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DISCLAIMER

This document is for consultation purposes only. It is not intended as legal advice and cannot be a substitute for legal advice. If you have legal questions or concerns, please seek legal counsel through your professional liability protection organization or union. Taskforce members’ participation does not imply endorsement.

INTRODUCTION

Over the past five years, Canada’s approach to choice on end-of-life decisions has undergone unprecedented reform, in the context of public opinion and in legal and social policy development. The most significant changes have been the 2015 Supreme Court of Canada decision in *Carter v. Canada (Attorney General)* and the passing of Bill C-14, *An Act to Amend the Criminal Code and to Make Related Amendments to Other Acts (Medical Assistance in Dying)*, in June 2016. The act’s amendments allow eligible persons to receive medical assistance in dying (MAID) under specific circumstances.

Following these reforms, Canada’s nurses¹ will continue to have a significant role in providing high-quality, person-centred end-of-life care that includes palliative care and natural death or MAID. To be eligible for MAID a person must have been informed of the means available to relieve their suffering including palliative care.² Nurses will also continue to interact with people at all stages of life, in situations of health, illness, injury and disability, and provide care across the continuum in a myriad of health settings. This includes advocating for persons in their care, providing information, participating in decision-making, supporting them and their families, and collaborating with members of the health-care team to ensure they have the care and information they need.

In providing such care, nurses “directly engage with people and their human condition, assessing suffering and survival while supporting them as they progress through death and dying.”³ Moreover, they “are the health-care professionals who people talk to and question most often, as they are the most constant care providers attending to people at home or in hospital.”⁴ Nurses may hear from people who ask that they be allowed to die and who may be seeking advice about how they can end their suffering. Nurses therefore have a unique perspective and bring an important contribution to providing end-of-life care that may include providing or aiding in MAID.

Like Canadian citizens, nurses hold a diversity of personal views on MAID. Nothing in the Criminal Code compels a nurse or nurse practitioner (NP) to participate in MAID.⁵

¹ Unless otherwise stated, the framework’s use of the term *nurses* includes all of the following: registered nurses, licensed/registered practical nurses, registered psychiatric nurses and nurse practitioners.

² See the related Canadian Nurses Association [CNA], Canadian Hospice Palliative Care Association [CHPCA] and Canadian Hospice Palliative Care Nurses Group [CHPC-NG] joint position statement, *The Palliative Approach to Care and the Role of the Nurse*.

³ (CNA, CHPCA, CHPC-NG, 2015, p. 4)

⁴ (CNA, 2015, p. 3)

⁵ See the conscientious objection section on p. 12.

PURPOSE OF THE FRAMEWORK

This framework has been developed with several purposes in mind:

- ▶ To raise awareness among nurses of the change in the federal law, which now permits MAID in certain circumstances and within regulatory direction.
- ▶ To guide nurses in reflecting on ethical issues that may occur as they care for persons considering MAID in various practice settings.
- ▶ To reinforce sound ethical nursing practice.
- ▶ To outline the role of nurses (i.e., NPs as compared to registered nurses, licensed practical nurses and registered psychiatric nurses) in MAID and to support nurses in their practice as they work with persons⁶ considering and receiving MAID and their families and interprofessional health-care teams (in alignment with regulatory direction in relevant jurisdictions).
- ▶ To raise the visibility of the profession's contribution to end-of-life care decision-making and care that includes MAID.
- ▶ To be a resource that supports nurse regulators, clinical nurse leaders, administrators/employers and interprofessional health-care teams to develop policies, guidelines, processes and services which use the knowledge and skills of nurses appropriately to provide or aid in MAID.
- ▶ To be a nursing resource for entry to practice and continuing education on MAID.

The framework is intended to supplement regulatory and employer standards, guidelines, policies and practices in each jurisdiction. Nurses must consult with their regulatory body and individual employer for specific direction.

The framework is meant to guide all nurses: registered nurses, licensed/registered practical nurses, registered psychiatric nurses and nurse practitioners.

⁶ For the purpose of this framework, the word *person* is used to refer to patients, clients, residents, etc.

OVERVIEW OF THE FRAMEWORK

The framework has three main sections:

1. **Statement of nursing values and responsibilities**
 - Providing safe, compassionate, competent and ethical care
 - Promoting health and well-being
 - Promoting and respecting informed decision-making
 - Preserving dignity
 - Maintaining privacy and confidentiality
 - Promoting justice
 - Being accountable

2. **A generic pathway for NPs providing MAID and nurses aiding in MAID**
 - Step 1. Determining eligibility for MAID
 - Step 2. Ensuring safeguards are met
 - Step 3. Providing and aiding MAID
 - Step 4. Filing information and reporting requirements

3. **Case studies**
 - Four cases that apply the values and responsibilities and offer other points for nurses to consider

BACKGROUND: CHANGES IN THE LAW

Canada has heard a “growing cry for clarity and for change in the law . . . to make room for choice in determining the timing of death.” Choice, for many, is a “critical element of a dignified death, particularly since medical science has advanced to such a degree that people’s lives can be prolonged amid severe disability or unalleviated suffering.”⁷

CARTER V. CANADA

On February 6, 2015, the Supreme Court of Canada rendered its unanimous decision in *Carter v. Canada (Attorney General)*.⁸ The court ruled that Criminal Code sections 241(b) and 14 violated section 7 of the Charter of Rights and Freedoms in so far as they prevented the two applicants (Kay Carter and Gloria Taylor) and persons in like circumstances from lawfully obtaining assistance from a doctor in committing suicide. The court then set out the following conditions which would make a person eligible for “physician-assisted death”:

Section 241(b) and s.14 of the Criminal Code unjustifiably infringe s.7 of the Charter and are of no force or effect to the extent that 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 condition.⁹

In other words, the Supreme Court decision changed the law to permit physician-assisted death in particular circumstances. Any legislative response by federal, provincial and territorial governments would have to adhere to the analysis of Section 7 in the Charter as set out in *Carter v. Canada*.

The court also recognized that Parliament faced a difficult task in developing a legislative framework to balance the competing social interests between persons who identify (or who are identified) as vulnerable and those seeking MAID. It therefore suspended the operation of its judgment for one year to allow the federal government time to decide upon legislative amendments. The government subsequently obtained a further four-month extension from the court, until June 6, 2016.

⁷ (CNA, 2015, p. 5)

⁸ For more on the ruling, see Martha Butler and Marlisa Tiedemann, *Carter v. Canada: The Supreme Court of Canada’s Decision on Assisted Dying* (Library of Parliament, 2015 [Publication No. 2015-47-E]).

⁹ (*Carter v. Canada (Attorney General)*, s. 147)

BILL C-14

To prepare for a new legislative framework, the House of Commons and Senate established a special joint committee on the issue in January 2016. In the presentations that were made, the committee “heard overwhelming support” for a collaborative and person-centred framework that would prevent “the eligibility and process for accessing MAID [to] vary greatly from one province or territory to another.”¹⁰ In its final report, *Medical Assistance in Dying: A Patient-Centred Approach*, the committee recommended that “medical assistance in dying” replace “physician-assisted death,” that the Criminal Code allow MAID to be directed by physicians and NPs, and that health-care professionals who assist them be protected.¹¹ On April 14, after the cabinet and the ministers of justice and health reviewed the report (among other documents), the government tabled Bill C-14, *An Act to Amend the Criminal Code and to Make Related Amendments to Other Acts (Medical Assistance in Dying)*. The bill’s royal assent on June 17 (now known as S.C. 2016, c.3) makes it possible for eligible persons to receive MAID in Canada and provides safeguards for vulnerable populations. The law also establishes safeguards and protections for health-care professionals who provide MAID, in accordance with the law, as well as for persons who assist them.

MAID, as defined in the act, means:

- (a) the administering by a medical practitioner or nurse practitioner of a substance to a person, at their request, that causes their death; or
- (b) the prescribing or providing by a medical practitioner or nurse practitioner of a substance to a person, at their request, so that they may self-administer the substance and in doing so cause their own death.¹²

The act amends the Criminal Code to, among other things:

- (a) create exemptions from the offences of culpable homicide, of aiding suicide and of administering a noxious thing, in order to permit medical practitioners and nurse practitioners to provide medical assistance in dying and to permit pharmacists and other persons to assist in the process;
- (b) specify the eligibility criteria and the safeguards that must be respected before medical assistance in dying may be provided to a person;

¹⁰ (Canada. Parliament, 2016, p. 2-3)

¹¹ *Ibid.*, p. 9.

¹² (S.C. 2016, c. 3, s. 241.1(1)(a)(b))

(c) require that medical practitioners and nurse practitioners who receive requests for, and pharmacists who dispense substances in connection with the provision of, medical assistance in dying provide information for the purpose of permitting the monitoring of medical assistance in dying, and authorize the Minister of Health to make regulations respecting that information; and

(d) create new offences for failing to comply with the safeguards, for forging or destroying documents related to medical assistance in dying, for failing to provide the required information and for contravening the regulations.¹³

Because the provinces and territories share responsibility for health care, they could choose to develop additional legislation and/or policies to clarify the rules affecting the service of MAID. Should they do so, any health-care professional participating in MAID would be required to comply with those additions since, according to the MAID legislation, “medical assistance in dying must be provided with reasonable knowledge, care and skill and in accordance with any applicable provincial laws, rules or standards.”¹⁴

NURSING PARTNERS: GOVERNMENT, REGULATORY BODIES, EMPLOYERS AND PROFESSIONAL LIABILITY PROTECTION SERVICES

In developing this document, taskforce members remained aware of the different roles among federal, provincial/territorial governments, nursing regulatory bodies, employers and professional liability protection services, who are working together to achieve a harmonized, effective and equitable legislative and regulatory framework for MAID in Canada.

Nursing regulatory bodies across the country have the legal mandate to protect the public by ensuring that nurses who practise are qualified and provide safe, competent, ethical care. These bodies are responsible for setting professional standards and guidelines that apply to the scopes of practice established for nurses under provincial or territorial legislation.

In assessing the implications of MAID legislation on the regulation of nursing practice, each provincial and territorial nursing regulatory body may provide direction to their members. It is important for nurses to consult their regulator for guidance, competencies, policies or standards pertaining to the provision of MAID. Nurses are responsible for practising in accordance with all relevant legislation in addition to specific professional standards, guidelines, conditions or rules established by their regulatory body.

¹³ (S.C. 2016, c. 3, p. ii) See the appendix for the full revisions to the Criminal Code.

¹⁴ (S.C. 2016, c. 3, s. 241.2(1)(7))

Provincial and territorial regulatory bodies for nurses, medical practitioners and pharmacists are collaborating with governments, employers and other stakeholders to ensure that coherent standards, guidelines, protocols, etc., are developed to support health-care professionals.

Within this regulatory and legislative framework employers will also play a key role in

- ▶ developing how MAID will operate at an organizational level;
- ▶ defining the role of various health-care professionals on interdisciplinary care teams;
- ▶ ensuring appropriate training in consultation with regulators; and
- ▶ providing clear and workable policies and procedures to support nurses in their workplace.

Employers should also develop processes to allow nurses to declare a conscientious objection with regard to MAID.

Professional liability protection services, offered by several organizations and unions across Canada, have developed MAID-specific legal resources for their members. Nurses and NPs are encouraged to seek legal counsel from their relevant professional liability protection organization or union.

STATEMENT OF NURSING VALUES AND RESPONSIBILITIES

To guide nursing practice, the framework offers seven core values and responsibilities, which are also meant to be used as an initial lens through which all ethical guidance and decisions for MAID are viewed. The values and responsibilities exist in all three nursing codes of ethics,¹⁵ although some have been adapted for nursing from other documents related to MAID.¹⁶

A. Providing safe, compassionate, competent and ethical care

- i. Nurses remain current on the state of the law and its implications for their professional practice.
- ii. Nurses adhere to the jurisdictional roles and responsibilities of their nursing regulatory body, which has legislative/regulatory oversight for the provision of safe, competent and ethical nursing care.
- iii. Nurses aid in the provision of MAID with reasonable knowledge, care and skill and in accordance with any applicable provincial laws, rules or standards.

¹⁵ (CNA, 2008; Canadian Council for Practical Nurse Regulators, 2013; Registered Psychiatric Nurses of Canada, 2010)

¹⁶ (College of Family Physicians of Canada, 2015; Incardona, Bean, Reel, & Wagner, 2016; Oregon Nurses Association, 1997)

B. Promoting health and well-being

- i. Nurses support persons in achieving their highest level of health in ways that are meaningful and acceptable to those persons.
- ii. Nurses strive for excellence in end-of-life care options including palliative care and natural death or MAID.

C. Promoting and respecting informed decision-making

- i. Nurses recognize, respect and promote a capable person's right to be informed and make decisions about their health and end-of-life care options including MAID.
- ii. Nurses respect the wishes of capable persons who request information about MAID.
- iii. Nurses do not impose their own views and values onto others nor use their position to influence, judge or discriminate against others whose values are different from their own.
- iv. Nurses support a capable person's right to withdraw their request for MAID at any time.

D. Preserving dignity

- i. Nurses work with the person inquiring about or requesting MAID, and with family members, groups and communities, in accordance with the person's consent while respecting the person's values, beliefs and decision.
- ii. Nurses work to prevent or eliminate discrimination toward all those involved — persons, family members, health-care staff — in end-of-life care decisions and provisions, including MAID.
- iii. Nurses listen actively to persons' concerns, experiences and requests for information to identify opportunities for clarifying their goals of care, education needs, alterations in care and access to resources.
- iv. Nurses foster comfort and support a dignified death.
- v. Nurses provide support for the family during and following the death.
- vi. Nurses treat each other and all members of the health-care team respectfully, whether or not they choose to be involved in providing or aiding in MAID.

E. Maintaining privacy and confidentiality

- i. Nurses respect the privacy of persons who inquire about or request MAID and protect the privacy and confidentiality of sensitive information about diagnosis and cause of death.

- ii. Nurses adhere to current legislation, professional regulatory standards and employer policies regarding MAID, including IT security safeguards that protect and preserve the privacy of the person, as well as that of his or her family and the health-care professionals involved.

F. Promoting justice

- i. Nurses contribute to the development of processes and practices that enable persons to access information on and request MAID.
- ii. Nurses refrain from judging, labelling, demeaning, stigmatizing or humiliating persons who request MAID or who provide or aid in MAID (including each other), whether or not they have a conscientious objection to MAID.
- iii. When a person requests MAID, nurses make fair decisions about the allocation of resources within their control based on the needs of the person.
- iv. Nurses strive for sufficient resources that enable persons to access palliative care and MAID.

G. Being accountable

- i. Nurses practise according to their code of ethics, in keeping with the laws, regulations, professional standards and guidelines for MAID in the jurisdiction where they practise.
- ii. Nurses contribute to the development and evaluation of policies, guidelines and processes created for MAID.
- iii. Nurses who anticipate a conscientious objection regarding MAID have an obligation to notify their employers so alternative arrangements can be made prior to care requests.
- iv. Nurses who recognize a conscientious objection related to the provision of MAID must inform their employer or organization (either in accordance with this organization's policy or with guidelines from the nursing regulatory body) and continue to provide safe, compassionate, competent and ethical care outside of MAID.
- v. When MAID has a psychosocial impact that is affecting their capacity to practise safely and competently, they must consult their employer, undertake steps to address any impact and seek support as needed.

CONSCIENTIOUS OBJECTION

Nothing in the Criminal Code “compels nurses to aid in the provision of medical assistance in dying.”¹⁷ A nurse may have “beliefs and values that differ from”¹⁸ those of persons in their care. If nurses can anticipate a conscientious objection to MAID, they have an obligation to notify their employers as soon as possible or, in the case of self-employed nurses, inform persons seeking MAID that they do not provide this service so alternative arrangements can be made. NPs who do not personally provide MAID may have a professional duty in accordance with professional standards in their jurisdiction to refer the person who requests it to another NP or medical practitioner who provides this service.¹⁹

Nurses with a conscientious objection are required “to take all reasonable steps to ensure that the quality and continuity of care for clients are not compromised.”²⁰ If MAID is unexpectedly proposed or requested without an arrangement in place for alternative providers, “nurses must inform those most directly involved of their conscientious objection.”²¹ Nurses must also ensure a safe, continuous and respectful transfer of care to an alternate provider that addresses the unique needs of a client.²²

GENERIC PATHWAY FOR NPs PROVIDING MAID AND NURSES AIDING IN MAID

The generic pathway describes the overall process through which a capable adult person moves from the point of information seeking to a request for MAID and the role of nurses and NPs. The pathway’s four steps²³ should be understood as continuous and interrelated. Since NPs will be referred to separately because of their distinct roles in MAID, the term *nurses* in this section will mean registered nurses, licensed/registered practical nurses and registered psychiatric nurses. These nurses are not responsible for all the duties listed, as roles will differ according to their distinctive competencies and scopes of practice.

Nurses and NPs need to be aware that their provincial or territorial government, nursing regulatory body or employer may be developing service models, specific pathways, policies and practices for MAID. Employers will also be a key part of determining the MAID process, defining roles for various health-care professionals on interdisciplinary

¹⁷ (College of Registered Nurses of British Columbia [CRNBC], 2017, p. 49; College of Nurses of Ontario [CNO], 2016)

¹⁸ (CNO, 2016, p. 3; CRNBC, 2017, p. 49)

¹⁹ (CNO, 2016)

²⁰ (CRNBC, 2017, p. 49)

²¹ *Ibid.*

²² *Ibid.*

²³ These steps are consistent with the federal legislation on MAID.

teams, ensuring appropriate training (in consultation with regulators), and providing clear and workable policies and procedures to support nurses in their everyday practice.²⁴ As well, nurses and NPs are encouraged to access their professional liability protection/insurance services for legal counsel.

The pathway in this framework, which should be used in conjunction with those by nursing regulatory bodies and employers, is deliberately non-prescriptive. It is designed to provide guidance for nurses and NPs when the issue of MAID arises in their practice.

Nurses and NPs are not legally compelled to provide or aid in the provision of MAID.²⁵

To properly understand the pathway, nurses and NPs should familiarize themselves with the Criminal Code amendments related to MAID, which include the following:

- ▶ The different roles for medical practitioners and NPs as compared with those who aid them, such as registered nurses, registered/licensed practical nurses and registered psychiatric nurses
- ▶ Requirements for eligibility for MAID
- ▶ The independence of the medical practitioner or NP
- ▶ Informed consent
- ▶ Conditions to be satisfied at the time of administration
- ▶ Reporting requirements
- ▶ That MAID must be provided with reasonable knowledge, care and skill and in accordance with any applicable provincial laws, rules or standards

PATHWAY STEPS

Step 1. Determining eligibility for MAID

Only NPs or medical practitioners who are duly authorized within their jurisdiction to provide MAID are responsible for establishing the person's eligibility.²⁶ To be eligible for MAID, the law states that a person must meet all of the following criteria:

- (a) they are eligible . . . for health services funded by a government in Canada;
- (b) they are at least 18 years of age and capable of making decisions with respect to their health;

²⁴ It is also important for employers to include processes that allow nurses to exercise their choice to participate or opt out of MAID.

²⁵ See the Conscientious Objection section on page 12.

²⁶ Nurses aiding in MAID as a member of the health-care team are not permitted to determine eligibility, which remains the responsibility of the providing NP or physician.

- (c) they have a grievous and irremediable medical condition;
- (d) they have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure; and
- (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.²⁷

The law considers a person to have a grievous and irremediable medical condition only if they meet all of the following criteria:

- (a) they have a serious and incurable illness, disease or disability;
- (b) they are in an advanced state of irreversible decline in capability;
- (c) that illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and
- (d) their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining.²⁸

Nurses who assist in MAID as a member of the health-care team are not permitted to determine the person's eligibility, as that role remains the responsibility of the providing NP or medical practitioner. Within their role in MAID, nurses should discuss the person's request for MAID with other members of the team and review the person's record and written request for MAID beforehand. Nurses must adhere to any applicable employer or agency policies and practices regarding their role in MAID.

Nurses and NPs who participate in MAID can legally provide information about the lawful provision of MAID, if such a request is initiated by a person in their care. Yet, because it is a criminal offence to counsel a person to commit suicide, nurses and NPs *must not* encourage or recommend MAID. Nurses and NPs must also comply with employer policies regarding MAID.

In organizations that provide MAID, nurses and NPs should be aware that employer policies regarding their role need to be consistent with the law. If they have questions, they should raise them with the employer.

²⁷ (S.C. 2016, c. 3, s. 241.2(1))

²⁸ (S.C. 2016, c. 3, s. 241.2(2))

Step 2. Ensuring safeguards are met

Before an NP or medical practitioner provides a person with MAID, the law states that she or he must

- (a) be of the opinion that the person meets all of the [eligibility] criteria set out in subsection (1);²⁹
- (b) ensure the person's request for medical assistance in dying was
 - (i) made in writing and signed and dated by the person or another person under subsection (4)³⁰ and
 - (ii) signed and dated after the person was informed by a medical practitioner or nurse practitioner that the person has a grievous and irremediable medical condition;
- (c) be satisfied that request was signed and dated by the person — or by another person under subsection (4) — before two independent witnesses³¹ who then also signed and dated the request:
- (d) ensure that the person has been informed that they may, at any time and in any manner, withdraw their request;
- (e) ensure that another medical practitioner or nurse practitioner has provided a written opinion confirming that the person meets all of the criteria set out in subsection (1);
- (f) be satisfied that they and the other medical practitioner or nurse practitioner referred to in paragraph (e) are independent;³²
- (g) ensure that there are at least 10 clear days between the day on which the request was signed by the person and the day on which the medical assistance in dying is provided or — if they or the medical practitioner referred to in paragraph (e) are both of the opinion that the person's death, or the loss of capacity to provide informed consent, is imminent — any shorter period that the first medical practitioner or nurse practitioner considers appropriate in the circumstances;
- (h) immediately before the provision of medical assistance in dying, give the person an opportunity to withdraw their request and ensure that the person gives express consent to receive medical assistance in dying; and

²⁹ See S.C. 2016, c. 3, s. 241.2(1) in the appendix.

³⁰ See S.C. 2016, c. 3, s. 241.2(4) in the appendix.

³¹ See S.C. 2016, c. 3, s. 241.2(5) in the appendix.

³² See S.C. 2016, c. 3, s. 241.2(6) in the appendix.

(i) if the person has difficulty communicating, take all necessary measures to provide a reliable means by which the person may understand the information that is provided to them and communicate their decision.³³

An independent NP or medical practitioner may provide a second opinion on a person's eligibility to receive MAID as long as he or she meets the criteria set out in the Criminal Code.

Step 3. Providing and aiding in MAID

For persons who have requested MAID and meet all of the eligibility criteria, the law allows NPs or medical practitioners to

- ▶ administer a medication to the person, at their request, that will cause their death; or
- ▶ prescribe or provide a medication to the person to self-administer, and in doing so, cause their own death.

NPs should ascertain whether MAID can be provided in the employment setting and, if so, review any applicable laws, policies, guidelines, procedures and processes in place to guide them.

It may not always be appropriate for an NP to provide MAID. For example, an NP may not be competent to perform MAID, or providing it may not be within her or his provincial or territorial scope of practice. NPs must ensure that administering or prescribing a substance that causes a person's death, etc., falls within their scope of practice and that they possess the necessary knowledge, skill and judgment to fulfil their responsibilities in the provision of MAID. All NPs should check with their nursing regulatory body beforehand.

The legislation requires that an NP or medical practitioner who, in providing MAID, "prescribes or obtains a substance for that purpose must, before any pharmacist dispenses the substance, inform the pharmacist that the substance is intended for that purpose."³⁴

Nurses who choose to aid in MAID need to consult with their nursing regulatory body and employer policies.

Nurses are not authorized to administer the medication that causes the person's death under any circumstances, even if requested by the providing NP, the medical practitioner or the person. Nurses may, however, aid the providing NP or medical practitioner, where the safeguards outlined above have been met, by

³³ (S.C. 2016, c. 3, s. 241.2(3))

³⁴ (S.C. 2016, c. 3, s. 241.2(8))

- ▶ inserting “an intravenous line that will later be used by an NP or medical practitioner to administer the medication;
- ▶ [being] present during the administration of the medication to provide holistic nursing interventions to meet the needs of the [person] and their family during the dying process;
- ▶ in the case of a person seeking to self-administer the medication, passing the oral medication to the [person], so long as the [person] explicitly asks for [the nurse’s] assistance. In this scenario, [nurses] should refrain from activities that may be viewed as the actual administration of the medication, such as placing oral medication in the [person’s] mouth or pushing medication into the [person’s] intravenous line”³⁵ or altering the medication to ease ingestion such as mixing the medication with food or liquid.

Prior to aiding with MAID the nurse should verify that the legal conditions for MAID have been satisfied. This can occur by

- ▶ reviewing the chart to determine whether documentation clearly indicates that all requirements have been met (this may be in the form of a standardized document, completed by the NP or medical practitioner); or
- ▶ inquiring directly with the NP or medical practitioner providing MAID; or
- ▶ participating with the person as a member of a MAID interprofessional team.

Step 4. Filing information and reporting requirements

An NP or medical practitioner who provides MAID is responsible for completing all necessary documentation required by federal and provincial/territorial law and by employer, organizational and provincial/territorial policies. This process includes thoroughly documenting the care provided before, during and after MAID has been performed. In those jurisdictions where NPs cannot sign the death certificate, appropriate arrangements should be made to increase efficiency and decrease potential family stress or unnecessary delays.

The NP or medical practitioner must maintain within the person’s chart all documents specified in the relevant sections of the Criminal Code for the provision of MAID, including

- ▶ the written request for MAID;
- ▶ the written opinion from another medical practitioner or NP confirming that the person has met all of the criteria; and

³⁵ (College of Registered Nurses of Nova Scotia & College of Licensed Practical Nurses of Nova Scotia, 2016, p. 3)

- ▶ any other relevant documentation that will be required under the regulations.

A nurse who is aiding an NP or medical practitioner in the care of a person receiving MAID should carefully document in the person's chart:

- ▶ any request for information on MAID directed to the nurse and the information provided;
- ▶ any request for MAID directed to the nurse and the action taken;
- ▶ prior to aiding with MAID, verification from the nurse confirming that the legal conditions for MAID have been satisfied (along with the steps that were taken to do so). This can occur by
 - reviewing the chart to determine whether documentation clearly indicates that all requirements have been met (this may be in the form of a standardized document, completed by the NP or medical practitioner);
 - inquiring directly with the NP or medical practitioner providing MAID;
 - participating with the person as a member of a MAID interprofessional team.
- ▶ that aiding with MAID was performed under the direction and supervision of the providing NP or medical practitioner.

Under no circumstance should a nurse obtain informed consent from a person requesting MAID at any step in the process. The nurse must not document the care provided by any other member of the health-care team. Consent must be obtained by an NP or medical practitioner and documented by the person obtaining consent in the manner required by law. No responsibilities specifically assigned to an NP or medical practitioner by MAID legislation, such as obtaining consent and administering medications, can be delegated to a nurse.

The Criminal Code imposes several procedural safeguards including the requirement that a person's request for MAID must be made in writing in the presence of two independent witnesses, who must then also sign the request. Nurses may be asked to be an independent witness and sign the person's request for MAID. Nurses must ensure they meet all the criteria set out in the Criminal Code regarding independent witness.³⁶ Nurses must also comply with nursing regulatory body and employer policies regarding acting as a witness.

If a person requesting MAID is unable to sign their request, "another person — who is at least 18 years of age, who understands the nature of the request for MAID and who does not know or believe that they are a beneficiary under the will of the person making the request, or a recipient, in any other way, of a financial or other material benefit resulting from that person's death — may sign the request in the person's presence, on

³⁶ See S.C. 2016, c. 3, s. 241.2(5).

the person's behalf and under the person's express direction."³⁷ Nurses may also be asked to assume this role and should consult employer and nursing regulatory body policies and practices.

Following Step 4, normal practice would entail having the nurse and/or NP support the family of the person receiving MAID through bereavement care. For the interprofessional team involved in MAID, it may also be useful to support each other (e.g., in the form of a debriefing session), which may also serve as a quality improvement opportunity. Employers should provide support and resources to the team for such activities.

CASE STUDIES

The four case studies that follow apply the nursing ethical values and responsibilities in different practice settings while adhering to the pathway to providing MAID. They offer a practical lens to guide nurses and NPs in providing the most appropriate care. Once again, NPs will be referred to separately because of their distinct role in MAID. *Nurses* will mean registered nurses, licensed or registered practical nurses and registered psychiatric nurses.

1. A remote community where a group of RNs and LPNs provide 24/7 health-care services with regular, scheduled MD visits once a week

Mrs. S is a senior with stage-four lung cancer, who is essentially housebound with oxygen-dependent emphysema. She has just returned from a health centre 400 kilometres away having completed two months of chemotherapy, which she says was unbearable. You are a registered nurse. In your visit to her, she tells you she has decided against continuing further treatments and wishes to consider having MAID at home while she is still capable of making choices. Mrs. S says she became interested in choosing MAID after following media reports on the topic. Her two adult children do not agree with her wishes. Mrs. S asks you for more information on how to proceed with the arrangements for MAID. You are familiar with the information to be provided.

Through active listening and engagement with Mrs. S, you reflect her feelings of conflict and her lack of confidence in her family's acceptability of her wishes back to her. In this context, Mrs. S trusts that she could openly share and not be judged for her attitude. She also becomes open to both discussing her concerns and MAID with the community physician, initially by web conferencing and shortly thereafter in person during visits. While Mrs. S does not want to talk with her oncologist, she is interested in the

³⁷ (S.C. 2016, c. 3, s. 241.2(4))

possibility of a meeting with her children. You contact the physician and discuss her request for MAID and for the family meeting.

DISCUSSION

Nurses and NPs are instrumental in building relationships with persons in their care and listening to their concerns. When persons bring up difficult issues such as MAID, engaging with them can provide an opening to active listening toward their requests for information and expressions of human experience, including joy, fear and suffering. The nurse in this situation has recognized, respected and promoted Mrs. S's right to be informed and to make decisions about her health, including withdrawing from cancer treatments and requesting MAID. In this conversation, the nurse could provide accurate and objective information to Mrs. S on the lawful provision of MAID. It would also be appropriate for the nurse to discuss palliative care, including relief of distressing symptoms. The physician, in determining her eligibility for MAID, would legally be required to inform Mrs. S of the means that are available to relieve her suffering, including palliative care.

Given the pattern of nurse staffing in the health clinic, where nurses work six weeks on, six weeks off, provision must also be made for good communication and continuity of care with other nurses in the community as well as with the physicians who provide weekly visits. Effective interprofessional and intraprofessional collaboration is important. A well-documented health-care team plan for Mrs. S should be put in place immediately. In a remote or isolated setting, access to MAID can bring unique challenges. For example, the nurse must be familiar with policies and procedures and, in this case, the technology required to give Mrs. S access to her primary physician through web conferencing.

Given that the nurse practises in a remote community with potentially limited onsite professional resources, it would be very important for them to contact their nursing regulatory body.

2. An NP who works in home care providing primary care services in a city setting

Mr. B is a middle-aged man who has suffered with amyotrophic lateral sclerosis (ALS) for 10 years. He is now rapidly deteriorating with what he describes as little to no quality of life. He feels the end of his life is near and wishes relief from his suffering through MAID. He expresses his wish for MAID to his primary care provider, an NP who works in home care. The NP is prepared for such a request but does not wish to take part in providing MAID because of her religious beliefs. She informs Mr. B that she will help him by initiating the process of MAID and, in the meantime, continue with his

care. Following her employer policy, the NP calls the regional referral centre and provides the relevant information.

DISCUSSION

Based on their beliefs and values, NPs or nurses may choose not to provide or participate in MAID, and the law does not compel them to do so. Section 241.2 (9) of the Criminal Code clearly states: “For greater certainty, nothing in this section compels an individual to provide or assist in providing medical assistance in dying.” NPs who opt out of providing MAID, however, in accordance with professional standards in their jurisdiction, may have a professional duty to refer the person who requests it to another NP or medical practitioner who provides this service. The NP also would be required to inform her employer as early as possible of her conscientious objection.

In such scenarios, NPs should consult with their nursing regulatory body and adhere to professional standards regarding conscientious objection. An NP should not express any moral judgments about the beliefs, lifestyle, identity or characteristics of the person. With Mr. B, the NP respected his decision and demonstrated accountability by initiating the appropriate MAID pathway. She also respected his privacy and confidentiality by directly calling the referral centre and providing only the required information. As well, the NP continued to provide safe, compassionate, competent and ethical nursing care outside of MAID until alternative care arrangements were in place. It is important to note that not every person who inquires about MAID will be eligible and, among those, only a certain number will proceed. It is also important to devise ways in which members of a health-care team can support each other in clarifying and living with respect for diversity.

3. An urban acute care hospital medical unit where a multidisciplinary team provides 24/7 health care

Mrs. A is a 42-year-old teacher who was diagnosed two years ago with terminal brain cancer. Now on the medical unit of a large teaching hospital, she is capable of making decisions with respect to her health but is partially paralyzed and struggling to breathe. In addition, she has daily seizures, no control of her bodily functions and is in constant pain that is not relieved by medication. She asks to have MAID.

You are a registered nurse returning from a one-year maternity leave and have been assigned to Mrs. A. You are not that familiar with MAID, and no person has ever approached you for information about it.

DISCUSSION

To provide safe, compassionate, competent and ethical care, an RN who elects to aid in MAID, needs to

- ▶ become familiar with the Criminal Code amendments that make provision for MAID;
- ▶ review and adhere to any guiding documents from the nursing regulatory body in their province or territory;
- ▶ determine the employer's position on permitting MAID in the employment setting and be aware of any applicable policies, guidelines, procedures and processes in place to guide the nurse's practice in MAID, including the responsibility to refer if required;
- ▶ seek guidance and education from the employer, including a manager, clinical leader, educator and colleagues (nurses and other health-care professionals) to explore personal and professional values and become knowledgeable about MAID;
- ▶ seek the involvement and collaborate with other members of the health-care team including the providing medical practitioner or NP;
- ▶ ensure that her or his practice is in accordance with the applicable provisions of all applicable laws, rules and standards; and
- ▶ seek legal advice on questions that cannot be answered by information in this framework or by the RN's regulatory body.

All requests for MAID must be initiated by the person involved and must be made voluntarily, without external pressure or advice. Any information an RN provides must be accurate and objective. It should also be limited to (1) how MAID may be an option for persons who meet the eligibility criteria; and (2) how the process works in their jurisdiction.

Nurses are not to impose their own views and values onto others nor use their position to influence, judge or discriminate against persons whose values are different from their own. They must also be mindful not to suggest, counsel, encourage or incite a person to seek MAID. The law makes it an offence to counsel (i.e., solicit, incite or encourage) a person to die by suicide.³⁸ Therefore, in their interactions with persons in their care, all nurses and NPs must be careful to comply with the law, which restricts them to giving information on the lawful provision of MAID.

³⁸ (S.C. 2016, c. 3, s. 241(1)(a))

4. A licensed practical nurse who works in a long-term care facility

Mr. J is a 76-year-old engineer who has resided at his local long-term care facility for four years. He is mentally capable and was diagnosed with multiple myeloma in the past three months. While he is experiencing increasing levels of pain throughout his entire body, which limits his mobility, he has been reluctant to take pain medication. You are a licensed practical nurse who has provided regular care to Mr. J since his arrival at the facility. One day, as you are checking his vital signs, he says to you, "I've had enough now. I'm ready to die." You recognize this statement as an opportunity to explore his suffering. You respond with, "It sounds like you're feeling overwhelmed by how things are going." This begins a therapeutic discussion in which Mr. J reveals he has been reluctant to take pain medication because he thought doing so would make him an addict. You reassure him that this is not the case and discuss effective pain management options. Feeling relieved, Mr. J agrees to talk further about appropriate pain management with his physician. You inform the physician and document the discussion in his chart.

DISCUSSION

If a person in a nurse's care expresses a wish to die, the nurse should consider it "an opportunity to open a dialogue. Such comments might be transient, the result of a temporary distress or an expression of suffering due to unmet needs"³⁹ that could be treated or addressed. The role of the nurse is to identify and alleviate the factors prompting such requests, whether these stem from physical symptoms like pain or are related to anxiety or fear. Nurses have an obligation to try to understand the person's request and to bring in appropriate resources to address unmet needs. Nurses are accountable and responsible for listening to and acknowledging the suffering of every person in their care since failure to do so can increase suffering unnecessarily.

In this case, Mr. J's request was based on fear arising from a misunderstanding about the use of medication to alleviate chronic pain. It was not an inquiry about MAID. It was an expression of his suffering.

Whether or not a nurse aids in the provision of MAID, "there is an obligation to provide safe, competent, professional and ethical care to the person and his or her family at all times."⁴⁰ This includes addressing suffering and possibly exploring various end-of-life options other than MAID. A compassionate response to a person's comment about wanting to die may include spiritual care, a palliative approach to care, counselling or other services, depending on the reason for the suffering. This would also be an opportune time for the nurse to consult with other members of the health-care team to

³⁹ (Manitoba Provincial Health Ethics Network, 2016, p. 2)

⁴⁰ *Ibid.*, p. 3.

develop an interprofessional approach to end-of-life care, including relief of distressing symptoms and team support.

CONCLUSION

Nurses have a unique perspective and bring an important contribution to the health-care team in the provision of palliative and end-of-life care that includes MAID.

This framework was developed to give nurses and NPs information about MAID and guide their reflection on the ethical issues that may occur as they care for persons considering MAID. Nurses and NPs may choose not to participate in MAID. The legislation does not require them to do so. The framework is intended to support sound ethical nursing practice, nationally and locally, while recognizing the important contribution of nursing to quality decision-making in end-of-life care, including MAID. It is also a resource to support nurse regulators, educators, employers and others in developing policies, processes, educational programs and services that appropriately use nurses' knowledge and skills to deliver MAID.

Nurses and NPs are encouraged to use this framework as a practical guide for their practice within the Criminal Code. The framework is not a substitute for legal advice or for nursing regulatory body or employer-based policies. Instead, it is meant to complement the legislation; nursing regulatory standards, conditions, limits and guidelines; legal counsel; and employer policies that govern nursing practice pertaining to MAID.

GLOSSARY

capable. Being “able to understand and appreciate the consequences of various options and make informed decisions about one’s own care and treatment.”⁴¹

informed choice. A decision “that is informed, consistent with the decision maker’s values, and behaviorally implemented.”⁴²

nursing values and ethical responsibilities. Describe “the core responsibilities central to ethical nursing practice. These ethical responsibilities are articulated through seven primary values and accompanying responsibility statements, which are grounded in nurses’ professional relationships with individuals, families, groups, populations and communities as well as with students, colleagues and other health-care professionals.”⁴³

withholding, withdrawing and refusal of treatment. “Honoring the refusal of treatments that a patient does not desire, that are disproportionately burdensome to the patient, or that will not benefit the patient, is ethically and legally permissible. Within this context, withholding or withdrawing life-sustaining therapies or risking the hastening of death through treatments aimed at alleviated suffering and/or controlling symptoms are ethically acceptable and do not constitute euthanasia. There is no ethical or legal distinction between withholding or withdrawing treatments, though the latter may create more emotional distress for the nurse and others involved.”⁴⁴

⁴¹ (CNA, 2008, p. 23)

⁴² (Public Health Action Support Team, n.d., para. 2)

⁴³ (CNA, 2008, p. 3)

⁴⁴ (Oregon Nurses Association, 1997, p. 4)

WORKING DEFINITIONS

The following definitions use legal language given that the authority for the practice of MAID stems from a Supreme Court of Canada case and subsequent Criminal Code changes.

medical assistance in dying. “(a) the administering by a medical practitioner or nurse practitioner of a substance to a person, at their request, that causes their death; or (b) the prescribing or providing by a medical practitioner or nurse practitioner of a substance to a person, at their request, so that they may self-administer the substance and in doing so cause their own death.”⁴⁵

nurse practitioner. A “registered nurse who, under the laws of a province, is entitled to practise as a nurse practitioner — or under an equivalent designation — and to autonomously make diagnoses, order and interpret diagnostic tests, prescribe substances and treat patients.”⁴⁶

person. For the purposes of this framework only, a capable adult 18 years or older as defined in the MAID legislation.⁴⁷

⁴⁵ (S.C. 2016, c. 3, s. 241.1)

⁴⁶ Ibid.

⁴⁷ (S.C. 2016, c. 3, s. 241.2(1)(b))

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Oregon Nurses Association. (1997). Assisted suicide: The debate continues. *Oregon Nurse*, 62(3), 1-6. Retrieved from http://c.ymcdn.com/sites/www.oregonrn.org/resource/resmgr/Docs/ONA_AssistedSuicide_2015-06-.pdf

Public Health Action Support Team. (n.d.). The principles of informed choice. Retrieved from <http://www.healthknowledge.org.uk/public-health-textbook/disease-causation-diagnostic/2c-diagnosis-screening/principles-informed-choice>

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RESOURCES

Codes of Ethics

Canadian Nurses Association code of ethics

Canadian Council for Practical Nurse Regulators code of ethics

Registered Psychiatric Nurses of Canada code of ethics

RN Regulatory Bodies

Association of Registered Nurses of Newfoundland and Labrador

Association of Registered Nurses of Prince Edward Island

College of Registered Nurses of Nova Scotia

Nurses Association of New Brunswick

Ordre des infirmières et infirmiers du Québec

College of Nurses of Ontario

College of Registered Nurses of Manitoba

Saskatchewan Registered Nurses' Association

College and Association of Registered Nurses of Alberta

College of Registered Nurses of British Columbia

Registered Nurses Association of the Northwest Territories and Nunavut

Yukon Registered Nurses Association

LPN Regulatory Bodies

College of Licensed Practical Nurses of British Columbia

College of Licensed Practical Nurses of Alberta

Saskatchewan Association of Licensed Practical Nurses

College of Licensed Practical Nurses of Manitoba

Ordre des infirmières et infirmiers auxiliaires du Québec

Association of New Brunswick Licensed Practical Nurses

College of Licensed Practical Nurses of Nova Scotia

Prince Edward Island Licensed Practical Nurses Registration Board

College of Licensed Practical Nurses of Newfoundland and Labrador

Government of Yukon, Professional Licensing and Regulatory Affairs

RPN Regulatory Bodies

College of Registered Psychiatric Nurses of British Columbia

College of Registered Psychiatric Nurses of Alberta

Registered Psychiatric Nurses Association of Saskatchewan
College of Registered Psychiatric Nurses of Manitoba

Other

Canadian Nurses Association, Canadian Hospice Palliative Care Association and Canadian Hospice Palliative Care Nurses Group: *The Palliative Approach to Care and the Role of the Nurse*. (position statement, 2015).

Canadian Nurses Protective Society: *Medical Assistance in Dying: What Every Nurse Should Know*. (web resource, 2016)

College of Family Physicians of Canada: *A Guide for Reflection on Ethical Issues Concerning Assisted Suicide and Voluntary Euthanasia*

Government of Canada: *Legislative Background: Medical Assistance in Dying (Bill C-14)*

La Capitale assurances générales: *Programme d'assurance responsabilité professionnelle au Québec*

Oregon Nurses Association: *ONA Position Statement: Assisted Suicide* (November 2015)

Lavoie, M., Godin, G., Vézina-Im, L. A., Blondeau, D., Martineau, I., & Roy, L. (2016). Psychosocial determinants of nurses' intention to practise euthanasia in palliative care. *Nursing Ethics, 23*, 48-60. doi:10.1177/0969733014557117

Registered Nurses' Association of Ontario professional liability protection

Registered Nurses' Association of Ontario webinars on MAID

Quaghebeur, T., de Casterlé, B. D., & Gastmans, C. (2009). Nursing and euthanasia: A review of argument-based ethics literature. *Nursing Ethics, 16*, 466-486. doi:10.1177/0969733009104610

Vézina-Im, L. A., Lavoie, M., Krol, P., & Olivier-D'Avignon, M. (2014). Motivations of physicians and nurses to practice voluntary euthanasia: A systematic review. *BMC palliative care, 13*(1). doi:10.1186/1472-684X-13-20

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APPENDIX

MEDICAL ASSISTANCE IN DYING LEGISLATION

First Session, Forty-second
Parliament,
64-65 Elizabeth II, 2015-2016

STATUTES OF CANADA 2016

CHAPTER 3

An Act to amend the Criminal Code
and to make related amendments
to other Acts (medical assistance in
dying)

Première session, quarante-
deuxième législature,
64-65 Elizabeth II, 2015-2016

LOIS DU CANADA (2016)

CHAPITRE 3

Loi modifiant le Code criminel et
apportant des modifications
connexes à d'autres lois (aide
médicale à mourir)

ASSENTED TO
JUNE 17, 2016
BILL C-14

SANCTIONNÉE
LE 17 JUIN 2016
PROJET DE LOI C-14

SUMMARY

This enactment amends the *Criminal Code* to, among other things,

- (a)** create exemptions from the offences of culpable homicide, of aiding suicide and of administering a noxious thing, in order to permit medical practitioners and nurse practitioners to provide medical assistance in dying and to permit pharmacists and other persons to assist in the process;
- (b)** specify the eligibility criteria and the safeguards that must be respected before medical assistance in dying may be provided to a person;
- (c)** require that medical practitioners and nurse practitioners who receive requests for, and pharmacists who dispense substances in connection with the provision of, medical assistance in dying provide information for the purpose of permitting the monitoring of medical assistance in dying, and authorize the Minister of Health to make regulations respecting that information; and
- (d)** create new offences for failing to comply with the safeguards, for forging or destroying documents related to medical assistance in dying, for failing to provide the required information and for contravening the regulations.

This enactment also makes related amendments to other Acts to ensure that recourse to medical assistance in dying does not result in the loss of a pension under the *Pension Act* or benefits under the *Canadian Forces Members and Veterans Re-establishment and Compensation Act*. It amends the *Corrections and Conditional Release Act* to ensure that no investigation need be conducted under section 19 of that Act in the case of an inmate who receives medical assistance in dying.

This enactment provides for one or more independent reviews relating to requests by mature minors for medical assistance in dying, to advance requests and to requests where mental illness is the sole underlying medical condition.

Lastly, this enactment provides for a parliamentary review of its provisions and of the state of palliative care in Canada to commence at the start of the fifth year following the day on which it receives royal assent.

Available on the Parliament of Canada Web Site at the following address:
<http://www.parl.gc.ca>

SOMMAIRE

Le texte modifie le *Code criminel* afin notamment :

- a)** de créer des exemptions à l'égard des infractions d'homicide coupable, d'aide au suicide et d'administration d'une substance délétère, dans le but de permettre aux médecins et aux infirmiers praticiens de fournir l'aide médicale à mourir et aux pharmaciens ainsi qu'à d'autres personnes de leur porter assistance à cette occasion;
- b)** de préciser les critères d'admissibilité et les mesures de sauvegarde à respecter préalablement à la prestation de l'aide médicale à mourir;
- c)** d'exiger des médecins et des infirmiers praticiens qui reçoivent des demandes d'aide médicale à mourir ainsi que des pharmaciens qui délivrent des substances dans le cadre de la prestation de l'aide médicale à mourir qu'ils communiquent les renseignements nécessaires à la surveillance de l'aide médicale à mourir et d'autoriser le ministre de la Santé à prendre des règlements relatifs à ces renseignements;
- d)** de créer de nouvelles infractions relatives au non-respect des mesures de sauvegarde, à la falsification ou à la destruction de documents relatifs à l'aide médicale à mourir, à l'omission de fournir les renseignements exigés ou à la contravention des règlements.

Le texte apporte également des modifications connexes à d'autres lois pour faire en sorte que le recours à l'aide médicale à mourir n'entraîne pas la perte d'une pension prévue par la *Loi sur les pensions* ou d'avantages prévus par la *Loi sur les mesures de réinsertion et d'indemnisation des militaires et vétérans des Forces canadiennes*. Il modifie également la *Loi sur le système correctionnel* et la *mise en liberté sous condition* afin d'éviter la tenue d'une enquête, en application de l'article 19 de cette loi, lorsqu'un détenu reçoit l'aide médicale à mourir.

Il prévoit un ou des examens indépendants des questions portant sur les demandes d'aide médicale à mourir faites par les mineurs matures, les demandes anticipées et les demandes où la maladie mentale est la seule condition médicale invoquée.

Il prévoit enfin un examen parlementaire de ses dispositions ainsi que de la situation des soins palliatifs au Canada qui commence au début de la cinquième année qui suit sa sanction.

Disponible sur le site Web du Parlement du Canada à l'adresse suivante :
<http://www.parl.gc.ca>

An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)

[Assented to 17th June, 2016]

Preamble

Whereas the Parliament of Canada recognizes the autonomy of persons who have a grievous and irremediable medical condition that causes them enduring and intolerable suffering and who wish to seek medical assistance in dying;

Whereas robust safeguards, reflecting the irrevocable nature of ending a life, are essential to prevent errors and abuse in the provision of medical assistance in dying;

Whereas it is important to affirm the inherent and equal value of every person's life and to avoid encouraging negative perceptions of the quality of life of persons who are elderly, ill or disabled;

Whereas vulnerable persons must be protected from being induced, in moments of weakness, to end their lives;

Whereas suicide is a significant public health issue that can have lasting and harmful effects on individuals, families and communities;

Whereas, in light of the above considerations, permitting access to medical assistance in dying for competent adults whose deaths are reasonably foreseeable strikes the most appropriate balance between the autonomy of persons who seek medical assistance in dying, on one hand, and the interests of vulnerable persons in need of protection and those of society, on the other;

Whereas it is desirable to have a consistent approach to medical assistance in dying across Canada, while recognizing the provinces' jurisdiction over various matters related to medical assistance in dying, including the delivery of health care services and the regulation of health care professionals, as well as insurance contracts and coroners and medical examiners;

Loi modifiant le Code criminel et apportant des modifications connexes à d'autres lois (aide médicale à mourir)

[Sanctionnée le 17 juin 2016]

Préambule

Attendu :

que le Parlement du Canada reconnaît l'autonomie des personnes qui sont affectées de problèmes de santé graves et irrémédiables leur causant des souffrances persistantes et intolérables et qui souhaitent demander l'aide médicale à mourir; que de solides mesures de sauvegarde qui reflètent l'irrévocabilité de l'acte consistant à mettre fin à la vie d'une personne sont essentielles pour prévenir les erreurs et les abus lors de la prestation de l'aide médicale à mourir;

qu'il importe d'affirmer la valeur inhérente et l'égalité de chaque vie humaine et d'éviter d'encourager les perceptions négatives au sujet de la qualité de vie des personnes âgées, malades ou handicapées; que les personnes vulnérables doivent être protégées contre toute incitation à mettre fin à leur vie dans un moment de détresse;

que le suicide constitue un important enjeu de santé publique qui peut avoir des conséquences néfastes et durables sur les personnes, les familles et les collectivités;

que, à la lumière de ce qui précède, le fait de permettre l'accès à l'aide médicale à mourir aux adultes capables dont la mort est raisonnablement prévisible établit l'équilibre le plus approprié entre, d'une part, l'autonomie des personnes qui demandent cette aide et, d'autre part, les intérêts des personnes vulnérables qui ont besoin de protection et ceux de la société;

qu'il est souhaitable d'adopter une approche cohérente dans tout le pays en matière d'aide médicale à mourir, tout en reconnaissant la compétence des provinces en ce qui a trait à différentes questions liées à l'aide médicale à mourir, notamment la prestation de services de soins de santé, la réglementation des professions de la santé,

Whereas persons who avail themselves of medical assistance in dying should be able to do so without adverse legal consequences for their families — including the loss of eligibility for benefits — that would result from their death;

Whereas the Government of Canada has committed to uphold the principles set out in the *Canada Health Act* — public administration, comprehensiveness, universality, portability and accessibility — with respect to medical assistance in dying;

Whereas everyone has freedom of conscience and religion under section 2 of the *Canadian Charter of Rights and Freedoms*;

Whereas nothing in this Act affects the guarantee of freedom of conscience and religion;

Whereas the Government of Canada recognizes that in the living conditions of Canadians, there are diverse circumstances and that different groups have unique needs, and it commits to working with provinces, territories and civil society to facilitate access to palliative and end-of-life care, care and services for individuals living with Alzheimer's and dementia, appropriate mental health supports and services and culturally and spiritually appropriate end-of-life care for Indigenous patients;

And whereas the Government of Canada has committed to develop non-legislative measures that would support the improvement of a full range of options for end-of-life care, respect the personal convictions of health care providers and explore other situations — each having unique implications — in which a person may seek access to medical assistance in dying, namely situations giving rise to requests by mature minors, advance requests and requests where mental illness is the sole underlying medical condition;

Now, therefore, Her Majesty, by and with the advice and consent of the Senate and House of Commons of Canada, enacts as follows:

les contrats d'assurance ainsi que les coroners et les médecins légistes;

que les personnes qui se prévalent de l'aide médicale à mourir devraient pouvoir le faire sans que leur famille ne subisse de conséquences juridiques négatives en raison de leur mort, notamment la perte d'admissibilité à des avantages;

que le gouvernement du Canada s'est engagé à respecter les principes prévus par la *Loi canadienne sur la santé* — la gestion publique, l'intégralité, l'universalité, la transférabilité et l'accessibilité — à l'égard de l'aide médicale à mourir;

que chacun jouit de la liberté de conscience et de religion au titre de l'article 2 de la *Charte canadienne des droits et libertés*;

que la présente loi n'a pas pour effet de porter atteinte à la garantie dont fait l'objet cette liberté;

que le gouvernement du Canada reconnaît que les Canadiens n'ont pas tous les mêmes conditions de vie, chaque groupe ayant des besoins particuliers, et qu'il s'engage à collaborer avec les provinces, les territoires et les organisations de la société civile afin de faciliter l'accès aux soins palliatifs et aux soins de fin de vie, aux soins et aux services offerts aux personnes atteintes d'Alzheimer et de démence, à des services de soutien et autres en santé mentale et, s'agissant des Autochtones, à des soins de fin de vie adaptés à leur culture et à leurs croyances spirituelles; que le gouvernement du Canada s'est engagé à élaborer des mesures non législatives visant à soutenir l'amélioration d'une gamme complète d'options de soins de fin de vie, à respecter les convictions personnelles des fournisseurs de soins de santé et à explorer d'autres situations — chacune ayant des incidences qui lui sont propres — où une personne peut demander l'aide médicale à mourir, à savoir les cas de demandes faites par les mineurs matures, de demandes anticipées et de demandes où la maladie mentale est la seule condition médicale invoquée,

Sa Majesté, sur l'avis et avec le consentement du Sénat et de la Chambre des communes du Canada, édicte :

Criminal Code

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

Consent to death

14 No person is entitled to consent to have death inflicted on them, and such consent does not affect the criminal responsibility of any person who inflicts death on the person who gave consent.

2 The Act is amended by adding the following after section 226:

Exemption for medical assistance in dying

227 (1) No medical practitioner or nurse practitioner commits culpable homicide if they provide a person with medical assistance in dying in accordance with section 241.2.

Exemption for person aiding practitioner

(2) No person is a party to culpable homicide if they do anything for the purpose of aiding a medical practitioner or nurse practitioner to provide a person with medical assistance in dying in accordance with section 241.2.

Reasonable but mistaken belief

(3) For greater certainty, the exemption set out in subsection (1) or (2) applies even if the person invoking it has a reasonable but mistaken belief about any fact that is an element of the exemption.

Non-application of section 14

(4) Section 14 does not apply with respect to a person who consents to have death inflicted on them by means of medical assistance in dying provided in accordance with section 241.2.

Definitions

(5) In this section, *medical assistance in dying*, *medical practitioner* and *nurse practitioner* have the same meanings as in section 241.1.

R.S., c. 27 (1st Supp.), s. 7(3)

3 Section 241 of the Act is replaced by the following:

Counselling or aiding suicide

241 (1) Everyone is guilty of an indictable offence and liable to imprisonment for a term of not more than 14 years who, whether suicide ensues or not,

Code criminel

1 L'article 14 du *Code criminel* est remplacé par ce qui suit :

Consentement à la mort

14 Nul n'a le droit de consentir à ce que la mort lui soit infligée, et un tel consentement n'atteint pas la responsabilité pénale d'une personne qui inflige la mort à celui qui a donné ce consentement.

2 La même loi est modifiée par adjonction, après l'article 226, de ce qui suit :

Exemption – aide médicale à mourir

227 (1) Ne commet pas un homicide coupable le médecin ou l'infirmier praticien qui fournit l'aide médicale à mourir à une personne en conformité avec l'article 241.2.

Exemption — personne aidant le médecin ou l'infirmier praticien

(2) Ne participe pas à un homicide coupable la personne qui fait quelque chose en vue d'aider un médecin ou un infirmier praticien à fournir l'aide médicale à mourir à une personne en conformité avec l'article 241.2.

Croyance raisonnable mais erronée

(3) Il est entendu que l'exemption prévue aux paragraphes (1) ou (2) s'applique même si la personne qui l'invoque a une croyance raisonnable, mais erronée, à l'égard de tout fait qui en est un élément constitutif.

Non-application de l'article 14

(4) L'article 14 ne s'applique pas à l'égard d'une personne qui consent à ce que la mort lui soit infligée au moyen de l'aide médicale à mourir fournie en conformité avec l'article 241.2.

Définitions

(5) Au présent article, *aide médicale à mourir*, *infirmier praticien* et *médecin* s'entendent au sens de l'article 241.1.

L.R., ch. 27 (1^{er} suppl.), par. 7(3)

3 L'article 241 de la même loi est remplacé par ce qui suit :

Fait de conseiller le suicide ou d'y aider

241 (1) Est coupable d'un acte criminel et passible d'un emprisonnement maximal de quatorze ans quiconque, que le suicide s'ensuive ou non, selon le cas :

(a) counsels a person to die by suicide or abets a person in dying by suicide; or

(b) aids a person to die by suicide.

Exemption for medical assistance in dying

(2) No medical practitioner or nurse practitioner commits an offence under paragraph (1)(b) if they provide a person with medical assistance in dying in accordance with section 241.2.

Exemption for person aiding practitioner

(3) No person is a party to an offence under paragraph (1)(b) if they do anything for the purpose of aiding a medical practitioner or nurse practitioner to provide a person with medical assistance in dying in accordance with section 241.2.

Exemption for pharmacist

(4) No pharmacist who dispenses a substance to a person other than a medical practitioner or nurse practitioner commits an offence under paragraph (1)(b) if the pharmacist dispenses the substance further to a prescription that is written by such a practitioner in providing medical assistance in dying in accordance with section 241.2.

Exemption for person aiding patient

(5) No person commits an offence under paragraph (1)(b) if they do anything, at another person's explicit request, for the purpose of aiding that other person to self-administer a substance that has been prescribed for that other person as part of the provision of medical assistance in dying in accordance with section 241.2.

Clarification

(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.

Reasonable but mistaken belief

(6) For greater certainty, the exemption set out in any of subsections (2) to (5) applies even if the person invoking the exemption has a reasonable but mistaken belief about any fact that is an element of the exemption.

a) conseille à une personne de se donner la mort ou l'encourage à se donner la mort;

b) aide quelqu'un à se donner la mort.

Exemption — aide médicale à mourir

(2) Ne commet pas l'infraction prévue à l'alinéa (1)b) le médecin ou l'infirmier praticien qui fournit l'aide médicale à mourir à une personne en conformité avec l'article 241.2.

Exemption — personne aidant le médecin ou l'infirmier praticien

(3) Ne participe pas à l'infraction prévue à l'alinéa (1)b) la personne qui fait quelque chose en vue d'aider un médecin ou un infirmier praticien à fournir l'aide médicale à mourir à une personne en conformité avec l'article 241.2.

Exemption — pharmacien

(4) Ne commet pas l'infraction prévue à l'alinéa (1)b) le pharmacien qui délivre une substance à une personne, autre qu'un médecin ou un infirmier praticien, s'il la délivre sur ordonnance médicale rédigée, dans le cadre de la prestation de l'aide médicale à mourir en conformité avec l'article 241.2, par un médecin ou un infirmier praticien.

Exemption — personne aidant le patient

(5) Ne commet pas l'infraction prévue à l'alinéa (1)b) quiconque fait quelque chose, à la demande expresse d'une autre personne, en vue d'aider celle-ci à s'administrer la substance qui a été prescrite pour elle dans le cadre de la prestation de l'aide médicale à mourir en conformité avec l'article 241.2.

Précision

(5.1) Il est entendu que ne commet pas d'infraction le travailleur social, le psychologue, le psychiatre, le thérapeute, le médecin, l'infirmier praticien ou tout autre professionnel de la santé qui fournit à une personne des renseignements sur la prestation légitime de l'aide médicale à mourir.

Croyance raisonnable mais erronée

(6) Il est entendu que l'exemption prévue à l'un des paragraphes (2) à (5) s'applique même si la personne qui l'invoque a une croyance raisonnable, mais erronée, à l'égard de tout fait qui en est un élément constitutif.

Definitions

(7) In this section, *medical assistance in dying, medical practitioner, nurse practitioner* and *pharmacist* have the same meanings as in section 241.1.

Medical Assistance in Dying

Definitions

241.1 The following definitions apply in this section and in sections 241.2 to 241.4.

medical assistance in dying means

- (a) the administering by a medical practitioner or nurse practitioner of a substance to a person, at their request, that causes their death; or
- (b) the prescribing or providing by a medical practitioner or nurse practitioner of a substance to a person, at their request, so that they may self-administer the substance and in doing so cause their own death. (*aide médicale à mourir*)

medical practitioner means a person who is entitled to practise medicine under the laws of a province. (*médecin*)

nurse practitioner means a registered nurse who, under the laws of a province, is entitled to practise as a nurse practitioner — or under an equivalent designation — and to autonomously make diagnoses, order and interpret diagnostic tests, prescribe substances and treat patients. (*infirmier praticien*)

pharmacist means a person who is entitled to practise pharmacy under the laws of a province. (*pharmacien*)

Eligibility for medical assistance in dying

241.2 (1) A person may receive medical assistance in dying only if they meet all of the following criteria:

- (a) they are eligible — or, but for any applicable minimum period of residence or waiting period, would be eligible — for health services funded by a government in Canada;
- (b) they are at least 18 years of age and capable of making decisions with respect to their health;
- (c) they have a grievous and irremediable medical condition;

Définitions

(7) Au présent article, *aide médicale à mourir, infirmier praticien, médecin* et *pharmacien* s'entendent au sens de l'article 241.1.

Aide médicale à mourir

Définitions

241.1 Les définitions qui suivent s'appliquent au présent article et aux articles 241.2 à 241.4.

aide médicale à mourir Selon le cas, le fait pour un médecin ou un infirmier praticien :

- a) d'administrer à une personne, à la demande de celle-ci, une substance qui cause sa mort;
- b) de prescrire ou de fournir une substance à une personne, à la demande de celle-ci, afin qu'elle se l'administre et cause ainsi sa mort. (*medical assistance in dying*)

infirmier praticien Infirmier agréé qui, en vertu du droit d'une province, peut de façon autonome, à titre d'infirmier praticien ou sous toute autre appellation équivalente, poser des diagnostics, demander et interpréter des tests de diagnostic, prescrire des substances et traiter des patients. (*nurse practitioner*)

médecin Personne autorisée par le droit d'une province à exercer la médecine. (*medical practitioner*)

pharmacien Personne autorisée par le droit d'une province à exercer la profession de pharmacien. (*pharmacist*)

Critères d'admissibilité relatifs à l'aide médicale à mourir

241.2 (1) Seule la personne qui remplit tous les critères ci-après peut recevoir l'aide médicale à mourir :

- a) elle est admissible — ou serait admissible, n'était le délai minimal de résidence ou de carence applicable — à des soins de santé financés par l'État au Canada;
- b) elle est âgée d'au moins dix-huit ans et est capable de prendre des décisions en ce qui concerne sa santé;
- c) elle est affectée de problèmes de santé graves et irrémédiables;
- d) elle a fait une demande d'aide médicale à mourir de manière volontaire, notamment sans pressions extérieures;

- (d) they have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure; and
- (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.

Grievous and irremediable medical condition

(2) A person has a grievous and irremediable medical condition only if they meet all of the following criteria:

- (a) they have a serious and incurable illness, disease or disability;
- (b) they are in an advanced state of irreversible decline in capability;
- (c) that illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and
- (d) their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining.

Safeguards

(3) Before a medical practitioner or nurse practitioner provides a person with medical assistance in dying, the medical practitioner or nurse practitioner must

- (a) be of the opinion that the person meets all of the criteria set out in subsection (1);
- (b) ensure that the person's request for medical assistance in dying was
 - (i) made in writing and signed and dated by the person or by another person under subsection (4), and
 - (ii) signed and dated after the person was informed by a medical practitioner or nurse practitioner that the person has a grievous and irremediable medical condition;
- (c) be satisfied that the request was signed and dated by the person — or by another person under subsection (4) — before two independent witnesses who then also signed and dated the request;

- e) elle consent de manière éclairée à recevoir l'aide médicale à mourir après avoir été informée des moyens disponibles pour soulager ses souffrances, notamment les soins palliatifs.

Problèmes de santé graves et irrémédiables

(2) Une personne est affectée de problèmes de santé graves et irrémédiables seulement si elle remplit tous les critères suivants :

- a) elle est atteinte d'une maladie, d'une affection ou d'un handicap graves et incurables;
- b) sa situation médicale se caractérise par un déclin avancé et irréversible de ses capacités;
- c) sa maladie, son affection, son handicap ou le déclin avancé et irréversible de ses capacités lui cause des souffrances physiques ou psychologiques persistantes qui lui sont intolérables et qui ne peuvent être apaisées dans des conditions qu'elle juge acceptables;
- d) sa mort naturelle est devenue raisonnablement prévisible compte tenu de l'ensemble de sa situation médicale, sans pour autant qu'un pronostic ait été établi quant à son espérance de vie.

Mesures de sauvegarde

(3) Avant de fournir l'aide médicale à mourir, le médecin ou l'infirmier praticien doit, à la fois :

- a) être d'avis que la personne qui a fait la demande d'aide médicale à mourir remplit tous les critères prévus au paragraphe (1);
- b) s'assurer que la demande :
 - (i) a été faite par écrit et que celle-ci a été datée et signée par la personne ou le tiers visé au paragraphe (4),
 - (ii) a été datée et signée après que la personne a été avisée par un médecin ou un infirmier praticien qu'elle est affectée de problèmes de santé graves et irrémédiables;
- c) être convaincu que la demande a été datée et signée par la personne ou par le tiers visé au paragraphe (4) devant deux témoins indépendants, qui l'ont datée et signée à leur tour;

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

(e) ensure that another medical practitioner or nurse practitioner has provided a written opinion confirming that the person meets all of the criteria set out in subsection (1);

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

(g) ensure that there are at least 10 clear days between the day on which the request was signed by or on behalf of the person and the day on which the medical assistance in dying is provided or — if they and the other medical practitioner or nurse practitioner referred to in paragraph (e) are both of the opinion that the person's death, or the loss of their capacity to provide informed consent, is imminent — any shorter period that the first medical practitioner or nurse practitioner considers appropriate in the circumstances;

(h) immediately before providing the medical assistance in dying, give the person an opportunity to withdraw their request and ensure that the person gives express consent to receive medical assistance in dying; and

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

Unable to sign

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

Independent witness

(5) Any person who is at least 18 years of age and who understands the nature of the request for medical assistance in dying may act as an independent witness, except if they

d) s'assurer que la personne a été informée qu'elle pouvait, en tout temps et par tout moyen, retirer sa demande;

e) s'assurer qu'un avis écrit d'un autre médecin ou infirmier praticien confirmant le respect de tous les critères prévus au paragraphe (1) a été obtenu;

f) être convaincu que lui et l'autre médecin ou infirmier praticien visé à l'alinéa e) sont indépendants;

g) s'assurer qu'au moins dix jours francs se sont écoulés entre le jour où la demande a été signée par la personne ou en son nom et celui où l'aide médicale à mourir est fournie ou, si lui et le médecin ou l'infirmier praticien visé à l'alinéa e) jugent que la mort de la personne ou la perte de sa capacité à fournir un consentement éclairé est imminente, une période plus courte qu'il juge indiquée dans les circonstances;

h) immédiatement avant de fournir l'aide médicale à mourir, donner à la personne la possibilité de retirer sa demande et s'assurer qu'elle consent expressément à recevoir l'aide médicale à mourir;

i) si la personne éprouve de la difficulté à communiquer, prendre les mesures nécessaires pour lui fournir un moyen de communication fiable afin qu'elle puisse comprendre les renseignements qui lui sont fournis et faire connaître sa décision.

Incapacité de signer

(4) Lorsque la personne qui demande l'aide médicale à mourir est incapable de dater et de signer la demande, un tiers qui est âgé d'au moins dix-huit ans, qui comprend la nature de la demande d'aide médicale à mourir et qui ne sait pas ou ne croit pas qu'il est bénéficiaire de la succession testamentaire de la personne qui fait la demande ou qu'il recevra autrement un avantage matériel, notamment pécuniaire, de la mort de celle-ci peut le faire expressément à sa place, en sa présence et selon ses directives.

Témoins indépendants

(5) Toute personne qui est âgée d'au moins dix-huit ans et qui comprend la nature de la demande d'aide médicale à mourir peut agir en qualité de témoin indépendant, sauf si :

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

Independence — medical practitioners and nurse practitioners

(6) The medical practitioner or nurse practitioner providing medical assistance in dying and the medical practitioner or nurse practitioner who provides the opinion referred to in paragraph (3)(e) are independent if they

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

Reasonable knowledge, care and skill

(7) Medical assistance in dying must be provided with reasonable knowledge, care and skill and in accordance with any applicable provincial laws, rules or standards.

Informing pharmacist

(8) The medical practitioner or nurse practitioner who, in providing medical assistance in dying, prescribes or obtains a substance for that purpose must, before any pharmacist dispenses the substance, inform the pharmacist that the substance is intended for that purpose.

- a)** elle sait ou croit qu'elle est bénéficiaire de la succession testamentaire de la personne qui fait la demande ou qu'elle recevra autrement un avantage matériel, notamment pécuniaire, de la mort de celle-ci;
- b)** elle est propriétaire ou exploitant de l'établissement de soins de santé où la personne qui fait la demande reçoit des soins ou de l'établissement où celle-ci réside;
- c)** elle participe directement à la prestation de services de soins de santé à la personne qui fait la demande;
- d)** elle fournit directement des soins personnels à la personne qui fait la demande.

Indépendance des médecins et infirmiers praticiens

(6) Pour être indépendant, ni le médecin ou l'infirmier praticien qui fournit l'aide médicale à mourir ni celui qui donne l'avis visé à l'alinéa (3)e) ne peut :

- a)** conseiller l'autre dans le cadre d'une relation de mentorat ou être chargé de superviser son travail;
- b)** savoir ou croire qu'il est bénéficiaire de la succession testamentaire de la personne qui fait la demande ou qu'il recevra autrement un avantage matériel, notamment pécuniaire, de la mort de celle-ci, autre que la compensation normale pour les services liés à la demande;
- c)** savoir ou croire qu'il est lié à l'autre ou à la personne qui fait la demande de toute autre façon qui porterait atteinte à son objectivité.

Connaissance, soins et habileté raisonnables

(7) L'aide médicale à mourir est fournie avec la connaissance, les soins et l'habileté raisonnables et en conformité avec les lois, règles ou normes provinciales applicables.

Avis au pharmacien

(8) Le médecin ou l'infirmier praticien qui, dans le cadre de la prestation de l'aide médicale à mourir, prescrit ou obtient une substance à cette fin doit, avant que la substance ne soit délivrée, informer le pharmacien qui la délivre qu'elle est destinée à cette fin.

Clarification

(9) For greater certainty, nothing in this section compels an individual to provide or assist in providing medical assistance in dying.

Failure to comply with safeguards

241.3 A medical practitioner or nurse practitioner who, in providing medical assistance in dying, knowingly fails to comply with all of the requirements set out in paragraphs 241.2(3)(b) to (i) and subsection 241.2(8) is guilty of an offence and is liable

- (a) on conviction on indictment, to a term of imprisonment of not more than five years; or
- (b) on summary conviction, to a term of imprisonment of not more than 18 months.

Forgery

241.4 (1) Everyone commits an offence who commits forgery in relation to a request for medical assistance in dying.

Destruction of documents

(2) Everyone commits an offence who destroys a document that relates to a request for medical assistance in dying with intent to interfere with

- (a) another person's access to medical assistance in dying;
- (b) the lawful assessment of a request for medical assistance in dying; or
- (c) another person invoking an exemption under any of subsections 227(1) or (2), 241(2) to (5) or 245(2).

Punishment

(3) Everyone who commits an offence under subsection (1) or (2) is liable

- (a) on conviction on indictment, to a term of imprisonment of not more than five years; or
- (b) on summary conviction, to a term of imprisonment of not more than 18 months.

Definition of *document*

(4) In subsection (2), *document* has the same meaning as in section 321.

4 The Act is amended by adding the following after section 241.3:

Filing information — medical practitioner or nurse practitioner

Précision

(9) Il est entendu que le présent article n'a pas pour effet d'obliger quiconque à fournir ou à aider à fournir l'aide médicale à mourir.

Non-respect des mesures de sauvegarde

241.3 Le médecin ou l'infirmier praticien qui, dans le cadre de la prestation de l'aide médicale à mourir, omet sciemment de respecter toutes les exigences prévues aux alinéas 241.2(3)b) à i) et au paragraphe 241.2(8) commet une infraction et encourt, sur déclaration de culpabilité :

- a) par mise en accusation, un emprisonnement maximal de cinq ans;
- b) par procédure sommaire, un emprisonnement maximal de dix-huit mois.

Commission d'un faux

241.4 (1) Commet une infraction quiconque commet un faux relatif à une demande d'aide médicale à mourir.

Destruction d'un document

(2) Commet une infraction quiconque détruit un document relatif à une demande d'aide médicale à mourir avec l'intention d'entraver, selon le cas :

- a) l'accès d'une personne à l'aide médicale à mourir;
- b) l'évaluation légitime d'une demande d'aide médicale à mourir;
- c) l'invocation par une personne de l'exemption prévue à l'un des paragraphes 227(1) ou (2), 241(2) à (5) ou 245(2).

Peine

(3) Quiconque commet l'infraction prévue aux paragraphes (1) ou (2) encourt, sur déclaration de culpabilité :

- a) par mise en accusation, un emprisonnement maximal de cinq ans;
- b) par procédure sommaire, un emprisonnement maximal de dix-huit mois.

Définition de *document*

(4) Au paragraphe (2), *document* s'entend au sens de l'article 321.

4 La même loi est modifiée par adjonction, après l'article 241.3, de ce qui suit :

Renseignements à fournir — médecin ou infirmier praticien

241.31 (1) Unless they are exempted under regulations made under subsection (3), a medical practitioner or nurse practitioner who receives a written request for medical assistance in dying must, in accordance with those regulations, provide the information required by those regulations to the recipient designated in those regulations.

Filing information — pharmacist

(2) Unless they are exempted under regulations made under subsection (3), a pharmacist who dispenses a substance in connection with the provision of medical assistance in dying must, in accordance with those regulations, provide the information required by those regulations to the recipient designated in those regulations.

Regulations

(3) The Minister of Health must make regulations that he or she considers necessary

- (a)** respecting the provision and collection, for the purpose of monitoring medical assistance in dying, of information relating to requests for, and the provision of, medical assistance in dying, including
 - (i)** the information to be provided, at various stages, by medical practitioners or nurse practitioners and by pharmacists, or by a class of any of them,
 - (ii)** the form, manner and time in which the information must be provided,
 - (iii)** the designation of a person as the recipient of the information, and
 - (iv)** the collection of information from coroners and medical examiners;
- (b)** respecting the use of that information, including its analysis and interpretation, its protection and its publication and other disclosure;
- (c)** respecting the disposal of that information; and
- (d)** exempting, on any terms that may be specified, a class of persons from the requirement set out in subsection (1) or (2).

Guidelines — information on death certificates

(3.1) The Minister of Health, after consultation with representatives of the provincial governments responsible for health, must establish guidelines on the information to be included on death certificates in cases where medical assistance in dying has been provided, which may include the way in which to clearly identify medical assistance in dying as the manner of death, as well as the

241.31 (1) Sous réserve d'une exemption accordée au titre des règlements pris en vertu du paragraphe (3), le médecin ou l'infirmier praticien qui reçoit une demande écrite d'aide médicale à mourir doit, en conformité avec ces règlements, fournir les renseignements qui y sont exigés à la personne qui y est désignée à titre de destinataire.

Renseignements à fournir — pharmacien

(2) Sous réserve d'une exemption accordée au titre des règlements pris en vertu du paragraphe (3), le pharmacien qui délivre une substance dans le cadre de la prestation de l'aide médicale à mourir doit, en conformité avec ces règlements, fournir les renseignements qui y sont exigés à la personne qui y est désignée à titre de destinataire.

Règlements

(3) Le ministre de la Santé prend des règlements qu'il estime nécessaires :

- a)** pour régir, aux fins de surveillance de l'aide médicale à mourir, la fourniture et la collecte de renseignements relatifs aux demandes d'aide médicale à mourir ou à la prestation de celle-ci, notamment :
 - (i)** les renseignements qui doivent, à différentes étapes, être fournis par les médecins ou les infirmiers praticiens et les pharmaciens, ou par toute catégorie de ceux-ci,
 - (ii)** les modalités, de temps ou autres, selon lesquelles ces renseignements doivent être fournis,
 - (iii)** la désignation d'une personne à titre de destinataire des renseignements,
 - (iv)** la collecte de renseignements provenant des coroners et des médecins légistes;
- b)** pour régir l'utilisation de ces renseignements, notamment leur analyse et leur interprétation, leur protection, leur publication et autre communication;
- c)** pour régir la destruction de ces renseignements;
- d)** pour soustraire, aux conditions précisées, toute catégorie de personnes aux obligations prévues aux paragraphes (1) ou (2).

Lignes directrices — certificat de décès

(3.1) Le ministre de la Santé, après consultation des représentants des provinces responsables de la santé, établit des lignes directrices sur les renseignements qu'il faut inclure dans le certificat de décès des personnes ayant eu recours à l'aide médicale à mourir, lesquelles lignes directrices peuvent notamment prévoir la manière de préciser clairement que l'aide médicale à mourir est le mode de décès et d'indiquer clairement la

illness, disease or disability that prompted the request for medical assistance in dying.

Offence and punishment

(4) A medical practitioner or nurse practitioner who knowingly fails to comply with subsection (1), or a pharmacist who knowingly fails to comply with subsection (2),

(a) is guilty of an indictable offence and liable to a term of imprisonment of not more than two years; or

(b) is guilty of an offence punishable on summary conviction.

Offence and punishment

(5) Everyone who knowingly contravenes the regulations made under subsection (3)

(a) is guilty of an indictable offence and liable to a term of imprisonment of not more than two years; or

(b) is guilty of an offence punishable on summary conviction.

5 Subsection 241.4(2) of the Act is amended by striking out “or” at the end of paragraph (b), by adding “or” at the end of paragraph (c) and by adding the following after that paragraph:

(d) the provision by a person of information under section 241.31.

6 Section 245 of the Act is renumbered as subsection 245(1) and is amended by adding the following after that subsection:

Exemption

(2) Subsection (1) does not apply to

(a) a medical practitioner or nurse practitioner who provides medical assistance in dying in accordance with section 241.2; and

(b) a person who does anything for the purpose of aiding a medical practitioner or nurse practitioner to provide medical assistance in dying in accordance with section 241.2.

Definitions

(3) In subsection (2), *medical assistance in dying*, *medical practitioner* and *nurse practitioner* have the same meanings as in section 241.1.

maladie, l'affection ou le handicap qui ont poussé la personne à y avoir recours.

Infraction et peine

(4) Le médecin ou l'infirmier praticien qui omet sciemment de se conformer au paragraphe (1) ou le pharmacien qui omet sciemment de se conformer au paragraphe (2) commet une infraction et est coupable :

a) soit d'un acte criminel passible d'un emprisonnement maximal de deux ans;

b) soit d'une infraction punissable sur déclaration de culpabilité par procédure sommaire.

Infraction et peine

(5) Toute personne qui contrevient sciemment aux règlements pris en vertu du paragraphe (3) commet une infraction et est coupable :

a) soit d'un acte criminel passible d'un emprisonnement maximal de deux ans;

b) soit d'une infraction punissable sur déclaration de culpabilité par procédure sommaire.

5 Le paragraphe 241.4(2) de la même loi est modifié par adjonction, après l'alinéa c), de ce qui suit :

d) la fourniture de renseignements par une personne en application de l'article 241.31.

6 L'article 245 de la même loi devient le paragraphe 245(1) et est modifié par adjonction de ce qui suit :

Exemption

(2) Le paragraphe (1) ne s'applique pas :

a) au médecin ou à l'infirmier praticien qui fournit l'aide médicale à mourir en conformité avec l'article 241.2;

b) à la personne qui fait quelque chose en vue d'aider un médecin ou un infirmier praticien à fournir l'aide médicale à mourir en conformité avec l'article 241.2.

Définitions

(3) Au paragraphe (2), *aide médicale à mourir*, *infirmier praticien* et *médecin* s'entendent au sens de l'article 241.1.

Related Amendments

R.S., c. P-6

Pension Act

7 (1) The definition *improper conduct* in subsection 3(1) of the *Pension Act* is replaced by the following:

improper conduct includes wilful disobedience of orders, vicious or criminal conduct and wilful self-inflicted wounding — **except if the wound** results from the receipt of medical assistance in dying and the requirement set out in paragraph 241.2(3)(a) of the *Criminal Code* has been met; (*mauvaise conduite*)

(2) Subsection 3(1) of the Act is amended by adding the following in alphabetical order:

medical assistance in dying has the same meaning as in section 241.1 of the *Criminal Code*; (*aide médicale à mourir*)

(3) Section 3 of the Act is amended by adding the following after subsection (3):

Deeming — **medical assistance in dying**

(4) For the purposes of this Act, if a member of the forces receives medical assistance in dying, that member is deemed to have died as a result of the illness, disease or disability for which they were determined to be eligible to receive that assistance, in accordance with paragraph 241.2(3)(a) of the *Criminal Code*.

1992, c. 20

Corrections and Conditional Release Act

8 Section 19 of the *Corrections and Conditional Release Act* is amended by adding the following after subsection (1):

Medical assistance in dying

(1.1) Subsection (1) does not apply to a death that results from an inmate receiving *medical assistance in dying*, as defined in section 241.1 of the *Criminal Code*, in accordance with section 241.2 of that Act.

2005, c. 21

Modifications connexes

L.R., ch. P-6

Loi sur les pensions

7 (1) La définition de *mauvaise conduite*, au paragraphe 3(1) de la *Loi sur les pensions*, est remplacée par ce qui suit :

mauvaise conduite Sont assimilés à une mauvaise conduite la désobéissance préméditée aux ordres, la conduite malveillante ou criminelle et le fait de se blesser délibérément soi-même sauf si la blessure résulte du fait d'avoir reçu l'aide médicale à mourir et que l'exigence prévue à l'alinéa 241.2(3)a du *Code criminel* a été remplie. (*improper conduct*)

(2) Le paragraphe 3(1) de la même loi est modifié par adjonction, selon l'ordre alphabétique, de ce qui suit :

aide médicale à mourir S'entend au sens de l'article 241.1 du *Code criminel*. (*medical assistance in dying*)

(3) L'article 3 de la même loi est modifié par adjonction, après le paragraphe (3), de ce qui suit :

Présomption — **aide médicale à mourir**

(4) Pour l'application de la présente loi, le membre des forces qui a reçu l'aide médicale à mourir est réputé être décédé en raison de la maladie, de l'affection ou du handicap pour lequel il a été jugé admissible à cette aide au titre de l'alinéa 241.2(3)a du *Code criminel*.

1992, ch. 20

Loi sur le système correctionnel et la mise en liberté sous condition

8 L'article 19 de la *Loi sur le système correctionnel et la mise en liberté sous condition* est modifié par adjonction, après le paragraphe (1), de ce qui suit :

Aide médicale à mourir

(1.1) Le paragraphe (1) ne s'applique pas dans le cas où le décès du détenu résulte du fait qu'il a reçu l'aide médicale à mourir au sens de l'article 241.1 du *Code criminel* en conformité avec l'article 241.2 de cette loi.

2005, ch. 21

Canadian Forces Members and Veterans Re-establishment and Compensation Act

9 (1) Subsection 2(1) of the *Canadian Forces Members and Veterans Re-establishment and Compensation Act* is amended by adding the following in alphabetical order:

medical assistance in dying has the same meaning as in section 241.1 of the *Criminal Code*.
(aide médicale à mourir)

(2) Section 2 of the Act is amended by adding the following after subsection (5):

Interpretation — **medical assistance in dying**

(6) For the purposes of this Act, a member or veteran has neither inflicted wilful self-injury nor engaged in improper conduct by reason only that they receive medical assistance in dying, if the requirement set out in paragraph 241.2(3)(a) of the *Criminal Code* has been met.

Deeming — **medical assistance in dying**

(7) For the purposes of this Act, if a member or a veteran receives medical assistance in dying, that member or veteran is deemed to have died as a result of the illness, disease or disability for which they were determined to be eligible to receive that assistance, in accordance with paragraph 241.2(3)(a) of the *Criminal Code*.

Independent Review

Mature minors, advance requests and mental illness

9.1 (1) The Minister of Justice and the Minister of Health must, no later than 180 days after the day on which this Act receives royal assent, initiate one or more independent reviews of issues relating to requests by mature minors for medical assistance in dying, to advance requests and to requests where mental illness is the sole underlying medical condition.

Loi sur les mesures de réinsertion et d'indemnisation des militaires et vétérans des Forces canadiennes

9 (1) Le paragraphe 2(1) de la *Loi sur les mesures de réinsertion et d'indemnisation des militaires et vétérans des Forces canadiennes* est modifié par adjonction, selon l'ordre alphabétique, de ce qui suit :

aide médicale à mourir S'entend au sens de l'article 241.1 du *Code criminel*. (*medical assistance in dying*)

(2) L'article 2 de la même loi est modifié par adjonction, après le paragraphe (5), de ce qui suit :

Interprétation — **aide médicale à mourir**

(6) Pour l'application de la présente loi, ne constitue pas de l'automutilation ou une mauvaise conduite le seul fait pour le militaire ou le vétéran d'avoir reçu l'aide médicale à mourir si l'exigence prévue à l'alinéa 241.2(3)a) du *Code criminel* a été remplie.

Présomption — **aide médicale à mourir**

(7) Pour l'application de la présente loi, le militaire ou le vétéran qui a reçu l'aide médicale à mourir est réputé être décédé en raison de la maladie, de l'affection ou du handicap pour lequel il a été jugé admissible à cette aide au titre de l'alinéa 241.2(3)a) du *Code criminel*.

Examen indépendant

Mineurs matures, demandes anticipées et maladie mentale

9.1 (1) Le ministre de la Justice et le ministre de la Santé lancent, au plus tard cent quatre-vingts jours après la date de sanction de la présente loi, un ou des examens indépendants des questions portant sur les demandes d'aide médicale à mourir faites par les mineurs matures, les demandes anticipées et les demandes où la maladie mentale est la seule condition médicale invoquée.

(2) The Minister of Justice and the Minister of Health must, no later than two years after the day on which a review is initiated, cause one or more reports on the review, including any findings or recommendations resulting from it, to be laid before each House of Parliament.

Review of Act

Review by committee

10 (1) At the start of the fifth year after the day on which this Act receives royal assent, the provisions enacted by this Act are to be referred to the committee of the Senate, of the House of Commons or of both Houses of Parliament that may be designated or established for the purpose of reviewing the provisions.

Report

(2) The committee to which the provisions are referred is to review them and the state of palliative care in Canada and submit a report to the House or Houses of Parliament of which it is a committee, including a statement setting out any changes to the provisions that the committee recommends.

Coming into Force

Order in council

11 Sections 4 and 5 come into force 12 months after the day on which this Act receives royal assent or on any earlier day that may be fixed by order of the Governor in Council.

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<http://www.parl.gc.ca>

(2) Le ministre de la Justice et le ministre de la Santé font déposer devant chaque chambre du Parlement, au plus tard deux ans après le début d'un examen, un ou des rapports sur celui-ci, lesquels rapports comportent notamment toute conclusion ou recommandation qui en découle.

Examen de la loi

Examen par un comité

10 (1) Au début de la cinquième année suivant la date de la sanction de la présente loi, les dispositions édictées par la présente loi sont soumises à l'examen d'un comité soit du Sénat, soit de la Chambre des communes, soit mixte, constitué ou désigné pour les examiner.

Rapport

(2) Le Comité procède à l'examen de ces dispositions ainsi que de la situation des soins palliatifs au Canada et remet à la chambre ou aux chambres l'ayant constitué ou désigné un rapport comportant les modifications, s'il en est, qu'il recommande d'y apporter.

Entrée en vigueur

Décret

11 Les articles 4 et 5 entrent en vigueur douze mois après la date de la sanction de la présente loi ou à la date antérieure fixée par décret.

Disponible sur le site Web du Parlement du Canada à l'adresse suivante :
<http://www.parl.gc.ca>