

Model Practice Standard for Medical Assistance in Dying (MAID)

Regulatory authority for [*Physicians/Nurses*] of [*jurisdiction*]

Standard of Practice

Medical Assistance in Dying (MAID)

Document History

First approved by [*approval body*]: [*date*]

Amended and approved by [*approval body*]: [*date*]

Date of next scheduled review: [*date*]



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1.0 Preamble

Medical assistance in dying (MAID) has been legal in Québec since 2015 and in the rest of Canada since 2016.¹ Since then, the law with respect to eligibility for MAID has continued to evolve.²

This Standard reflects the current state of Canadian law with respect to MAID (as established by the *Criminal Code*). Except where otherwise noted, this Standard applies to all MAID cases including requests for MAID where a mental disorder is the sole underlying medical condition (MAID MD-SUMC) when such requests become legal on March 17, 2024.³

Throughout the Standard, the terms ‘must’ and ‘should’ are used to articulate the regulatory authority’s expectations. ‘Must’ indicates a mandatory requirement. ‘Should’ indicates that [physicians/nurse practitioners] can use reasonable discretion when applying this expectation to practice.

This Standard must be interpreted in the context of federal⁴ and [provincial/territorial]⁵ legislation relating to MAID. Nothing in this Standard reduces a [physician’s/nurse practitioner’s] obligation to comply with any and all applicable laws.

This Standard must be read in conjunction with other regulatory standards including the [names of other relevant Practice Standards, especially consent, scope of practice, and effective referral/transfer of care].

This Standard should also be read in conjunction with the Advice to the Profession: Medical Assistance in Dying (MAID) and [Canadian Medical Association Code of Ethics/Code de Déontologie du Collège des Médecins du Québec/Canadian Nurses Association Code of Ethics/other relevant ethical statements⁶].

[Physicians/Nurse Practitioners] are encouraged to consult with the resources available through the Canadian Medical Protective Association, Canadian Nurses Protective Society, the Canadian Association of MAID Assessors and Providers, and relevant professional associations.

¹ *Carter v Canada (Attorney General)* [2015] 1 SCR 331. *Bill C-14, An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*, 1st Session, 42nd Parliament, 2016.

² *Bill C-14, An Act to amend the Criminal Code (medical assistance in dying)* 1st session, 42nd Parliament, 2016; *Truchon c. Procureur général du Canada*, 2019 QCCS 3792 (CanLII); *Bill C-7, An Act to amend the Criminal Code (medical assistance in dying)*, 2nd Session, 43rd Parliament, 2021.

³ There are specific challenges related to the assessment of persons with intellectual disabilities and persons experiencing long-term incarceration that require additional recommendations from professional associations and community organizations working with persons with relevant lived experience. The [regulatory authority] will revise this Standard in light of any such recommendations as appropriate.

⁴ <https://www.canada.ca/en/health-canada/services/medical-assistance-dying.html>

⁵ [reference to provincial/territorial legislation – if any]

⁶ [reference to other relevant ethical statements to specific jurisdiction]

2.0 Purposes

2.1 This Standard has been established:

2.1.1 to provide information that will assist [*physicians/nurse practitioners*] and the public in understanding the eligibility criteria, procedural safeguards, and reporting requirements that must be met regarding MAID;

2.1.2 to set the professional expectations of [*physicians/nurse practitioners*] who are involved with MAID; and

2.1.3 to outline the specific legal requirements for MAID assessors and providers.

3.0 Reasonable Knowledge, Care, and Skill

3.1 MAID must be provided with reasonable knowledge, care, and skill and in accordance with any applicable provincial/territorial laws, rules, or standards.

4.0 Scope of Practice⁷

4.1 [*Physicians/Nurse Practitioners*] must practice only within a scope for which they are appropriately trained, licensed, and competent.

4.2 [*Physicians/Nurse Practitioners*] who choose to assess eligibility for or provide MAID, must have sufficient training, experience, and qualifications to safely and competently do so in the circumstances of each case. This should include training in capacity assessment, trauma-informed care, and cultural safety and humility.

5.0 Responsibilities of [*Physicians/Nurse Practitioners*] Unable or Unwilling to Participate in MAID

5.1 No [*physician/nurse practitioner*] can be compelled to prescribe or administer substances for the purpose of MAID.

⁷ This section should be read in conjunction with the Regulatory Standard [*name of existing scope of practice standard*].

5.2 *[Physicians/Nurse Practitioners]* who are unable or unwilling to participate in MAID practice as set out in this Standard:⁸

5.2.1 must complete an effective *[referral/transfer of care]* for any person seeking to make a request, requesting, or eligible to receive MAID;

5.2.2 must advise the person that they are not able or willing to assist with the making of a request for an assessment for MAID or the provision of MAID;

5.2.3 must provide, with the consent of the person, all relevant and necessary health records to the *[physician/nurse practitioners]* or program providing services related to MAID;⁹

5.2.4 must continue to provide care and treatment not related to MAID if the person chooses; and

5.2.5 should make an effective *[referral/transfer of care]* to another *[physician/nurse practitioner]* if the person does not wish to remain in their care.¹⁰

5.3 *[Physicians/Nurse Practitioners]* with an existing therapeutic relationship with a person requesting MAID (independent of the MAID request) must not discharge the person from their care on the grounds that a MAID request has been made or the person is also receiving services from a MAID team or centralized process.

6.0 Duties to Persons Potentially Eligible for MAID

6.1 *[Physicians/Nurse Practitioners]* must take reasonable steps to ensure persons are informed of the full range of treatment options available to relieve suffering.

6.2 *[Physicians/Nurse Practitioners]* must not assume all persons potentially eligible for MAID are aware that MAID is legal and available in Canada.

6.3 Upon forming reasonable grounds to believe that a person may be eligible for MAID, a *[physician/nurse practitioner]* must determine whether MAID is consistent with the person's values and goals of care and:

⁸ Conscientious objection may be case specific. Some *[physicians/nurse practitioners]* are conscientiously opposed to all MAID. Some to only certain kinds of MAID (e.g., Track 2). Some to only specific cases given the specific circumstances. The same rules apply no matter the scope of objection – *[physicians/nurse practitioners]* cannot be compelled to participate but they must follow the steps laid out in 5.2 if they are unwilling to participate.

⁹ *[Note to users: in some jurisdictions and in some clinical circumstances, consent is not required for the provision of health records. In such cases, the clause 'with the consent of the person' can be deleted]*

¹⁰ See also *[name of Practice Standard on ending therapeutic relationships]*.

- 6.3.1 if consistent,
 - (a) advise the person of the potential for MAID; or
 - (b) provide an effective [*referral/transfer of care*] to another physician, nurse practitioner, or program known to be willing to discuss eligibility for MAID;
- 6.3.2 if not consistent, do not advise the person of the potential for MAID;
- 6.3.3 whether consistent or not, document what action was taken and the rationale for it.
- 6.4 [*Physicians/Nurse Practitioners*] must respond to all reasonable questions from persons regarding MAID or make an effective [*referral/transfer of care*] to another [*physician/nurse practitioner*] or program known to be willing to discuss eligibility for MAID.
- 6.5 When advising persons on their potential eligibility for MAID, [*physicians/nurse practitioners*] must take reasonable steps to ensure the person does not perceive coercion, inducement, or pressure to pursue or not pursue MAID. Advising persons of potential eligibility for MAID is distinct from counselling persons to consider MAID.

7.0 Involvement of [*Medical/Nurse Practitioner*] Trainees

[*Note to users: For physician regulators that allow trainee participation*]

7.1 Postgraduate medical trainees can participate in the MAID process, but must only do so within the terms, conditions, and limitations of their certificate of registration.

7.2 Postgraduate medical trainees and other [*physicians/nurse practitioners*] involved in assessing a person's eligibility for MAID must ensure that there is independence between the provider and the assessor. Specifically, the requirement for independence between the provider and assessor is not satisfied if one is a mentor or supervisor to the other.

7.3 Medical students must not act as assessors or providers. They may observe assessments and provisions but only with the express consent of the person.

OR

[*Note to users: For physician regulators that do not allow trainee participation*]

7.1 Residents must not perform the role of the provider or assessor under this Standard. Residents may participate in MAID in an assisting or learning capacity only, with the consent of the person.

7.2 Medical students may observe assessments and provisions with the consent of the person.

[Note to users: For nurse regulators]

7.1 Pre-licensure nurse practitioner students can participate in providing nursing care in their current capacity as a registered nurse but they cannot perform eligibility assessments for MAID nor provide MAID. Only physicians and nurse practitioners have this authority. Pre-licensure nurse practitioner students can, however, learn about the MAID process through observation and discussion with their mentors.

8.0 Duties of Assessors and Providers¹¹

A. General

8.1 At least two practitioners must be involved in the assessment of eligibility of a person requesting MAID.

8.2 Assessors and providers must:

8.2.1 be independent practitioners;¹²

8.2.2 act consistently with the [Practice Standard/Guidance Document] regarding treating family members or anyone with whom they have a close personal or emotional involvement;¹³ and

8.2.3 complete all the required documentation and reporting as set out in section 16.0 below.

8.3 Assessors and providers must not disclose that a person has requested a MAID assessment or provision without the consent to do so from the person.¹⁴

B. Duties of Providers

8.4 [Physicians/Nurse Practitioners] must not provide MAID on the direction of anyone other than the person requesting MAID.

¹¹ [Note to users: There are differences between regulators as to specific duties of the provider and assessor. In this Model Standard we have included only those duties established by the federal MAID legislation and/or recommended by the federal Expert Panel on MAID and Mental Illness. This section will need to be supplemented by those regulators that create additional duties or prohibit certain things permitted under the federal law.]

¹² See glossary for definition of this term in the context of this Standard. [Note to users: This is a distinct requirement from the Criminal Code. As needed, regulators may wish to add a provision stating any additional requirements with respect to holding a license for independent practice].

¹³ [reference to relevant standard/guidance document]

¹⁴ [reference to relevant standard/guidance document]

8.5 Before providing MAID, providers must assess eligibility (see section 9.0) and ensure that all procedural safeguards are met (see section 10.0).

8.6 The provider who prescribes or obtains a substance for the purpose of MAID must, before the pharmacist dispenses the substance, inform the pharmacist that the substance is intended for that purpose.

8.7 Providers must ensure safe prescribing, use, storage, and return of substances related to the provision of MAID.

C. Duties of Assessors

8.8 [*Physicians/Nurse Practitioners*] must not conduct an assessment for MAID on the direction of anyone other than the person requesting MAID.

8.9 Assessors must provide a written opinion attesting to whether the person requesting MAID meets the eligibility criteria for MAID.

8.10 Where natural death is not reasonably foreseeable, assessors must discuss with the person requesting MAID the reasonable and available means to relieve the person's suffering and determine whether the person has given serious consideration to those means.¹⁵

8.11 Where natural death is not reasonably foreseeable and a reduction in the 90 day period is being considered by the provider, assessors must provide an opinion as to whether the loss of the person's capacity to provide consent to receive MAID is imminent.

9.0 Eligibility for MAID

A. Eligibility Criteria

9.1 [*Physicians/Nurse Practitioners*] must only provide MAID to a person requesting MAID where all the following eligibility criteria are met:

9.1.1 the person is 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;

9.1.2 the person is at least 18 years of age and capable of making decisions with respect to their health;

¹⁵ While an assessor may discuss the means available to relieve the person's suffering for persons under Track 1, it is only a *Criminal Code* requirement that both the assessor and the provider do so for persons under Track 2.

9.1.3 the person has made a voluntary request for MAID that, in particular, was not made as a result of external pressure;

9.1.4 the person has given informed consent to receive MAID after having been informed of the means that are available to relieve their suffering, including palliative care;

9.1.5 the person has a grievous and irremediable medical condition. These criteria are met only where the provider and assessor are of the opinion that:

- (a) the person has a serious and incurable illness, disease, or disability;
- (b) the person is in an advanced state of irreversible decline in capability; and
- (c) the illness, disease, or disability or that state of decline causes the person enduring physical or psychological suffering that is intolerable to the person and cannot be relieved under conditions that the person considers acceptable.

9.2 [*Physicians/Nurse Practitioners*] must only apply the criteria for MAID eligibility set out in this Standard.

B. Assessing Eligibility

9.3 Capacity

9.3.1 To find a person eligible for MAID, the provider and assessor must be of the opinion that the person requesting MAID has capacity to make decisions with respect to MAID at the time of the MAID assessment.

9.3.2 When assessing for capacity to make decisions with respect to MAID, the provider and assessor must determine whether the person has the capacity to understand and appreciate:

- (a) the history and prognosis of their medical condition(s);
- (b) their treatment options and their risks and benefits; and
- (c) that the intended outcome of the provision of MAID is death.

9.3.3 As capacity is fluid and may change over time, [*physicians/nurse practitioners*] must be alert to potential changes in a person's capacity. Where appropriate, assessors and providers should undertake serial assessments of a person's decision-making capacity.

9.3.4 Where appropriate, assessors and providers should consult with clinicians with expertise in the assessment of decision-making capacity.

9.3.5 All capacity assessments must be conducted in accordance with clinical standards and legal criteria.

9.3.6 Assessors and providers must document the reasoning and evidence upon which their assessment of capacity was based.

9.4 Grievous and irremediable medical condition¹⁶

9.4.1 To find a person eligible for MAID, the provider and assessor must be of the opinion that the person has ‘a grievous and irremediable medical condition.’

9.4.2 A person has a ‘grievous and irremediable medical condition’ if:

- (a) they have a serious and incurable illness, disease, or disability;
- (b) they are in an advanced state of irreversible decline in capability; and,
- (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.

9.5 Serious and incurable illness, disease, or disability

9.5.1 To find a person has a grievous and irremediable medical condition, the provider and assessor must be of the opinion that the person has a serious and incurable illness, disease, or disability.

9.5.2 ‘Incurable’ means there are no reasonable treatments remaining where reasonable is determined by the clinician and person together exploring the recognized, available, and potentially effective treatments in light of the person’s overall state of health, beliefs, values, and goals of care.

9.6 An advanced state of irreversible decline in capability

9.6.1 To find a person has a grievous and irremediable medical condition, the provider and assessor must be of the opinion that the person is in an advanced state of irreversible decline in capability.

9.6.2 Capability refers to a person’s functioning (physical, social, occupational, or other important areas), not the symptoms of their condition. Function refers to the ability to undertake those activities that are meaningful to the person.

9.6.3 ‘Advanced state of decline’ means the reduction in function is severe.

9.6.4 ‘Irreversible’ means there are no reasonable interventions remaining where reasonable is determined by the clinician and person together exploring the recognized,

¹⁶ ‘Grievous and irremediable medical condition’ is not standard clinical terminology, however, it is defined in the *Criminal Code* and explained below and in the document ‘Advice to the Profession.’

available, and potentially effective interventions in light of the person's overall state of health, beliefs, values, and goals of care.

9.7 Enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable.

9.7.1 To find that a person has a grievous and irremediable medical condition, the provider and assessor must be of the opinion that the person's illness, disease, or disability or state of decline causes the person enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable.

9.7.2 For the purposes of forming the opinion that the suffering criterion for MAID is met, assessors and providers:

- (a) must explore all dimensions of the person's suffering (physical, psychological, social, existential) and the means available to relieve them;
- (b) must explore the consistency of the person's assessment of their suffering with the person's overall clinical presentation, expressed wishes over time, and life narrative;
- (c) must be of the opinion that it is the person's illness, disease, or disability and/or state of decline in capability that is the cause of the person's suffering;
- (d) must be of the opinion that the suffering is enduring; and
- (e) must respect the subjectivity of suffering.

C. Voluntariness

9.8 To find a person eligible for MAID, assessors and providers must be satisfied that the person's decision to request MAID has been made freely, without undue influence (contemporaneous or past) from family members, health care providers, or others.

9.9 Assessors and providers must be familiar with and adhere to any [*provincial/territorial*] requirements relating to MAID for persons who are involuntarily hospitalized or under a Community Treatment Order. Similarly, they must be familiar with and adhere to any [*provincial/territorial*] or federal requirements re: MAID for persons who are being held under a Not Criminally Responsible order or are incarcerated.

D. Informed Consent

9.10 Providers must obtain informed consent directly from the person requesting MAID, not the substitute decision-maker of an incapable person.

9.11 When seeking informed consent, providers must:

9.11.1 discuss all reasonable, accepted, and available treatment options with the person requesting MAID, including the associated benefits, risks, and side effects, which include informing the person of the means that are available to relieve their suffering, including palliative care;

9.11.2 inform the person whose natural death is not reasonably foreseeable of the means available to relieve their suffering, including, where appropriate, counselling services, mental health and disability support services, community services, and palliative care and offer consultations with relevant professionals who provide those services or that care;

9.11.3 inform the person that they may, at any time and in any manner, withdraw their request for MAID, and that they will be given an opportunity to withdraw their request immediately before MAID is provided (except where there is a valid final consent waiver – see section 13.0 below);

9.11.4 inform the person requesting MAID of any possible complications associated with provider-administered and self-administered MAID, including the possibility that death may not occur; and

9.11.5 inform the person who is indicating a preference for self-administered MAID that if the person's death is prolonged or not achieved, it will not be possible for the provider to intervene and administer a substance causing their death unless the person is capable and can provide consent immediately prior to administering, or the person has entered into a written arrangement providing advance consent for [*physician/nurse practitioner*]-administered MAID (see section 14.0 below).

10.0 Procedural Safeguards

A. Procedural Safeguards

10.1 Before providing MAID to a person **whose natural death is reasonably foreseeable** (Track 1), 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, the provider must:

10.1.1 be of the opinion that the person meets all of the eligibility criteria for MAID;

10.1.2 ensure that the person's request for MAID was:

- (a) made in writing and signed and dated by the person (or by another person as permitted by law); and
- (b) signed and dated after the person was informed by a physician or nurse practitioner that the person has a grievous and irremediable medical condition;

10.1.3 be satisfied that the request was signed and dated by the person, or by another person as permitted by law,¹⁷ before an independent witness who then also signed and dated the request;

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

10.1.5 ensure that another physician or nurse practitioner has provided a written opinion confirming that the person meets all of the eligibility criteria for MAID;

10.1.6 be satisfied that they and the assessor are independent of each other;

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

10.1.8 unless the conditions for a waiver of final consent or advance consent – self-administration have been met (see sections 13.0 and 14.0), immediately before providing MAID, give the person an opportunity to withdraw their request and ensure that the person gives express consent to receive MAID.

10.2 Before providing MAID to a person **whose natural death is not reasonably foreseeable** taking into account all of their medical circumstances (Track 2), the provider must:

10.2.1 be of the opinion that the person meets all of the eligibility criteria for MAID;

10.2.2 ensure that the person's request for MAID was:

- (a) made in writing and signed and dated by the person or by another person as permitted by law; and
- (b) signed and dated after the person was informed by a physician or nurse practitioner that the person has a grievous and irremediable medical condition;

10.2.3 be satisfied that the request was signed and dated by the person — or by another person as permitted by law — before an independent witness who then also signed and dated the request;

¹⁷ If the person requesting MAID 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 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 do so in the person's presence, on the person's behalf and under the person's express direction.

10.2.4 ensure that the person has been informed that the person may, at any time and in any manner, withdraw their request;

10.2.5 ensure that another physician or nurse practitioner has provided a written opinion confirming that the person meets all of the eligibility criteria for MAID;

10.2.6 if neither they nor the assessor has expertise in the condition that is causing the person's suffering, ensure that they or the assessor consults with a physician or nurse practitioner who has that expertise and shares the results of that consultation with the other practitioner (see section 10.3.7 for further content on 'expertise');

10.2.7 be satisfied that they and the assessor are independent of each other;

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

10.2.9 ensure that they and the assessor have discussed with the person the reasonable and available means to relieve the person's suffering and they and the assessor agree with the person that the person has given serious consideration to those means;

10.2.10 ensure that there are at least 90 clear days between the day on which the first eligibility assessment for the current request begins and the day on which MAID is provided to them or — if the assessments have been completed and they and the assessor are both of the opinion that the loss of the person's capacity to provide consent to receive MAID is imminent — any shorter period that the provider considers appropriate in the circumstances;

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

10.2.12 unless the conditions for an advance consent – self-administration have been met (see section 14.0), immediately before providing MAID, give the person an opportunity to withdraw their request and ensure that the person gives express consent to receive MAID.

B. Implementing Procedural Safeguards

10.3 Being of the opinion (Tracks 1 and 2 unless otherwise noted)

10.3.1 Before a [*physician/nurse practitioner*] provides MAID, they must be of the opinion that the person meets all of the eligibility criteria set out in the *Criminal Code* and the

assessor must have provided a written opinion confirming the person meets the eligibility criteria.

10.3.2 Assessors and providers must only provide opinions on MAID eligibility that are within their scope of practice.¹⁸

10.3.3 When providing opinions on MAID eligibility, [*physicians/nurse practitioners*] should respect existing ethical norms as found for example, in the [*Canadian Medical Association's Code of Ethics or the Collège des Médecins du Québec's Code de Déontologie, the Canadian Nurses Association's Code of Ethics, and the practice standards of the assessor's regulatory authority*].

10.3.4 Forming an opinion about MAID eligibility may require the provider or assessor to undertake certain actions:

10.3.4.1 Obtaining health records

- (a) Assessors and providers must attempt to obtain all health records and personal data that is necessary for the completion of a MAID assessment.
- (b) Where a capable person refuses consent to obtaining health record and personal data necessary for the completion of a MAID assessment, the assessors and providers must explain that, without such information, the assessment cannot be completed and therefore the person cannot be found to be eligible.

10.3.4.2 Gathering collateral information (including from treating team, family members, and significant contacts)

- (a) Assessors and providers must attempt to obtain all collateral information necessary for the completion of a MAID assessment. This may include information known to the current or previous treating team and/or family members and/or significant contacts.
- (b) The provider and assessor must have received consent from the capable person prior to gathering collateral information.
- (c) Where a capable person refuses consent to obtaining collateral information necessary for the completion of a MAID assessment, then the assessors and providers must explain that without such information, the assessment cannot be completed and therefore the person cannot be found to be eligible.

10.3.4.3 Involvement of other healthcare professionals

¹⁸ See [*name of Scope of Practice standard or other relevant regulatory documents*].

- (a) Assessors and providers should involve medical specialists, subspecialists, and other healthcare professionals for consultations and additional expertise where necessary and with the consent of the person requesting MAID.
- (b) Where a capable person refuses consent to the involvement of other health care practitioners that is necessary for the completion of a MAID assessment, then the assessors and providers must explain that without such involvement, the assessment cannot be completed and therefore the person cannot be found to be eligible.

10.3.5 Means available to relieve suffering (only Track 2)

10.3.5.1 Before a [*physician/nurse practitioner*] provides MAID, they must ensure that the person has been informed of the means available to relieve their suffering, including, where appropriate, counselling services, mental health and disability support services, community services, and palliative care and has been offered consultations with relevant professionals who provide those services or that care.

10.3.5.2 ‘Community services’ must be interpreted as including housing and income supports.

10.3.5.3 ‘Means available’ must be interpreted as available means that are reasonable and recognized.

10.3.5.4 Informing and offering of consultations may be achieved by the [*physician/nurse practitioner*] or by others with relevant knowledge (e.g., social workers, the person’s family physician or most responsible provider) about the means of relieving suffering (e.g., community services). The provider must confirm that the requester has been informed of the means available and consultations with the relevant professionals have been offered.

10.3.6 Serious consideration of the reasonable and available means to relieve the person’s suffering (only Track 2)

10.3.6.1 Before a [*physician/nurse practitioner*] provides MAID, they must ensure that they and the assessor have discussed with the person the reasonable and available means to relieve the person’s suffering and they and the assessor agree with the person that the person has given serious consideration to those means.

10.3.6.2 Serious consideration must be understood to mean: a) exercising capacity, not merely having it; b) exhibiting careful thought; and c) not being impulsive.

10.3.7 Practitioner with expertise – consulting (where neither assessor has expertise in the condition causing suffering) (only Track 2)

10.3.7.1 If neither the provider nor the assessor has expertise in the condition that is causing the person's suffering, the provider must ensure that they or the assessor consult with a physician or nurse practitioner who has that expertise and share the results of that consultation with the other practitioner.

10.3.7.2 A 'practitioner with expertise' is not required to have a specialist designation. Rather, expertise can be obtained through physician or nurse education, training, and substantial experience in treating the condition causing the person's suffering.

10.3.7.3 [*Physicians/Nurse Practitioners*] must ensure that they have the expertise necessary to provide the consultation. In doing so, they must work within their scope of practice.¹⁹

10.3.7.4 The 'practitioner with expertise' under this provision of the *Criminal Code* is providing a consultation to the assessor and provider, not a MAID eligibility assessment.

10.3.7.5 A review of the requester's prior health records (including past specialist consultation reports) can be an important part of a complete MAID eligibility assessment. However, such a review does not constitute 'consultation' for the purposes of section 10.2.6 as that requires direct contemporaneous communication with the practitioner with expertise.

11.0 Additional Considerations Relating to Eligibility Assessments and Procedural Safeguards

A. Suicidality

11.1 Assessors and providers must take steps to ensure that the person's request for MAID is consistent with the person's values and beliefs, and is unambiguous and enduring. They must ensure it is rationally considered during a period of stability, and not during a period of crisis. This may require serial assessments.

11.2 A request for MAID by a person with a mental disorder in the absence of any criteria for involuntary admission as enumerated in [*province/territory*] mental health legislation, is not grounds for involuntary psychiatric assessment or admission (see Advice to the Profession for more detail).

¹⁹ This section must be read in conjunction with the Regulatory Standard [*name of existing scope of practice standard*].

11.3 Assessors and providers must consider making a referral for suicide prevention supports and services for persons who are found to be ineligible for MAID if, in the opinion of the assessor, the finding increases the individual's risk of suicide.

B. Challenging Interpersonal Dynamics

11.4 Assessors and providers must be alert to challenging interpersonal dynamics such as threatening behaviours of MAID requesters or their family members. If these challenging dynamics compromise the ability to carry out the assessment in accordance with professional norms, assessors and providers should seek information and/or advice from mentors and colleagues, and/or discontinue involvement in the assessment process (see Advice to the Profession for more details).

12.0 Virtual Care

[Note to users: include this section if the regulatory authority allows virtual care]

12.1 *[Physicians/Nurse Practitioners]* may assess a person's request for MAID and obtain consultations in relation to MAID virtually.

12.2 When assessing a person for MAID eligibility virtually, *[physicians/nurse practitioners]* must:

- 12.2.1 confirm the person agrees with the assessment proceeding virtually;
- 12.2.2 determine that a valid conclusion can be drawn about the person's eligibility for MAID; and
- 12.2.3 ensure that the assessment aligns with the provisions of other relevant College Standards.

[Note to users: sections 13.0 to 16.0 are intentionally left blank as the logistics of these topics vary by jurisdiction. Regulatory authorities can populate these sections based on the Criminal Code, the regulations under the Criminal Code, provincial/territorial legislation and policy, and their individual requirements].

13.0 Waiver of Final Consent

14.0 Advance Consent – Self-Administration



15.0 Provision of MAID

15.1 Prescribing

15.2 Providing

15.3 Obtaining and Returning MAID Substances

16.0 Documentation and Reporting

16.1 Documentation (Health Record-keeping)

16.2 Certification of Death

16.3 Reporting

17.0 Glossary

90 day period: for requesters whose natural death is not reasonably foreseeable, this refers to the minimum 90 clear days that must have passed between the day on which a Track 2 assessment by a provider or assessor begins and the day on which MAID is provided.

Advance consent — self-administration: consent to receive MAID given by a person with capacity before the loss of capacity in the context of self-administered MAID.

Assessor: the physician or nurse practitioner who provides a written opinion as to whether the person requesting MAID meets the eligibility criteria for MAID.

Capacity: the legal status of being able to provide informed consent for or refusal of healthcare interventions (i.e., having decision-making capacity). *[Note to users: some jurisdictions use different terminology.]*

Clinical Practice Guidelines, or “Guidelines”: documents typically developed by healthcare professional associations that summarize knowledge about a particular practice area and offer recommendations based on that knowledge to support clinician decision-making in specific circumstances.

Collateral information: information provided about a person by the person’s treating team, family members, or significant contacts.

Cultural safety: an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the health care system. It results in an environment free of racism and discrimination including intersections with for example, gender, where people feel safe when receiving health care.²⁰

Cultural humility: a process of self-reflection to understand personal and systemic biases and to develop and maintain respectful processes and relationships based on mutual trust. Cultural humility involves humbly acknowledging oneself as a learner when it comes to understanding another’s experience.²¹

Effective referral: taking positive action to ensure the person requesting MAID is connected in a timely manner to a non-objecting, available, and accessible physician or nurse practitioner, other health-care professional, or *[name of agency, program, office responsible for patient navigation]* that provides the health service (eligibility assessments for, and provision of, MAID) or connects the person directly with a health-care professional who does. ‘Timely manner’ means such that the person will not experience an adverse clinical outcome or prolonged

²⁰ <https://www.fnha.ca/Documents/FNHA-Creating-a-Climate-For-Change-Cultural-Humility-Resource-Booklet.pdf>

²¹ [ibid.](#)

suffering due to a delay in making the connection. *[Note to users: delete this definition if the regulatory authority uses wording of effective transfer of care instead of effective referral]*

Effective transfer of care: a transfer made by one physician or nurse practitioner in good faith to another physician or nurse practitioner who is available to accept the transfer, accessible to the person requesting MAID, and willing to provide MAID to that person if the eligibility criteria are met. *[Note to users: delete this definition if the regulatory authority uses the wording of effective referral instead of effective transfer of care]*

Eligibility criteria: the criteria set out in section 9.0 of this Standard which must be met by a person in order to access MAID. ‘Eligible’ and ‘eligibility’ have similar meanings.

Guidance Document: A document prepared by an organization (professional society, regulator or other) that offers non-binding recommendations on a specific topic.

Health Professional association: a non-governmental organization representing specific types or groups of professionals. Depending on their mandate, health professional associations may seek to advance the professional interests of their members, advocate for patients, develop clinical practice guidelines, and support research and educational activities for their members.

Independent practitioner: a physician or nurse practitioner who:

- (a) is not a mentor to the other practitioner or responsible for supervising their work;
- (b) 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, other than standard compensation for their services relating to the request; and
- (c) does 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.

Independent witness: an individual who is at least 18 years of age, who understands the nature of the request for MAID, and who is not excluded from acting as a witness to a person’s request for MAID for any reason, including the limitations set out in s.241.2 of the *Criminal Code* or any other legislative requirement.

Informed consent: consent provided by a person who has the capacity to make the decision and has been given an adequate explanation about the nature of the proposed intervention and its anticipated outcome(s) as well as the potential benefits and material risks involved and alternatives available.

Medical Assistance in Dying (MAID): an umbrella term that includes clinician-administered MAID and self-administered MAID. These practices include what is sometimes called euthanasia (clinician-administered), assisted suicide (self-administered), or voluntary assisted dying in other jurisdictions.

MAID MD-SUMC: MAID where a mental disorder (see definition below) is the sole underlying medical condition.

Mental disorder: a mental disorder is a condition as described in standard psychiatric diagnostic classification schemes such as the DSM5-TR.²² The *Criminal Code* uses the term ‘mental illness.’ According to the federal legislative background document prepared for Bill C-7, the term ‘mental illness’ would not include neurocognitive or neurodevelopmental disorders, or other conditions that may affect cognitive abilities, such as dementias, autism spectrum disorders, or intellectual disabilities.²³

Nurse practitioner: a registered nurse who, under the laws of a province or territory, is entitled to practise as a nurse practitioner – or under an equivalent designation.

Physician: a person who is entitled to practise medicine under the laws of a province or territory.

Provider: the physician or nurse practitioner who assesses whether the person requesting MAID meets the eligibility criteria for MAID, ensures that the procedural safeguards have been met and, if so, provides MAID.

Provider-administered MAID: the administering by a physician or nurse practitioner of a substance to a person, at their request, that causes their death.

Reasonably foreseeable natural death:

According to the only Canadian court to opine on the interpretation of ‘natural death has become reasonably foreseeable’:

[79] ... natural death need not be imminent and that what is a reasonably foreseeable death is a person-specific medical question to be made without necessarily making, but not necessarily precluding, a prognosis of the remaining lifespan.

[80] ... in formulating an opinion, the physician need not opine about the specific length of time that the person requesting medical assistance in dying has remaining in his or her lifetime.²⁴

The interpretation of ‘natural death has become reasonably foreseeable’ remains the same under Bill C-7 as it was under Bill C-14.²⁵

²² American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). <https://doi.org/10.1176/appi.books.9780890425596>.

²³ Legislative Background Bill C-7: Government of Canada’s Legislative Response to the Superior Court of Québec *Truchon* Decision.

²⁴ 2017 ONSC 3759, par. 79-80. *AB c. Canada*.

²⁵ <https://www.ctvnews.ca/politics/lametti-sows-uncertainty-over-meaning-of-foreseeable-death-in-assisted-dying-bill-1.4836211>

Safeguards: refers to protective legislative measures enacted through the *Criminal Code*.

Self-administered MAID: the prescribing or providing by a physician 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.

Track 1: refers to the procedural safeguards applicable to a request for MAID made by a person whose natural death is reasonably foreseeable.

Track 2: refers to the procedural safeguards applicable to a request for MAID made by a person whose natural death is not reasonably foreseeable.

Trauma-informed services: integrate an understanding of trauma and prioritize the individual's safety, choice, and control in service delivery. Such services create a treatment culture of nonviolence, learning, and collaboration. Utilizing a trauma-informed approach does not necessarily require disclosure of trauma. Rather, services are provided in ways that recognize the need for physical and emotional safety, as well as choice and control in decisions affecting one's treatment. A key aspect of trauma-informed services is to create an environment where service users do not experience re-traumatization and where they can learn coping or self-regulation skills and make decisions about their treatment needs at a pace that feels safe to them.²⁶

Virtual care: encompasses all means by which healthcare providers remotely interact with their patients using communications and digital technology.

Waiver of final consent: an arrangement in writing between the person (on Track 1) requesting MAID and their provider that the provider would administer substances to cause their death after they have lost decision-making capacity.

²⁶ https://cewh.ca/wp-content/uploads/2018/06/Opioid-TIP-Guide_May-2018.pdf.

Appendix: Model Practice Standard with Plug-ins Highlighted

These (highlighted) plug-ins are short sections of text that can be inserted into existing regulatory MAID standards in order to ensure coverage of particularly complex MAID requests including MAID MD-SUMC.

1.0 Preamble

Medical assistance in dying (MAID) has been legal in Québec since 2015 and in the rest of Canada since 2016.²⁷ Since then, the law with respect to eligibility for MAID has continued to evolve.²⁸

This Standard reflects the current state of Canadian law with respect to MAID (as established by the *Criminal Code*). Except where otherwise noted, this Standard applies to all MAID cases including requests for MAID where a mental disorder is the sole underlying medical condition (MAID MD-SUMC) when such requests become legal on March 17, 2024.²⁹

Throughout the Standard, the terms ‘must’ and ‘should’ are used to articulate the regulatory authority’s expectations. ‘Must’ indicates a mandatory requirement. ‘Should’ indicates that [physicians/nurse practitioners] can use reasonable discretion when applying this expectation to practice.

This Standard must be interpreted in the context of federal³⁰ and [provincial/territorial]³¹ legislation relating to MAID. Nothing in this Standard reduces a [physician’s/nurse practitioner’s] obligation to comply with any and all applicable laws.

This Standard must be read in conjunction with other regulatory standards including the [names of other relevant Practice Standards, especially consent, scope of practice, and effective referral/transfer of care].

This Standard should also be read in conjunction with the Advice to the Profession: Medical Assistance in Dying (MAID) and [Canadian Medical Association Code of Ethics/Code de Déontologie du Collège des Médecins du Québec/Canadian Nurses Association Code of Ethics/other relevant ethical statements³²].

[Physicians/Nurse Practitioners] are encouraged to consult with the resources available through the [Canadian Medical Protective Association](#), [Canadian Nurses Protective Society](#), the [Canadian Association of MAID Assessors and Providers](#), and relevant professional associations.

²⁷ *Carter v Canada (Attorney General)* [2015] 1 SCR 331. *Bill C-14, An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*, 1st Session, 42nd Parliament, 2016.

²⁸ *Bill C-14, An Act to amend the Criminal Code (medical assistance in dying)* 1st session, 42nd Parliament, 2016; *Truchon c. Procureur général du Canada*, 2019 QCCS 3792 (CanLII); *Bill C-7, An Act to amend the Criminal Code (medical assistance in dying)*, 2nd Session, 43rd Parliament, 2021.

²⁹ There are specific challenges related to the assessment of persons with intellectual disabilities and persons experiencing long-term incarceration that require additional recommendations from professional associations and community organizations working with persons with relevant lived experience. The [regulatory authority] will revise this Standard in light of any such recommendations as appropriate.

³⁰ <https://www.canada.ca/en/health-canada/services/medical-assistance-dying.html>

³¹ [reference to provincial/territorial legislation – if any]

³² [reference to other relevant ethical statements to specific jurisdiction]

2.0 Purposes

This Standard has been established:

2.1.1 to provide information that will assist [*physicians/nurse practitioners*] and the public in understanding the eligibility criteria, procedural safeguards, and reporting requirements that must be met regarding MAID;

2.1.2 to set the professional expectations of [*physicians/nurse practitioners*] who are involved with MAID; and

2.1.3 to outline the specific legal requirements for MAID assessors and providers.

3.0 Reasonable Knowledge, Care, and Skill

3.1 MAID must be provided with reasonable knowledge, care, and skill and in accordance with any applicable provincial/territorial laws, rules, or standards.

4.0 Scope of Practice³³

4.1 [*Physicians/Nurse Practitioners*] must practice only within a scope for which they are appropriately trained, licensed, and competent.

4.2 [*Physicians/Nurse Practitioners*] who choose to assess eligibility for or provide MAID, must have sufficient training, experience, and qualifications to safely and competently do so in the circumstances of each case. This should include training in capacity assessment, trauma-informed care, and cultural safety and humility.

5.0 Responsibilities of [*Physicians/Nurse Practitioners*] Unable or Unwilling to Participate in MAID

5.1 No [*physician/nurse practitioner*] can be compelled to prescribe or administer substances for the purpose of MAID.

³³ This section should be read in conjunction with the Regulatory Standard [*name of existing scope of practice standard*].

5.2 [*Physicians/Nurse Practitioners*] who are unable or unwilling to participate in MAID practice as set out in this Standard.³⁴

5.2.1 must complete an effective [*referral/transfer of care*] for any person seeking to make a request, requesting, or eligible to receive MAID;

5.2.2 must advise the person that they are not able or willing to assist with the making of a request for an assessment for MAID or the provision of MAID;

5.2.3 must provide, with the consent of the person, all relevant and necessary health records to the [*physician/nurse practitioners*] or program providing services related to MAID;³⁵

5.2.4 must continue to provide care and treatment not related to MAID if the person chooses; and

5.2.5 should make an effective [*referral/transfer of care*] to another [*physician/nurse practitioner*] if the person does not wish to remain in their care.³⁶

5.3 [*Physicians/Nurse Practitioners*] with an existing therapeutic relationship with a person requesting MAID (independent of the MAID request) must not discharge the person from their care on the grounds that a MAID request has been made or the person is also receiving services from a MAID team or centralized process.

6.0 Duties to Persons Potentially Eligible for MAID

6.1 [*Physicians/Nurse Practitioners*] must take reasonable steps to ensure persons are informed of the full range of treatment options available to relieve suffering.

6.2 [*Physicians/Nurse Practitioners*] must not assume all persons potentially eligible for MAID are aware that MAID is legal and available in Canada.

6.3 Upon forming reasonable grounds to believe that a person may be eligible for MAID, a [*physician/nurse practitioner*] must determine whether MAID is consistent with the person's values and goals of care and:

³⁴ Conscientious objection may be case specific. Some [*physicians/nurse practitioners*] are conscientiously opposed to all MAID. Some to only certain kinds of MAID (e.g., Track 2). Some to only specific cases given the specific circumstances. The same rules apply no matter the scope of objection – [*physicians/nurse practitioners*] cannot be compelled to participate but they must follow the steps laid out in 5.2 if they are unwilling to participate.

³⁵ [*Note to users: in some jurisdictions and in some clinical circumstances, consent is not required for the provision of health records. In such cases, the clause 'with the consent of the person' can be deleted*]

³⁶ See also [*name of Practice Standard on ending therapeutic relationships*].

6.3.1 if consistent,

- (a) advise the person of the potential for MAID; or
- (b) provide an effective [*referral/transfer of care*] to another physician, nurse practitioner, or program known to be willing to discuss eligibility for MAID;

6.3.2 if not consistent, do not advise the person of the potential for MAID;

6.3.3 whether consistent or not, document what action was taken and the rationale for it.

6.4 [*Physicians/Nurse Practitioners*] must respond to all reasonable questions from persons regarding MAID or make an effective [*referral/transfer of care*] to another [*physician/nurse practitioner*] or program known to be willing to discuss eligibility for MAID.

6.5 When advising persons on their potential eligibility for MAID, [*physicians/nurse practitioners*] must take reasonable steps to ensure the person does not perceive coercion, inducement, or pressure to pursue or not pursue MAID. Advising persons of potential eligibility for MAID is distinct from counselling persons to consider MAID.

7.0 Involvement of [*Medical/Nurse Practitioner*] Trainees

[*Note to users: For physician regulators that allow trainee participation*]

7.1 Postgraduate medical trainees can participate in the MAID process, but must only do so within the terms, conditions, and limitations of their certificate of registration.

7.2 Postgraduate medical trainees and other [*physicians/nurse practitioners*] involved in assessing a person's eligibility for MAID must ensure that there is independence between the provider and the assessor. Specifically, the requirement for independence between the provider and assessor is not satisfied if one is a mentor or supervisor to the other.

7.3 Medical students must not act as assessors or providers. They may observe assessments and provisions but only with the express consent of the person.

OR

[*Note to users: For physician regulators that do not allow trainee participation*]

7.1 Residents must not perform the role of the provider or assessor under this Standard. Residents may participate in MAID in an assisting or learning capacity only, with the consent of the person.

7.2 Medical students may observe assessments and provisions with the consent of the person.

[Note to users: For nurse regulators]

7.1 Pre-licensure nurse practitioner students can participate in providing nursing care in their current capacity as a registered nurse but they cannot perform eligibility assessments for MAID nor provide MAID. Only physicians and nurse practitioners have this authority. Pre-licensure nurse practitioner students can, however, learn about the MAID process through observation and discussion with their mentors.

8.0 Duties of Assessors and Providers³⁷

A. General

8.1 At least two practitioners must be involved in the assessment of eligibility of a person requesting MAID.

8.2 Assessors and providers must:

8.2.1 be independent practitioners;³⁸

8.2.2 act consistently with the [*Practice Standard/Guidance Document*] regarding treating family members or anyone with whom they have a close personal or emotional involvement;³⁹ and

8.2.3 complete all the required documentation and reporting as set out in section 16.0 below.

8.3 Assessors and providers must not disclose that a person has requested a MAID assessment or provision without the consent to do so from the person.⁴⁰

B. Duties of Providers

8.4 [*Physicians/Nurse Practitioners*] must not provide MAID on the direction of anyone other than the person requesting MAID.

³⁷ [Note to users: There are differences between regulators as to specific duties of the provider and assessor. In this Model Standard we have included only those duties established by the federal MAID legislation and/or recommended by the federal Expert Panel on MAID and Mental Illness. This section will need to be supplemented by those regulators that create additional duties or prohibit certain things permitted under the federal law.]

³⁸ See glossary for definition of this term in the context of this Standard. [Note to users: This is a distinct requirement from the Criminal Code. As needed, regulators may wish to add a provision stating any additional requirements with respect to holding a license for independent practice].

³⁹ [reference to relevant standard/guidance document]

⁴⁰ [reference to relevant standard/guidance document]

8.5 Before providing MAID, providers must assess eligibility (see section 9.0) and ensure that all procedural safeguards are met (see section 10.0).

8.6 The provider who prescribes or obtains a substance for the purpose of MAID must, before the pharmacist dispenses the substance, inform the pharmacist that the substance is intended for that purpose.

8.7 Providers must ensure safe prescribing, use, storage, and return of substances related to the provision of MAID.

C. Duties of Assessors

8.8 [*Physicians/Nurse Practitioners*] must not conduct an assessment for MAID on the direction of anyone other than the person requesting MAID.

8.9 Assessors must provide a written opinion attesting to whether the person requesting MAID meets the eligibility criteria for MAID.

8.10 Where natural death is not reasonably foreseeable, assessors must discuss with the person requesting MAID the reasonable and available means to relieve the person's suffering and determine whether the person has given serious consideration to those means.⁴¹

8.11 Where natural death is not reasonably foreseeable and a reduction in the 90 day period is being considered by the provider, assessors must provide an opinion as to whether the loss of the person's capacity to provide consent to receive MAID is imminent.

9.0 Eligibility for MAID

A. Eligibility Criteria

9.1 [*Physicians/Nurse Practitioners*] must only provide MAID to a person requesting MAID where all the following eligibility criteria are met:

9.1.1 the person is 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;

9.1.2 the person is at least 18 years of age and capable of making decisions with respect to their health;

⁴¹ While an assessor may discuss the means available to relieve the person's suffering for persons under Track 1, it is only a *Criminal Code* requirement that both the assessor and the provider do so for persons under Track 2.

9.1.3 the person has made a voluntary request for MAID that, in particular, was not made as a result of external pressure;

9.1.4 the person has given informed consent to receive MAID after having been informed of the means that are available to relieve their suffering, including palliative care;

9.1.5 the person has a grievous and irremediable medical condition. These criteria are met only where the provider and assessor are of the opinion that:

- (a) the person has a serious and incurable illness, disease, or disability;
- (b) the person is in an advanced state of irreversible decline in capability; and
- (c) the illness, disease, or disability or that state of decline causes the person enduring physical or psychological suffering that is intolerable to the person and cannot be relieved under conditions that the person considers acceptable.

9.2 [*Physicians/Nurse Practitioners*] must only apply the criteria for MAID eligibility set out in this Standard.

B. Assessing Eligibility

9.3 Capacity

9.3.1 To find a person eligible for MAID, the provider and assessor must be of the opinion that the person requesting MAID has capacity to make decisions with respect to MAID at the time of the MAID assessment.

9.3.2 When assessing for capacity to make decisions with respect to MAID, the provider and assessor must determine whether the person has the capacity to understand and appreciate:

- (a) the history and prognosis of their medical condition(s);
- (b) their treatment options and their risks and benefits; and
- (c) that the intended outcome of the provision of MAID is death.

9.3.3 As capacity is fluid and may change over time, [*physicians/nurse practitioners*] must be alert to potential changes in a person's capacity. Where appropriate, assessors and providers should undertake serial assessments of a person's decision-making capacity.

9.3.4 Where appropriate, assessors and providers should consult with clinicians with expertise in the assessment of decision-making capacity.

9.3.5 All capacity assessments must be conducted in accordance with clinical standards and legal criteria.

9.3.6 Assessors and providers must document the reasoning and evidence upon which their assessment of capacity was based.

9.4 Grievous and irremediable medical condition⁴²

9.4.1 To find a person eligible for MAID, the provider and assessor must be of the opinion that the person has ‘a grievous and irremediable medical condition.’

9.4.2 A person has a ‘grievous and irremediable medical condition’ if:

- (a) they have a serious and incurable illness, disease, or disability;
- (b) they are in an advanced state of irreversible decline in capability; and,
- (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.

9.5 Serious and incurable illness, disease, or disability

9.5.1 To find a person has a grievous and irremediable medical condition, the provider and assessor must be of the opinion that the person has a serious and incurable illness, disease, or disability.

9.5.2 ‘Incurable’ means there are no reasonable treatments remaining where reasonable is determined by the clinician and person together exploring the recognized, available, and potentially effective treatments in light of the person’s overall state of health, beliefs, values, and goals of care.

9.6 An advanced state of irreversible decline in capability

9.6.1 To find a person has a grievous and irremediable medical condition, the provider and assessor must be of the opinion that the person is in an advanced state of irreversible decline in capability.

9.6.2 Capability refers to a person’s functioning (physical, social, occupational, or other important areas), not the symptoms of their condition. Function refers to the ability to undertake those activities that are meaningful to the person.

9.6.3 ‘Advanced state of decline’ means the reduction in function is severe.

9.6.4 ‘Irreversible’ means there are no reasonable interventions remaining where reasonable is determined by the clinician and person together exploring the recognized,

⁴² ‘Grievous and irremediable medical condition’ is not standard clinical terminology, however, it is defined in the *Criminal Code* and explained below and in the document ‘Advice to the Profession.’

available, and potentially effective interventions in light of the person's overall state of health, beliefs, values, and goals of care.

9.7 Enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable.

9.7.1 To find that a person has a grievous and irremediable medical condition, the provider and assessor must be of the opinion that the person's illness, disease, or disability or state of decline causes the person enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable.

9.7.2 For the purposes of forming the opinion that the suffering criterion for MAID is met, assessors and providers:

- (a) must explore all dimensions of the person's suffering (physical, psychological, social, existential) and the means available to relieve them;
- (b) must explore the consistency of the person's assessment of their suffering with the person's overall clinical presentation, expressed wishes over time, and life narrative;
- (c) must be of the opinion that it is the person's illness, disease, or disability and/or state of decline in capability that is the cause of the person's suffering;
- (d) must be of the opinion that the suffering is enduring; and
- (e) must respect the subjectivity of suffering.

C. Voluntariness

9.8 To find a person eligible for MAID, assessors and providers must be satisfied that the person's decision to request MAID has been made freely, without undue influence (contemporaneous or past) from family members, health care providers, or others.

9.9 Assessors and providers must be familiar with and adhere to any [provincial/territorial] requirements relating to MAID for persons who are involuntarily hospitalized or under a Community Treatment Order. Similarly, they must be familiar with and adhere to any [provincial/territorial] or federal requirements re: MAID for persons who are being held under a Not Criminally Responsible order or are incarcerated.

D. Informed Consent

9.10 Providers must obtain informed consent directly from the person requesting MAID, not the substitute decision-maker of an incapable person.

9.11 When seeking informed consent, providers must:

9.11.1 discuss all reasonable, accepted, and available treatment options with the person requesting MAID, including the associated benefits, risks, and side effects, which include informing the person of the means that are available to relieve their suffering, including palliative care;

9.11.2 inform the person whose natural death is not reasonably foreseeable of the means available to relieve their suffering, including, where appropriate, counselling services, mental health and disability support services, community services, and palliative care and offer consultations with relevant professionals who provide those services or that care;

9.11.3 inform the person that they may, at any time and in any manner, withdraw their request for MAID, and that they will be given an opportunity to withdraw their request immediately before MAID is provided (except where there is a valid final consent waiver – see section 13.0 below);

9.11.4 inform the person requesting MAID of any possible complications associated with provider-administered and self-administered MAID, including the possibility that death may not occur; and

9.11.5 inform the person who is indicating a preference for self-administered MAID that if the person's death is prolonged or not achieved, it will not be possible for the provider to intervene and administer a substance causing their death unless the person is capable and can provide consent immediately prior to administering, or the person has entered into a written arrangement providing advance consent for [*physician/nurse practitioner*]-administered MAID (see section 14.0 below).

10.0 Procedural Safeguards

A. Procedural Safeguards

10.1 Before providing MAID to a person **whose natural death is reasonably foreseeable** (Track 1), 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, the provider must:

10.1.1 be of the opinion that the person meets all of the eligibility criteria for MAID;

10.1.2 ensure that the person's request for MAID was:

- (a) made in writing and signed and dated by the person (or by another person as permitted by law); and
- (b) signed and dated after the person was informed by a physician or nurse practitioner that the person has a grievous and irremediable medical condition;

10.1.3 be satisfied that the request was signed and dated by the person, or by another person as permitted by law,⁴³ before an independent witness who then also signed and dated the request;

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

10.1.5 ensure that another physician or nurse practitioner has provided a written opinion confirming that the person meets all of the eligibility criteria for MAID;

10.1.6 be satisfied that they and the assessor are independent of each other;

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

10.1.8 unless the conditions for a waiver of final consent or advance consent – self-administration have been met (see sections 13.0 and 14.0), immediately before providing MAID, give the person an opportunity to withdraw their request and ensure that the person gives express consent to receive MAID.

10.2 Before providing MAID to a person **whose natural death is not reasonably foreseeable** taking into account all of their medical circumstances (Track 2), the provider must:

10.2.1 be of the opinion that the person meets all of the eligibility criteria for MAID;

10.2.2 ensure that the person's request for MAID was:

- (a) made in writing and signed and dated by the person or by another person as permitted by law; and
- (b) signed and dated after the person was informed by a physician or nurse practitioner that the person has a grievous and irremediable medical condition;

10.2.3 be satisfied that the request was signed and dated by the person — or by another person as permitted by law — before an independent witness who then also signed and dated the request;

⁴³ If the person requesting MAID 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 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 do so in the person's presence, on the person's behalf and under the person's express direction.

10.2.4 ensure that the person has been informed that the person may, at any time and in any manner, withdraw their request;

10.2.5 ensure that another physician or nurse practitioner has provided a written opinion confirming that the person meets all of the eligibility criteria for MAID;

10.2.6 if neither they nor the assessor has expertise in the condition that is causing the person's suffering, ensure that they or the assessor consults with a physician or nurse practitioner who has that expertise and shares the results of that consultation with the other practitioner (see section 10.3.7 for further content on 'expertise');

10.2.7 be satisfied that they and the assessor are independent of each other;

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

10.2.9 ensure that they and the assessor have discussed with the person the reasonable and available means to relieve the person's suffering and they and the assessor agree with the person that the person has given serious consideration to those means;

10.2.10 ensure that there are at least 90 clear days between the day on which the first eligibility assessment for the current request begins and the day on which MAID is provided to them or — if the assessments have been completed and they and the assessor are both of the opinion that the loss of the person's capacity to provide consent to receive MAID is imminent — any shorter period that the provider considers appropriate in the circumstances;

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

10.2.12 unless the conditions for an advance consent – self-administration have been met (see section 14.0), immediately before providing MAID, give the person an opportunity to withdraw their request and ensure that the person gives express consent to receive MAID.

B. Implementing Procedural Safeguards

10.3 Being of the opinion (Tracks 1 and 2 unless otherwise noted)

10.3.1 Before a [physician/nurse practitioner] provides MAID, they must be of the opinion that the person meets all of the eligibility criteria set out in the *Criminal Code* and the

assessor must have provided a written opinion confirming the person meets the eligibility criteria.

10.3.2 Assessors and providers must only provide opinions on MAID eligibility that are within their scope of practice.⁴⁴

10.3.3 When providing opinions on MAID eligibility, [*physicians/nurse practitioners*] should respect existing ethical norms as found for example, in the [*Canadian Medical Association's Code of Ethics or the Collège des Médecins du Québec's Code de Déontologie, the Canadian Nurses Association's Code of Ethics, and the practice standards of the assessor's regulatory authority*].

10.3.4 Forming an opinion about MAID eligibility may require the provider or assessor to undertake certain actions:

10.3.4.1 Obtaining health records

- (a) Assessors and providers must attempt to obtain all health records and personal data that is necessary for the completion of a MAID assessment.
- (b) Where a capable person refuses consent to obtaining health record and personal data necessary for the completion of a MAID assessment, the assessors and providers must explain that, without such information, the assessment cannot be completed and therefore the person cannot be found to be eligible.

10.3.4.2 Gathering collateral information (including from treating team, family members, and significant contacts)

- (a) Assessors and providers must attempt to obtain all collateral information necessary for the completion of a MAID assessment. This may include information known to the current or previous treating team and/or family members and/or significant contacts.
- (b) The provider and assessor must have received consent from the capable person prior to gathering collateral information.
- (c) Where a capable person refuses consent to obtaining collateral information necessary for the completion of a MAID assessment, then the assessors and providers must explain that without such information, the assessment cannot be completed and therefore the person cannot be found to be eligible.

10.3.4.3 Involvement of other healthcare professionals

⁴⁴ See [*name of Scope of Practice standard or other relevant regulatory documents*].

- (a) Assessors and providers should involve medical specialists, subspecialists, and other healthcare professionals for consultations and additional expertise where necessary and with the consent of the person requesting MAID.
- (b) Where a capable person refuses consent to the involvement of other health care practitioners that is necessary for the completion of a MAID assessment, then the assessors and providers must explain that without such involvement, the assessment cannot be completed and therefore the person cannot be found to be eligible.

10.3.5 Means available to relieve suffering (only Track 2)

10.3.5.1 Before a [*physician/nurse practitioner*] provides MAID, they must ensure that the person has been informed of the means available to relieve their suffering, including, where appropriate, counselling services, mental health and disability support services, community services, and palliative care and has been offered consultations with relevant professionals who provide those services or that care.

10.3.5.2 ‘Community services’ must be interpreted as including housing and income supports.

10.3.5.3 ‘Means available’ must be interpreted as available means that are reasonable and recognized.

10.3.5.4 Informing and offering of consultations may be achieved by the [*physician/nurse practitioner*] or by others with relevant knowledge (e.g., social workers, the person’s family physician or most responsible provider) about the means of relieving suffering (e.g., community services). The provider must confirm that the requester has been informed of the means available and consultations with the relevant professionals have been offered.

10.3.6 Serious consideration of the reasonable and available means to relieve the person’s suffering (only Track 2)

10.3.6.1 Before a [*physician/nurse practitioner*] provides MAID, they must ensure that they and the assessor have discussed with the person the reasonable and available means to relieve the person’s suffering and they and the assessor agree with the person that the person has given serious consideration to those means.

10.3.6.2 Serious consideration must be understood to mean: a) exercising capacity, not merely having it; b) exhibiting careful thought; and c) not being impulsive.

10.3.7 Practitioner with expertise – consulting (where neither assessor has expertise in the condition causing suffering) (only Track 2)

10.3.7.1 If neither the provider nor the assessor has expertise in the condition that is causing the person's suffering, the provider must ensure that they or the assessor consult with a physician or nurse practitioner who has that expertise and share the results of that consultation with the other practitioner.

10.3.7.2 A 'practitioner with expertise' is not required to have a specialist designation. Rather, expertise can be obtained through physician or nurse education, training, and substantial experience in treating the condition causing the person's suffering.

10.3.7.3 [Physicians/Nurse Practitioners] must ensure that they have the expertise necessary to provide the consultation. In doing so, they must work within their scope of practice.⁴⁵

10.3.7.4 The 'practitioner with expertise' under this provision of the *Criminal Code* is providing a consultation to the assessor and provider, not a MAID eligibility assessment.

10.3.7.5 A review of the requester's prior health records (including past specialist consultation reports) can be an important part of a complete MAID eligibility assessment. However, such a review does not constitute 'consultation' for the purposes of section 10.2.6 as that requires direct contemporaneous communication with the practitioner with expertise.

11.0 Additional Considerations Relating to Eligibility Assessments and Procedural Safeguards

A. Suicidality

11.1 Assessors and providers must take steps to ensure that the person's request for MAID is consistent with the person's values and beliefs, and is unambiguous, and enduring. They must ensure it is rationally considered during a period of stability, and not during a period of crisis. This may require serial assessments.

11.2 A request for MAID by a person with a mental disorder in the absence of any criteria for involuntary admission as enumerated in [province/territory] mental health legislation, is not grounds for involuntary psychiatric assessment or admission (see Advice to the Profession for more detail).

⁴⁵ This section must be read in conjunction with the Regulatory Standard [name of existing scope of practice standard].

11.3 Assessors and providers must consider making a referral for suicide prevention supports and services for persons who are found to be ineligible for MAID if, in the opinion of the assessor, the finding increases the individual's risk of suicide.

B. Challenging Interpersonal Dynamics

11.4 Assessors and providers must be alert to challenging interpersonal dynamics such as threatening behaviours of MAID requesters or their family members. If these challenging dynamics compromise the ability to carry out the assessment in accordance with professional norms, assessors and providers should seek information and/or advice from mentors and colleagues, and/or discontinue involvement in the assessment process (see Advice to the Profession for more details).

12.0 Virtual Care

[Note to users: include this section if the regulatory authority allows virtual care]

12.1 *[Physicians/Nurse Practitioners]* may assess a person's request for MAID and obtain consultations in relation to MAID virtually.

12.2 When assessing a person for MAID eligibility virtually, *[physicians/nurse practitioners]* must:

12.2.1 confirm the person agrees with the assessment proceeding virtually;

12.2.2 determine that a valid conclusion can be drawn about the person's eligibility for MAID; and

12.2.3 ensure that the assessment aligns with the provisions of other relevant College Standards.

[Note to users: sections 13.0 to 16.0 are intentionally left blank as the logistics of these topics vary by jurisdiction. Regulatory authorities can populate these sections based on the Criminal Code, the regulations under the Criminal Code, provincial/territorial legislation and policy, and their individual requirements].

13.0 Waiver of Final Consent

14.0 Advance Consent – Self-Administration



15.0 Provision of MAID

15.1 Prescribing

15.2 Providing

15.3 Obtaining and Returning MAID Substances

16.0 Documentation and Reporting

16.1 Documentation (Health Record-keeping)

16.2 Certification of Death

16.3 Reporting

17.0 Glossary

90 day period: for requesters whose natural death is not reasonably foreseeable, this refers to the minimum 90 clear days that must have passed between the day on which a Track 2 assessment by a provider or assessor begins and the day on which MAID is provided.

Advance consent — self-administration: consent to receive MAID given by a person with capacity before the loss of capacity in the context of self-administered MAID.

Assessor: the physician or nurse practitioner who provides a written opinion as to whether the person requesting MAID meets the eligibility criteria for MAID.

Capacity: the legal status of being able to provide informed consent for or refusal of healthcare interventions (i.e., having decision-making capacity). *[Note to users: some jurisdictions use different terminology.]*

Clinical Practice Guidelines, or “Guidelines” – documents typically developed by healthcare professional associations that summarize knowledge about a particular practice area and offer recommendations based on that knowledge to support clinician decision-making in specific circumstances.

Collateral information: information provided about a person by the person’s treating team, family members, or significant contacts.

Cultural safety: an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the health care system. It results in an environment free of racism and discrimination including intersections with for example, gender, where people feel safe when receiving health care.⁴⁶

Cultural humility: a process of self-reflection to understand personal and systemic biases and to develop and maintain respectful processes and relationships based on mutual trust. Cultural humility involves humbly acknowledging oneself as a learner when it comes to understanding another’s experience.⁴⁷

Effective referral: taking positive action to ensure the person requesting MAID is connected in a timely manner to a non-objecting, available, and accessible physician or nurse practitioner, other health-care professional, or *[name of agency, program, office responsible for patient navigation]* that provides the health service (eligibility assessments for, and provision of, MAID) or connects the person directly with a health-care professional who does. ‘Timely manner’ means such that the person will not experience an adverse clinical outcome or prolonged

⁴⁶ <https://www.fnha.ca/Documents/FNHA-Creating-a-Climate-For-Change-Cultural-Humility-Resource-Booklet.pdf>

⁴⁷ [ibid.](#)

suffering due to a delay in making the connection. *[Note to users: delete this definition if the regulatory authority uses wording of effective transfer of care instead of effective referral]*

Effective transfer of care: a transfer made by one physician or nurse practitioner in good faith to another physician or nurse practitioner who is available to accept the transfer, accessible to the person requesting MAID, and willing to provide MAID to that person if the eligibility criteria are met. *[Note to users: delete this definition if the regulatory authority uses the wording of effective referral instead of effective transfer of care]*

Eligibility criteria: the criteria set out in section 9.0 of this Standard which must be met by a person in order to access MAID. ‘Eligible’ and ‘eligibility’ have similar meanings.

Guidance Document: A document prepared by an organization (professional society, regulator or other) that offers non-binding recommendations on a specific topic.

Health Professional association: a non-governmental organization representing specific types or groups of professionals. Depending on their mandate, health professional associations may seek to advance the professional interests of their members, advocate for patients, develop clinical practice guidelines, and support research and educational activities for their members.

Independent practitioner: a physician or nurse practitioner who:
is not a mentor to the other practitioner or responsible for supervising their work;
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, other than standard compensation for their services relating to the request; and
does 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.

Independent witness: an individual who is at least 18 years of age, who understands the nature of the request for MAID, and who is not excluded from acting as a witness to a person’s request for MAID for any reason, including the limitations set out in s.241.2 of the *Criminal Code* or any other legislative requirement.

Informed consent: consent provided by a person who has the capacity to make the decision and has been given an adequate explanation about the nature of the proposed intervention and its anticipated outcome(s) as well as the potential benefits and material risks involved and alternatives available.

Medical Assistance in Dying (MAID): an umbrella term that includes clinician-administered MAID and self-administered MAID. These practices include what is sometimes called euthanasia (clinician-administered), assisted suicide (self-administered), or voluntary assisted dying in other jurisdictions.

MAID MD-SUMC: MAID where a mental disorder (see definition below) is the sole underlying medical condition.

Mental disorder: a mental disorder is a condition as described in standard psychiatric diagnostic classification schemes such as the DSM5-TR.⁴⁸ The *Criminal Code* uses the term ‘mental illness.’ According to the federal legislative background document prepared for Bill C-7, the term ‘mental illness’ would not include neurocognitive or neurodevelopmental disorders, or other conditions that may affect cognitive abilities, such as dementias, autism spectrum disorders, or intellectual disabilities.⁴⁹

Nurse practitioner: a registered nurse who, under the laws of a province or territory, is entitled to practise as a nurse practitioner – or under an equivalent designation.

Physician: a person who is entitled to practise medicine under the laws of a province or territory.

Provider: the physician or nurse practitioner who assesses whether the person requesting MAID meets the eligibility criteria for MAID, ensures that the procedural safeguards have been met and, if so, provides MAID.

Provider-administered MAID: the administering by a physician or nurse practitioner of a substance to a person, at their request, that causes their death.

Reasonably foreseeable natural death:

According to the only Canadian court to opine on the interpretation of ‘natural death has become reasonably foreseeable’:

[79] ... natural death need not be imminent and that what is a reasonably foreseeable death is a person-specific medical question to be made without necessarily making, but not necessarily precluding, a prognosis of the remaining lifespan.

[80] ... in formulating an opinion, the physician need not opine about the specific length of time that the person requesting medical assistance in dying has remaining in his or her lifetime.⁵⁰

The interpretation of ‘natural death has become reasonably foreseeable’ remains the same under Bill C-7 as it was under Bill C-14.⁵¹

Safeguards: refers to protective legislative measures enacted through the *Criminal Code*.

⁴⁸ American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). <https://doi.org/10.1176/appi.books.9780890425596>.

⁴⁹ Legislative Background Bill C-7: Government of Canada’s Legislative Response to the Superior Court of Québec *Truchon* Decision.

⁵⁰ 2017 ONSC 3759, par. 79-80. *AB c. Canada*.

⁵¹ <https://www.ctvnews.ca/politics/lametti-sows-uncertainty-over-meaning-of-foreseeable-death-in-assisted-dying-bill-1.4836211>

Self-administered MAID: the prescribing or providing by a physician 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.

Track 1: refers to the procedural safeguards applicable to a request for MAID made by a person whose natural death is reasonably foreseeable.

Track 2: refers to the procedural safeguards applicable to a request for MAID made by a person whose natural death is not reasonably foreseeable.

Trauma-informed services: integrate an understanding of trauma and prioritize the individual's safety, choice, and control in service delivery. Such services create a treatment culture of nonviolence, learning, and collaboration. Utilizing a trauma-informed approach does not necessarily require disclosure of trauma. Rather, services are provided in ways that recognize the need for physical and emotional safety, as well as choice and control in decisions affecting one's treatment. A key aspect of trauma-informed services is to create an environment where service users do not experience re-traumatization and where they can learn coping or self-regulation skills and make decisions about their treatment needs at a pace that feels safe to them.⁵²

Virtual care: encompasses all means by which healthcare providers remotely interact with their patients using communications and digital technology.

Waiver of final consent: an arrangement in writing between the person (on Track 1) requesting MAID and their provider that the provider would administer substances to cause their death after they have lost decision-making capacity.

⁵² https://cewh.ca/wp-content/uploads/2018/06/Opioid-TIP-Guide_May-2018.pdf.