Canadian Nurses
Protective Society

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Standing Committee on Justice and Human Rights
1 Wellington Street
Ottawa, ON K1A 0A6

To: Hon. Chair Anthony Housefather and Members of the Committee:

RE: Submissions in response to Bill C-14

The Canadian Nurses Protective Society ("CNPS") is a not-for-profit organization that provides professional liability protection, legal assistance, and risk management services to over 125,000 registered nurses and nurse practitioners in Canada.

The CNPS wishes to acknowledge the very difficult work that the Government of Canada had to undertake in providing reasonable access to medical assistance in dying ("MAID") for persons living with intractable and intolerable suffering while also protecting vulnerable citizens who are elderly, ill, or disabled. It is important to recognize that the legal development brought about by the Supreme Court of Canada in *Carter* also represents a paradigm shift for healthcare professionals in Canada. This shift compels healthcare professionals to re-examine personal/professional values and evaluate whether adequate protection is in place to ensure that those who wish to participate in MAID can do so with certainty that they are acting in compliance with the Criminal Code.

Healthcare professionals should be able to clearly delineate what constitutes criminal conduct, and what does not. The focus of this submission is on the adequacy of the exemptions in subsections 227(1), 227(2), 241(2) and 241(3). In order to invoke these exemptions, healthcare professionals participating in MAID will have to comply with every condition set out in 241.2. We identify conditions for the exemptions which, notwithstanding subs. 227(3) and 241(6), are too onerous, inconsistent with the *Charter,* or require clarification in order to ensure that healthcare professionals can participate in MAID with adequate certainty that they are not committing a criminal offence.

1. The quality of the exemption:

The CNPS concerns relate to the following provisions:

a) **The requirement to act with reasonable care and skill, and in accordance with any provincial legislation, rule and standard [subs. 241.2(7)]:** Failure to comply with this requirement could result in the commission of a criminal offence despite the complete absence of a *mens rea* component. As drafted, a practitioner who satisfies the *actus reus* component (failing to provide MAID without "reasonable knowledge, care and skill") but does not do so with any element of *mens rea* (such as intention, knowledge, willful blindness, or recklessness), will fall outside all of the exemptions. This is a much lower threshold of

culpability than criminal negligence under subsection 219(1), which requires the *mens rea* element of "wanton or reckless disregard for the lives or safety of others". It is noteworthy that nowhere else in the Criminal Code can a breach of the standard of care (i.e. acting without "reasonable knowledge, care and skill") give rise to a criminal offence.

In addition, this provision makes the exemption conditional upon compliance with requirements that are unknown and ill-defined: provincial legislation and standards have not yet been enacted and the term "rule" does not have a legal meaning. All provincial requirements are also incorporated by reference without regard to their importance; some could be merely administrative in nature. Attaching a criminal consequence to a breach of the standard may deter regulatory authorities from adopting standards and taking the very steps to enhance patient care and safety in this area.

It would be entirely unwarranted to import civil or regulatory notions as the basis for criminal conduct. The requirement to act with reasonable knowledge care and skill is a civil and regulatory standard that already carries civil and regulatory consequences. For the reasons set out above, subsection 241.2(7) should be deleted in its entirety.

b) **The requirement that a practitioner be satisfied that the request for MAID is signed and dated before two independent witnesses [subsection 241.2(3)(c)]:** The definition of an "independent witness", is contained at paragraph 241.2(5), but for all practical purposes, a medical or nurse practitioner is not in a position to determine whether those conditions exist. The word "independent" should be deleted from this paragraph and witnesses should bear the responsibility of any misrepresentation as to their independence. It is important to note that pursuant to paragraphs 241.2(3)(a) and 241.2(1)(d), the medical or nurse practitioner is already required to determine that the request is "voluntary" and "not as a result of external pressure".

c) **The requirement that a "business relationship" not exist as between the practitioners providing MAID and the practitioners who provide the opinion contemplated by subsection 241(3)(e) [subs. 241.2(6)(a)]:** Precluding any form of "business relationship", without a definition, will create uncertainty. For instance, would the existence of a pattern of referrals be considered to be a "business relationship"? Would a collaborative relationship between a nurse practitioner and a physician be considered a "business relationship"?

If the intention of subsection 241.2(6)(a) is to prevent the involvement of practitioners where they operate in partnership or otherwise within the same clinic, it should be expressly stipulated. We submit that a more expansive definition of business relationship would also create barriers to access especially in rural areas where practitioners need to collaborate on a regular basis.

d) **The requirement that practitioners "*do not know or believe that they are connected to the other practitioner or to the person making the request in any other way that would affect their objectivity*".[subs. 241.2(6)(c)]:** This requirement is too vague and much too subjective to be relied upon to delineate a criminal offense. Would living in the same community or referring patients to a practitioner meant that a "connection" existed between the practitioners which would impact "objectivity"? To avoid the introduction of a vague, overly broad provision, which could create so much uncertainty as to alone deter physicians and nurse practitioners from providing assistance, the CNPS recommends the elimination of this condition in its entirety.

2. **Fundamental uncertainty as to the role of the registered nurse, licensed/registered practical nurse and registered psychiatric nurse:** Due to the fact that the scope of practice of registered nurses typically permits the administration of a substance with the order of physician or nurse practitioner, subs. 227(2) and 241(3) would suggest that a registered nurse could indeed administer a substance in the provision of MAID with an order from a medical or nurse practitioner. However, pars. 241.1(a) and 241.2(3)(h) suggest that a medical or nurse practitioner must be present at the bedside and administer the substance that has been prescribed as part of the provision of MAID, unless the patient is able and willing to self-administer. The CNPS submits that if the intention of the legislation is to ensure the substance is administered by a medical practitioner or nurse practitioner with the exception of the patient self-administering, a clear statement that the substance is to be "administered personally by the medical practitioner or nurse practitioner" must be included.

3. **Inconsistent and unpredictable punishments:** Subsection 227(1) provides an exemption from culpable homicide if the conditions in section 241.2 are satisfied. Culpable homicide is defined in subsection 222(4) of the Code as "murder or manslaughter or infanticide". The possible punishments for the indictable offence of culpable homicide are set out in subsections 235(1), 236(a), 236(b), and 237. The punishment, depending on the type of culpable homicide, ranges from minimum imprisonment of four years to a maximum of life imprisonment. Failure to comply with the conditions of the exemption could also lead to a finding of guilt pursuant to section 241(1), which carries a potential term of imprisonment of not more than 14 years. Section 241.3, however, includes additional terms of punishment for failing to satisfy the requirements set out in subsections 241.2(3)(b) to (h) and 241.2(8).

4. **Healthcare providers' obligation to "counsel":** Subsection 241(1)(a) creates a criminal offence to "counsel" a person to commit suicide. "Counsel" is defined in subsection 22(3) of the Code as including "procur[ing], solicit[ing] or incit[ing]." In nursing, however, "counsel" is often used to describe information-sharing or engaging in an educational dialogue with a patient for the purpose of developing awareness of health options. In fact, Canadian nurses by legal and ethical duty must "counsel" or educate patients with respect to healthcare decision-making.

   With the proposed subsection 241(1)(a) in mind, nurses may be at risk of criminal prosecution as a result of carrying out their professional obligations by engaging in discussions with patients regarding end-of-life issues. Nurses may be reluctant to enter into discussions with patients regarding end-of-life questions due to a fear that it could be construed as "counselling". As a result, it is in the best interests of patients and the healthcare team to include an explicit exemption for nurses (and other healthcare professionals) who may have similar obligations to discuss end-of-life options.

   To distinguish the existing definition of "counselling" under subsection 22(3) of the Code from that of information providing in the healthcare context, CNPS recommends the following definition and exemption under section 241.1:

   > *"counsel" in relation to the death of a person, means to provide information on practitioner-assisted death in the course of the provision of professional healthcare services;*
   >
   > *S. 241.1(2)(b): An assisting practitioner, a consulting physician, or a nurse who, in the course of providing professional healthcare services, counsels a person about practitioner-assisted death is not guilty of an offence under section 241.*

5. **The definition of "nurse practitioner":** Section 241.1 defines "nurse practitioner" as "*a registered nurse who, under the laws of a province, is entitled to practice as a nurse practitioner – or under an equivalent designation – and to autonomously make diagnoses, order and interpret diagnostic tests, prescribe substances and treat patients*". When reviewing the definitions of "medical practitioner" or "pharmacist" under section 241.1, however, the definitions only refer to the provincial laws which regulate the professions. The CNPS submits that the same approach should be taken with the definition of "nurse practitioner" by adopting the following:

   Nurse practitioner *means a person who is entitled to practice as a nurse practitioner under the laws of a province.*

Concluding Remarks:

The CNPS submits that if the above-mentioned revisions, exclusions, and points requiring clarification are addressed, the proposed legislation will provide greater guidance and certainty for the healthcare team in providing MAID, will provide greater predictability of the consequences for failing to abide by the legislation, which in turn will generate a greater willingness to participate in the provision of MAID, and correspondingly greater access for patients who wish to exercise the choice to die.

All of which is respectively submitted,
THE CANADIAN NURSES PROTECTIVE SOCIETY

Chantal Léonard, CEO