Standards for the Practice of Nurse Practitioners: Medical Assistance in Dying

Mandate

Regulation for safe, competent, and ethical nursing care.

Under the *Nurses Act*, the Nurses Association of New-Brunswick (NANB) is legally responsible to protect the public by regulating members of the nursing profession in New Brunswick (NB). Regulation makes the profession, and nurses as individuals, accountable to the public for the delivery of safe, competent, and ethical nursing care.

Acknowledgements

This Medical Assistance in Dying (MAID) Standards document for nurse practitioners (NP) was developed through the adaption of the *Model Practice Standard for MAID* generated by the MAID Practice Standards Task Group convened by Health Canada from September 2022 to March 2023.

In addition, NANB stakeholders, including NPs, educators, advisory committees, council, government, and employers were consulted in the development of this document.

Words in bold print are found in the glossary. They are shown in bold on first appearance.

Table of Contents

Introduction

This Standard reflects the current state of Canadian law with respect to **MAID** (as established by the *Criminal Code*). It applies to the practice of all **nurse practitioners** (NPs) in NB and, except where otherwise noted, to all MAID cases.

Throughout the Standard, the terms 'must' and 'should' are used to articulate NANB's practice expectations. 'Must' indicates a mandatory requirement. 'Should' indicates that the NP can use reasonable discretion when applying this expectation to practice.

This Standard must be interpreted in the context of federal[1] and NB[2] legislation relating to MAID. Nothing in this Standard reduces a NP's obligation to comply with any and all applicable laws.

This Standard must be read in conjunction with other regulatory standards including the *Standards of Practice for Nurse Practitioners*, *Standards of Practice for Registered Nurses*, *Standards for the Nurse-Client Relationship*, and *Standards for Documentation*. This standard should also be read in conjunction with the Advice to the Profession: Medical Assistance in Dying , NANB Consent Fact Sheet, and the Canadian Nurses Association Code of Ethics. NPs are encouraged to consult with the resources available through the Canadian Nurses Protective Society, the Canadian Association of MAID Assessors and Providers, and relevant professional associations.

2.0 Purposes

2.1 This Standard has been established:

2.1.1 to provide information that will assist NPs 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 NPs in NB who are involved with MAID; and

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

[1] https://www.canada.ca/en/health-canada/services/medical-assistance-dying.html
[2] https://www2.gnb.ca/content/gnb/en/departments/health/patientinformation/content/MedicalAssistanceInDying.html

3.0 Reasonable Knowledge, Care, and Skill

3.1 MAID must be provided with reasonable knowledge, care, and skill.

3.2 NPs participating in any aspect of MAID must do so in accordance with the *Criminal Code of Canada* and any other applicable provincial laws, rules, or standards.

4.0 Scope of Practice

4.1 NPs must practice only within a scope for which they are appropriately trained, registered, and competent and in accordance with *the* *Nurse Practitioner Entry-Level Competencies* and the *Standards of Practice for Nurse Practitioners*.

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

5.0 Responsibilities of NPs Unable or Unwilling to Participate in MAID

5.1 No NP can be compelled to prescribe or administer substances for the purpose of MAID.

5.2 NPs who are unable or unwilling to participate in MAID practice as set out in this Standard:[3]

5.2.1 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;

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

5.2.3 must provide, with the consent of the person, all relevant and necessary health records to the NP, **physician**, or MAID program[4] providing services related to MAID;

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

[3] Conscientious objection may be case specific. Some NPs 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 – NPs cannot be compelled to participate but they must follow the steps laid out in 5.2 if they are unwilling to participate.
[4] https://horizonnb.ca/patients-visitors/patient-information-resources/medical-assistance-in-dying-maid/; https://www.vitalitenb.ca/en/patients/end-life-care/medical-assistance-dying

5.2.5 should make an **effective transfer of care t**o another NP or physician if the person does not wish to remain in their care.[5]

5.3 NPs 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 NPs must take reasonable steps to ensure persons are informed of the full range of treatment options available to relieve suffering.

6.2 NPs 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, the NP must determine whether MAID is consistent with the person's values and goals of care and:

6.3.1 if consistent,
(a) advise the person of the potential for MAID; or
(b) provide an effective referral or transfer of care to another NP, physician, or MAID 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 NPs must respond to all reasonable questions from persons regarding MAID or make an effective referral or transfer of care to another NP, physician, or MAID program known to be willing to discuss eligibility for MAID.

6.5 When advising persons on their potential eligibility for MAID, NPs 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.

[5] See also *Standards for the Nurse-Client Relationship* and *Guideline for Nurse Practitioner Practice*

7.0 Involvement of Nurse Practitioner Trainees

7.1 NP 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 NPs and physicians have this authority. NP students can; however, learn about the MAID process through observation and discussion with their mentors.

7.2 Graduate nurse practitioners (GNPs) have not completed all eligibility requirements and do not yet hold a practice permit as an NP. GNPs can aid in MAID as outlined within the registered nurse's role[6].

8.0 Duties of Assessors and Providers[7]

A. General

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

8.2 NPs as assessors and providers must:

8.2.1 be **independent practitioners**;

8.2.2 act consistently with the *Standards of Practice for Nurse Practitioners* and *Standards for the Nurse-Client Relationship;*

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

8.2.4 must not participate as an assessor or provider in MAID for themselves, their family members, or anyone with whom they have close personal or emotional involvement.

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.

[6] Practice Guideline for Registered Nurses: Medical Assistance in Dying

[7] Note to users: There are differences between regulators as to specific duties of the provider and assessor. In this 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.

B. Duties of Providers

8.4 NPs must not provide MAID on the direction of anyone other than the person requesting MAID.

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

8.6 The NP 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 (see section 15.0).

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

C. Duties of Assessors

8.8 NPs must not conduct an assessment for MAID on the direction of anyone other than the person requesting MAID.

8.9 NPs as 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**, NPs as 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.[8]

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

[8] 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.

9.0 Eligibility Criteria

A. Eligibility Criteria

9.1 NPs 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;

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

9.1.4 the provision of MAID by NPs is consistent with employer policy (if no policy is in place, it is the responsibility of the NP to advocate for the development of supporting policies);

9.1.5 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;

9.1.6 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 NPs 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 NP 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 NP 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, NPs must be alert to potential changes in a person's capacity. Where appropriate, NPs should undertake serial assessments of a person's decision-making capacity.

9.3.4 Where appropriate, NPs 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.

9.4 Grievous and irremediable medical condition[9]

9.4.1 To find a person eligible for MAID, the NP 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 NP 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] If your only medical condition is a mental illness, you are not eligible for medical assistance in dying until March 17, 2027. If you have a mental illness along with other medical conditions, you may be eligible for medical assistance in dying.

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 NP 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, 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 NP 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, NPs:

(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, NPs must be satisfied that the person's decision to request MAID has been made freely, without undue influence (contemporaneous or past) from family members, healthcare providers, or others.

9.9 NPs must be familiar with and adhere to provincial requirements relating to MAID for persons who are involuntarily hospitalized or under Supervised Community Care. Similarly, they must be familiar with and adhere to any provincial or federal requirements re: MAID for persons who are being held under a Not Criminally Responsible order or are incarcerated.

9.10 NPs as 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, NPs 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 NP-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 NP as a 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[10]); 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 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;

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

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 NP as 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;

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 NP or physician 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 NP or physician 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 less the conditions for **advanced 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 NP 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 NPs must only provide opinions on MAID eligibility that are within their scope of practice.

10.3.3 When providing opinions on MAID eligibility, NPs should respect existing ethical norms as found for example, in the Canadian Nurses Association's Code of Ethics and the Standards for the Practice of Primary Health Care Nurse Practitioners.

10.3.4 Forming an opinion about MAID eligibility may require the NP to undertake certain actions:

10.3.4.1 Obtaining health records

(a) NPs 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 NP must explain that, without such information, the assessment cannot b e 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) NPs 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 NP 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 NP 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

(a) NPs 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 NP 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 NP 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 NP or by others with relevant knowledge (e.g., social workers, the person's primary care provider) about the means of relieving suffering (e.g., community services). The NP as 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 NP as provider 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 NP as provider must ensure that they or the assessor consult with a NP or physician 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 NPs must ensure that they have the expertise necessary to provide the consultation. In doing so, they must work within their scope of practice.

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 NPs 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 NB legislation, is not grounds for involuntary psychiatric assessment or admission (see Advice to Nurse Practitioners for more detail).

11.3 NPs 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 NPs 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, NPs 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

12.1 NPs may assess a person's request for MAID and obtain consultations in relation to MAID virtually.

12.2 NPs must consider the appropriateness of using **virtual care** on a case-by-case basis, ensuring compliance with the Criminal Code (e.g., ensuring voluntariness) and that their legal and professional obligations can be met.

12.3 When assessing a person for MAID eligibility virtually, NPs must:

12.3.1 confirm the person agrees with the assessment proceeding virtually;

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

12.3.3 ensure that the assessment aligns with the provisions of the Standards for the Practice of Primary Health Care Nurse Practitioners and the Guideline for Telenursing Practice.

13.0 Waiver of Final Consent

13.1 In specific circumstances, the requirement for final consent at the time of the MAID procedure can be waived. When advanced consent has been given, MAID can be provided to the person whose natural death is reasonably foreseeable:

13.1.1 if they have been assessed and approved,

13.1.2 if they lose capacity to consent before their preferred date for MAID,

13.1.3 if they have a written arrangement with a nurse practitioner or physician; and

13.1.4 If they neither demonstrate refusal by words, sounds or gestures, nor resist the administration of the substance.

14.0 Advanced Consent – Self-Administration

14.1 Persons approved to receive MAID who choose to self-administer the substance for MAID can make an arrangement in writing with their NP or physician if complications arise after the ingestion of the substance, causing loss of decision-making capacity, but not death.

14.2 All persons who choose to self-administer a substance for the purpose of MAID can make such an arrangement with their NP, regardless of their prognosis.

14.3 The NP may administer MAID after the person has self-administered and lost the capacity to consent, but has not died;

14.3.1 if the person entered into an agreement in writing with the NP providing MAID,

14.3.2 if the NP is present at the time of self-administration,

14.3.3 if the person self-administered the first substance but did not die within the specified period and has lost capacity to consent to MAID.

15.0 Provision of MAID

15.1 NPs acting as providers must receive the substances for MAID directly from the dispensing pharmacist and must inform the dispensing pharmacist that the substances are intended for MAID.

15.2 NPs as provider must personally attend the client during the self-administration or personally administer the substances for MAID and must remain in attendance until death is confirmed. This responsibility must not be delegated or assigned to any other person.

15.3 NPs as provider are responsible for ensuring that any unused substances are returned to the pharmacy as soon as reasonably feasible, and within 72 hours of confirmation of the client's death.

(a) If a NP is not reasonably available to return unused substances to the pharmacy themselves, they may ask another NP, physician, pharmacist, or registered nurse – if supported by legislation, standards of practice, and employer policy – to return the substances to the pharmacy. The nurse practitioner must document the name of the person assigned to return the substances in the client record.

16.0 Documentation and Reporting

16.1 Documentation

16.1.1 NPs document their care appropriately in accordance with the reporting requirements set out by federal and provincial government, NANB Standards for Documentation and employer policies.

16.1.2 NPs document:
(a) The client's diagnosis and prognosis,
(b) Feasible alternatives to relieve suffering (including palliative care, pain control, and other services and supports),
(c) Options to withdraw the request for MAID at any time, and
(d) Risks of taking the prescribed substances intended to cause death.

16.2 Certification of Death

16.2.1 Certifying death[11] is a legislated act (*Vital Statistics Act*, amended April 1, 2017) and to be completed by the NP as provider of MAID wherein the Medical Certificate of Death is completed and signed, attesting to the fact, cause, and manner of the client's death.

16.3 Reporting

16.3.1 Reporting requires the collection of consistent, comprehensive information on MAID across the country by setting out reporting requirements for: health care professionals who conduct preliminary assessments of eligibility; physicians and nurse practitioners who conduct assessments of eligibility and deliver MAID; and for pharmacists and pharmacy technicians (in collaboration with a pharmacist) who dispense the necessary substances for the provision of MAID.

[11] https://www.nanb.nb.ca/wp-content/uploads/2022/08/NANB-FAQ-PronouncingAndCertifyingDeath-July21-E.pdf

16.3.2 NPs must comply with reporting requirements established for the oversight or monitoring of MAID[12] and submit reports through the Canadian MAID Data Collection Portal, which is a secure platform developed jointly by Health Canada and Statistics Canada.

[12] https://www.canada.ca/en/health-canada/services/publications/health-system-services/guidance-document-reporting-requirements-under-regulations-amending-regulations-monitoring-medical-assistance-dying.html

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.

Advanced 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).

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.[13]

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.[13]

Effective referral: taking positive action to ensure the person requesting MAID is connected in a timely manner to a non-objecting, available, and accessible NP or physician, other health-care professional, or MAID program 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 suffering due to a delay in making the connection.

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.

[13] https://www.fnha.ca/Documents/FNHA-Creating-a-Climate-For-Change-Cultural-Humility-Resource-Booklet.pdf

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.

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: the process of giving permission or making choices about care. It is based on both a legal doctrine and an ethical principle of respect for an individual's right to sufficient information to make decisions about care, treatment and involvement in research. In the *Code* the term 'informed decision-making' is primarily used to emphasize the choice involved.

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 and involves the situation where a person seeks and obtains medical help to end their life.

Mental disorder: a mental disorder is a condition as described in standard psychiatric diagnostic classification schemes such as the DSM5-TR.[14] 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.[15]

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

[15] Legislative Background Bill C-7: Government of Canada's Legislative Response to the Superior Court of Québec *Truchon* Decision.

Nurse practitioner: a registered nurse who has additional education and nursing experience. NPs are advanced practice nurses with graduate education, which enables them to autonomously diagnose and treat illnesses; order and interpret tests; prescribe medications; and perform medical procedures.

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

Provider: the NP or physician 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.

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.[16]

The interpretation of 'natural death has become reasonably foreseeable' remains the same under Bill C-7 as it was under Bill C-14.

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 and violence-informed care: creating emotionally, culturally, and physically safe services by understanding the experiences of trauma and their impacts on peoples' lives and behaviours. It also accounts for the intersecting impacts of systemic and interpersonal violence and the structural inequities on a person's life, emphasizing both historical and ongoing violence and their traumatic impacts. Key principles include: fostering trust by

[16] *2017 ONSC 3759, par. 79-80. AB c. Canada.*

offering authentic choice, collaboration, and connection; providing strengths-based and capacity-building care to support clients; and creating environments where clients do not experience re-traumatization or harm[17].

Virtual care: encompasses all means by which healthcare providers remotely interact with their client 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.

[17] Wathen, C. N., & Varcoe, C. (Eds.). (2023). *Implementing trauma- and violence-informed care: A handbook.* University of Toronto Press; https://equiphealthcare.ca/files/2021/05/GTV-EQUIP-Tool-TVIC-Spring2021.pdf

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