://www.ncbi.nlm.nih.gov/pubmed/18375675

[9] [2005] 2 SCR 100

It might be said that the need to have the intent to "incite" a patient to commit suicide could be sufficient to protect nurses against undue criminal complaints or criminal prosecution when they are addressing patient inquiries about medically assisted death. However, given the strongly divided opinions surrounding medically assisted dying and the very real possibility that a patient and his or her family may at times have different personal convictions regarding "what is best" for the patient, it is certainly conceivable that a patient or a loved one might perceive a genuine effort to inform about end-of-life issues, particularly if they include questions about medically assisted death, as an attempt to incite a patient to end his or her life prematurely. The result is that nurses may be at risk of criminal complaints, and possibly criminal prosecution, as a result of carrying out their professional obligations by engaging into discussions with patients regarding end-of-life issues. The existence of this risk or even the perception of risk may in turn have a deterrent effect, thereby compromising patient care and the patient's right to objective information. Therefore, it would be in the interest of all concerned to include in the Criminal Code an explicit exemption from criminal prosecution for nurses (and other health care professionals who may have similar obligations to discuss end-of-life issues with their patients).

b) The nursing role in the context of the prohibition in subsection 241(b) against aiding and abetting a patient to commit suicide

It is a hallmark of the Canadian health care system that it is delivered by a team working collaboratively. This is particularly true in a hospital setting, where health care professionals attend to the patient's needs 24/7. But it is now also true in the primary care setting, where recent health care initiatives seek to leverage the respective expertise of each health care professional. Within that treatment team, there is generally a designated Most Responsible Professional (MRP) who is generally a physician but can now also be a nurse practitioner. In the context of medically assisted death, the MRP would likely be the treatment team member who ultimately makes the determination that the circumstances satisfy the *Carter* requirements and would, if not administer, at least prescribe the means by which medically assisted death would occur. It is important to consider the risk of criminal prosecution arising from medically assisted death from the perspective of treatment team members who are not the MRP and from the perspective of the MRP.

i) Attending nurses who are not the MRP

It is clear, pursuant to *Carter v. Canada*, that the act of prescribing or administering medication to end a patient's life, absent the findings of the Supreme Court, would contravene 241(b) of the Criminal Code.

The act of assisting, or "aiding" and "abetting," is not an exclusive one. Within the Canadian health care system, it is within the nursing scope of practice and, as a matter of course, within the nurses' scope of employment to prepare medication,

provide counselling and support to the patient, and administer medications prescribed by a physician or a nurse practitioner. Nursing regulatory organizations in Canada have yet to adopt standards and guidelines as a result of the *Carter* decisions. It is expected that such guidelines will be adopted once the legislative framework is in place. Each provincial and territorial regulatory body can, within that specific legislative framework and the existing regulatory framework, adopt guidelines and standards applicable to specific circumstances that it deems most appropriate in order to satisfy the ethics of the profession, the needs of the health care system and the protection of the public. Unless nurses are then explicitly prohibited from engaging in activities which have traditionally been part of the core nursing practice where the patient has requested medical assistance in dying, nurses who prepare medication, provide support to the patient, or administer medications could be perceived, along with the attending physician who may have prescribed the medication, to have "aided and abetted" the patient to commit suicide within the meaning of paragraph 241(b). This could be the case despite the fact that they would not have personally undertaken to provide the means of assistance or ensured that the conditions precedent have been satisfied. Accordingly, to the extent that protection from prosecution is contemplated for physicians in such circumstances, it should also be contemplated for nurses who currently work alongside them, understanding that such protection would not, in either case, preclude a personal decision to refrain from providing such an assistance on the basis of a conscientious objection.

ii) The nurse practitioner as the MRP

All Canadian provinces and territories have authorized NPs to act within a greater scope of practice than other registered nurses. NPs may order and interpret diagnostic tests, prescribe pharmaceuticals, medical devices and other therapies, and perform procedures. The New Classes of Practitioners Regulations, SOR/2012-230 made pursuant to *The Controlled Drugs and Substances Act*, S.C. 1996, c.19, authorizes NPs to prescribe or possess a listed substance, or conduct an activity with a listed substance, in accordance with federal regulations, if they are permitted to prescribe that substance under the laws of the province in which they are registered and entitled to practise.

They practise autonomously and, in most Canadian jurisdictions, can act as the primary care provider of a roaster of patients. They initiate a consultation with physicians, including specialists, when the care required exceeds their personal competence.

Nurse practitioners can, as primary care providers, treat patients with debilitating medical conditions. In remote areas, they may be the only primary care provider available on a day-to-day basis.

Neither the *Carter* decision nor the public discussions surrounding medically assisted dying contemplated the role of nurse practitioner in relieving the patient from irremediable and intolerable suffering through medically assisted death. Nursing regulators have not yet expressed an intention to expand the nurse practitioner's scope of practice to include assistance in dying. At the same time, it is worth noting that nurse practitioners generally have the ability to prescribe the same drugs and combination of drugs as a physician. It is also worth noting that the role of nurse practitioners has evolved significantly over the last ten years in every jurisdiction in order to meet the needs of the health care system, particularly to ensure better access to care, which has been identified as a priority by every provincial and territorial government. Should one or more nursing regulatory body determine that the nurse practitioner could, acting within her scope of practice, provide medical assistance in dying, such a nurse would also be vulnerable to criminal prosecution, without a clear exemption in the Criminal Code.

6. Protecting nurses against an unnecessary risk of criminal prosecution

The circumstances set out above support the need for a clear protection from criminal prosecution for health care professionals who provide care to patients suffering from irremediable and intolerable medical conditions and who discuss end-of-life considerations with their patients. Having a clear exemption is particularly important because, as we have noted above, not only the existence of a risk but also the perception of a risk of criminal prosecution could compromise the quality of patient care.

We outline the important characteristics of such an exemption.

a) ***The exemption should include clear parameters delineating the circumstances when it can be invoked***

It is paramount that health care professionals in every Canadian jurisdiction and territory have the same understanding of the circumstances in which physician-assisted death is protected from criminal prosecution and what, conversely, constitutes criminal behaviour. In keeping with the *Carter* decision, the CNPS would also consider it appropriate to incorporate the following parameters:

i. The age of the person;

ii. The person's capacity to provide consent;

iii. The determination that the patient suffers from a "a grievous and irremediable medical condition (including an illness, disease or disability) that causes the person enduring physical or psychological suffering that is intolerable to that person in the circumstances of his or her condition," confirmed with a second medical opinion from a physician; and

iv. The need for an informed consent discussion.

While the requirement that the diagnosis be confirmed with a second medical opinion from a physician is not specifically outlined in the *Carter* decision, it is an important safeguard; and we agree that it would be appropriate to include it as a condition of the exemption.

b) On the other hand, the exemption should not aspire to be an exhaustive legislative procedural code on medically assisted death

Given that the purpose of the Criminal Code is to define the types of human conduct deserving of punishment, we submit that the exemption should serve that purpose alone. To attempt to make it a complete code that would set out all the details of the process to be followed, documentation to be taken, evidence to be collected, etc. would deter from this objective and very likely ultimately leave too much room for interpretation as to when an intervention by a health care professional would fall within the exemption and when it would not. For instance, while the CNPS is indebted to the authors of Bill S-225 for their forethought and the extent of the underlying analysis, we note it sets out in minute details the procedural and clinical requirements, about eligibility for medically assisted death and governance of interactions between a person seeking assistance in dying and practitioners, including the level of documentation required and the reports to be filed after it has taken place. It contains much more than the conditions that would justify an exemption to s. 241. We would encourage a less prescriptive approach. Being too prescriptive creates a risk that an inadvertent, inconsequential, administrative slip will give rise to criminal penalty for the practitioner. Additional safeguards can be introduced with a requirement that interactions and interventions to do with medically assisted death be in the course of professional medical or nursing services.

We also note the External Panel has already outlined, in the description of this mandate, the applicable constitutional limitations. While the Supreme Court of Canada recognized the power of the federal government to legislate on "federal matters, notably criminal law, that touch on health issues"[10], it remains that the delivery of health care remains fundamentally a matter of provincial and territorial jurisdiction. Standards of practice, documentation and monitoring requirements can be introduced in complementary provincial and territorial legislation, taking into account existing provincial or territorial legislation on consent and capacity, the scopes of practice of health care professionals who practice within the province or territory and the organization of the health care system.

Regulation and practice guidance with respect to applicable standards of care and professional responsibilities for any care provided to patients is given to health care professionals by their respective regulatory bodies. It would be appropriate to rely on the health professional regulatory bodies to continue to regulate and guide their own

[10] *Canada (Attorney General) v. PHS Community Services Society*, 2011 SCC 44 (CanLII), par. 68, cited with approval in *Carter.*

members with respect to other procedural and technical aspects of medically assisted death.

c) ***The exemption should include a definition of "counsel" and "assistance" applicable specifically to medically assisted death***

We include proposed wording in Appendix A for both definitions. The proposed definition of "counsel" encompasses the provision of all the information and education provided by a health care provider so that it would be clearly covered by the exemption.

d) ***The exemption should specifically protect all aspects of nursing care, including the following:***

i. ***all discussions of a general information or educational nature taking place in the course of the provision of professional health care services, even if they take place before a determination is made that the patient meets all the criteria for medically assisted death set out in the Carter decision;***

ii. ***the care that nurses provide as part of the treatment team but not as MRP (monitoring the patient's physical and mental condition, preparing the substances and administering the substances, as authorized by their regulatory body and governing legislation), taking into account that in that capacity they would not, like the MRP, have had the opportunity to ascertain personally that the patient meets all the criteria for medically assisted death set out in the Carter decision;***

iii. ***the potential role of the nurse practitioner as the MRP. The wording of the exemption applicable to physicians should be sufficiently inclusive to apply to other health care professionals acting as MRP who possess the necessary competencies and may, in specific circumstances, be given the express authority by legislation or by their regulatory body, to provide assistance in dying.***

For the reasons discussed above under the section 5 entitled "The risk of criminal prosecution," the legislative responses to *Carter* must protect nurses' existing roles and use the opportunity to protect the possible future role they may have in medically assisted death. Furthermore, in anticipation of this, it is suggested that Criminal Code s.241 be amended to permit "practitioner-assisted death," with practitioners being defined as physicians and NPs. Alternatively, Criminal Code, s.241 can be amended to address "assisted death" without a modifier preceding it.

7. Sample wording

We offer sample wording at Appendix A to amend sections 14 and 241 in accordance with the foregoing recommendations for your consideration.

8. Issues to be addressed by provincial legislation and/or professional standards

The CNPS endorses clarity and harmony in federal, provincial, and territorial legislation regarding medically assisted death. In the context of a comprehensive legislative response to the *Carter* decision, we highlight the following additional considerations at the provincial and territorial level:

a) Consent

Some provinces have legislation which designates a lower age of consent for medical treatment than the statutory age of majority in that jurisdiction (e.g. New Brunswick's *Medical Consent for Minors Act* or Quebec's *Civil Code*). Given that *Carter's* constitutional exemption will apply to "a competent adult person," the CNPS endorses clarity and harmony in federal, provincial and territorial legislation on the age at which a person can request medical assistance in dying.

b) Capacity

Clarity is needed on the time at which a person must be competent and capable in making a request for medical assistance in dying, such that it will be carried out. Provinces and territories have legislated, to different degrees, the requirements for valid advance directives which substitute decision-makers and practitioners must consider and respect when they apply to the person's situation. Consequently, at present, a capable person may direct the care he or she will receive in the future when he or she is no longer capable of understanding the care decisions to be made, up to and including the withholding and withdrawal of life sustaining care. It would be helpful to stipulate whether health care professionals can take into account a patient's advance directives in making decisions relating to medically assisted death in the following circumstances:

- Is medically assisted death available to a person who was deemed by practitioners to have met the criteria at the times the requests were made and granted but who has become incapable prior to its implementation?;

- Can an advance directive be executed at the time a person's request for medically assisted death is granted, such that if he or she becomes incapable, the substitute decision-maker and practitioners follow through with medical assistance in dying?; and

- Can an advance directive be acted upon by substitute decision-makers and practitioners when it was written in compliance with governing law but in

advance of the person having a grievous and irremediable condition that causes enduring, intolerable suffering to that person? (We have assumed, for the purpose of these submissions that it could not.)

c) Conscientious objections

The right of nurses to refuse to participate in medically assisted death should be expressly recognized in legislation, regulation or professional standards. In the case of nurses, it would be preferable if this right were to be specifically incorporated in legislation or regulation so as to clearly supersede employers' policies and procedure and allow a nurse to express and follow a conscientious objection without fear of reprisal in the workplace. This recommendation should not be perceived as putting into question an employer's compassion in the matter or its ability to address this issue privately. We rather consider this issue of such importance as to warrant a legislative pronouncement.

9. The implications on life insurance proceeds

Federal and provincial insurance legislation should be amended to clarify what is the impact of medically assisted death on the proceeds of a life insurance policy.

Conclusion

Specifically exempting legitimate professional nursing services from the application of section 241 of the Criminal Code will have the benefit of reflecting current reality and practice in which physicians and nurses work together to provide services to their patients. Health care professionals know they can rely on each other's professional standards, decisions, and practices when other team members are acting pursuant to the legislation specifically governing their profession. It is similarly important to offer the same protection from criminal sanction that is contemplated for physicians to nurses. Both professionals will then be secure in the knowledge that their respective and overlapping work with patients and others with assisted dying is equally protected. In the same way they can rely on each other to act in accordance with their legislated scope of practice, when physicians and nurses are both protected in law for their various and legitimate roles in medically assisted death, they are free to appropriately allocate different aspects of care, including patient education, amongst themselves.

Furthermore, it will not be possible, nor is it desirable, to legislatively protect only those discussions about assisted death that are had between a physician and a person requesting assisted death. It is foreseeable that nurses will be asked questions on the subject and not just from persons who are requesting or receiving assisted death. Nurses have an existing role in patient and family education as part of their daily professional practice, which should be protected when assisted death is legal.

Each patient or client has only one, unique end-of-life journey. It is important that heath care professionals be guided only by the needs of the patient, the standards of the profession and their respective legal rights and obligations as they support their patient in this journey.

We submit that incorporating a clear exemption to section 241 of the Criminal Code in reference to medically assisted death will serve that end.

All of which is respectively submitted,

THE CANADIAN NURSES PROTECTIVE SOCIETY

Chantal Léonard, CEO

APPENDIX A

Amendments to Criminal Code, ss. 14 and 241[11]

An Act to amend the Criminal Code (practitioner-assisted death)

1. Section 14 of the Criminal Code is replaced by the following:

14. (1) Subject to subsections (2) and (3), no person is entitled to consent to have death inflicted on him or her, and such consent does not affect the criminal responsibility of any person by whom death may be inflicted on the person by whom consent is given.
(2) A person may consent to practitioner-assisted death in accordance with the conditions and requirements set out in section 241.1.
(3) Practitioner-assisted death carried out in accordance with section 241.1 is not culpable homicide.
(4) In this section, "practitioner" and "practitioner-assisted death" have the same meanings as in section 241.1.

2. The heading before section 241 of the Act is replaced by the following:

SUICIDE AND PRACTITONER-ASSISTED DEATH

3. Section 241 is amended as follows:

241. Subject to section 241.1, ~~E~~every one who

(a) counsels a person to commit suicide, or

(b) aids or abets a person to commit suicide,

whether suicide ensues or not, is guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years.

[11] The proposed language was inspired by the wording of Senate Bill S-225 and the CNPS is indebted to the authors of the Bill for their insight and analysis. Resulting amendments to the original wording of sections 14 and 241 of the Criminal Code appear as redlined text.

4. The Act is amended by adding the following after section 241:

241.1(1) The following definitions apply in this section.

"assistance" means the provision of information or means to commit suicide, or the performance of an act with the intent to cause the person's death, with the person's informed consent, in the course of the provision of professional health care services, for the purpose of relieving the person from unbearable suffering;

"practitioner-assisted death" means death that results from suicide committed with the assistance of a practitioner or from voluntary euthanasia performed by a practitioner;

"assisting practitioner" means a practitioner who provides assistance to a person resulting in or in contemplation of practitioner-assisted death;

"consulting physician" means a physician who, in the course of providing health care services advises an assisting practitioner in relation to practitioner-assisted death;

"counsel" in relation to the death of a person, means to provide information on practitioner-assisted death in the course of the provision of professional health care services;

"nurse" means a person licensed to practice nursing under the laws of the province or territory in which assistance is provided, and includes a licensed practical nurse, a registered practical nurse, a registered psychiatric nurse, a registered nurse or a nurse practitioner or other equivalent designations;

"practitioner" means a physician licensed to practice medicine under the laws of the province or territory in which assistance is provided, or a regulated health care professional licensed to provide professional health care services and authorized to act as an assisting practitioner in the province or territory in which assistance is provided;

"voluntary euthanasia" means the intentional termination of a person's life by another person, in accordance with the former's request.

(2) An assisting practitioner, a consulting physician or a nurse who, in the course of providing professional health care services, counsels a person about practitioner-assisted death is not guilty of an offence under section 241.

(3) An assisting practitioner or a consulting physician who provides assistance to a person, in the course of providing professional health care services to that person, is not guilty of an offence under section 241 if the practitioner or physician made reasonable efforts to ascertain that the conditions set out in subsection (5) have been met.

(4) Except when acting as a practitioner, a nurse is not guilty of an offence under section 241 when providing assistance to a person in the course of providing professional nursing services to that person, unless the nurse knew or should have known that the conditions set out in subsection (5) have not been met. A nurse may ascertain that the conditions set out in subsection (5) have been met by seeking confirmation from the assisting practitioner.

(5) The person making the request for practitioner-assisted death

(a) is eighteen years of age or more, or alternatively, a competent adult as defined in the applicable provincial or territorial legislation;

(b) is a Canadian citizen or a permanent resident within the meaning of subsection 2(1) of the *Immigration and Refugee Protection Act* as of the date of the request;

(c) is acting voluntarily, free from coercion or undue influence;

(d) has been diagnosed with a grievous and irremediable medical condition (including an illness, disease or disability) that causes the person enduring physical or psychological suffering that is intolerable to that person in the circumstances of his or her condition;

(e) is of sound mind and capable of fully understanding his or her medical prognosis, the consequence of the request for practitioner-assisted death being honoured, the feasible alternative treatments and his or her right to revoke the request at any time;

(f) was assessed by a consulting physician who was of the opinion that the conditions set out in paragraphs (5)(a) to (e) were met; and

(g) if he or she received assistance, was given the opportunity to revoke his or her request immediately before receiving the assistance.