SUPREME COURT OF NOVA SCOTIA
Citation: Y v. Swinemar, 2020 NSSC 225

Date: 20200814
Docket: 499564
Registry: Bridgewater

Between:

Y

Applicant

v.

Schelene Swinemar, Nova Scotia Health Authority and X

Respondents

Decision

Judge:	The Honourable Justice Peter P. Rosinski
Heard:	August 7, 2020, in Bridgewater, Nova Scotia
Counsel:	Hugh Scher and Kate Naugler, for the Applicant Karen Bennett-Clayton, Mary Anne Persaud and Philip Romney, for the Respondents

By the Court:

Introduction[1]

In *Carter v Canada (Attorney General)*, 2015 SCC 5 the court was asked to strike down sections of the Criminal Code of Canada that prohibited physician-assisted dying. It did so; and through that and a subsequent decision, suspended the declaration of invalidity until June 6, 2016 in order to allow Parliament to create legislation to fill the void. In its decision the Supreme Court characterized the dispute as follows:

> 1 It is a crime in Canada to assist another person in ending her own life. As a result, people who are grievously and irremediably ill cannot seek a physician's assistance in dying and may be condemned to a life of severe and intolerable suffering. A person facing this prospect has two options: she can take her own life prematurely, often by violent or dangerous means, or she can suffer until she dies from natural causes. The choice is cruel.
>
> 2 The question on this appeal is whether the criminal prohibition that puts a person to this choice violates her *Charter* rights to life, liberty and security of the person (s. 7) and to equal treatment by and under the law (s.15). This is a question that asks us to balance competing values of great importance. On the one hand stands the autonomy and dignity of a competent adult who seeks death as a response to a grievous and irremediable medical condition. On the other stands the sanctity of life and the need to protect the vulnerable.

[1] They went on to address the remedy:

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[1] There is no ban on publication on the identities of the Applicant, Respondent, or any of the Doctors and Nurse Practitioners involved in this case as no motion for a publication ban was made. Such publication bans are possible, and some of the early cases arising after the Criminal Code provisions prohibiting medically assisted dying were struck down are instructive: *HS(Re),* 2016 ABQB 121; *AB v Canada (Atty. Gen.),* 2016 ONSC 1571; *AA (Re),* 2016 BCSC 511; *Patient v Canada (Atty. Gen.),* 2016 MB QB 63. There are likely few decisions more personal and private than engaging those involved with, and legally available to provide the service components of a lawful medically assisted dying process. Courts are expected to be sensitive to privacy interests arising in the cases before them, while mindful of the presumptive "open courts" principle which makes all court hearings open to the public, unless there are demonstrable countervailing interests to make exceptions thereto: *Dagenais v CBC*, [1994] 3 SCR 385; *R v Mentuck*, [2001]3 SCR 442; *Vancouver Sun (Re*), [2004] 2 SCR 332; *AB v Bragg Communications Inc.*, 2012 SCC 46. In this case the court has determined it appropriate to superficially anonymize the identities of the parties. Their identities may nevertheless still be gleaned by an inspection of the publicly accessible court file.

> 127 The appropriate remedy is therefore *a declaration that s. 241(*b*) and s. 14 of the* Criminal Code *are void insofar as they prohibit physician-assisted death for a competent adult person who (1) clearly consents to the termination of life; and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition. "Irremediable", it should be added, does not require the patient to undertake treatments that are not acceptable to the individual.* The scope of this declaration is intended to respond to the factual circumstances in this case. We make no pronouncement on other situations where physician-assisted dying may be sought.
>
> …
>
> 132 In our view, nothing in the declaration of invalidity which we propose to issue would compel physicians to provide assistance in dying. The declaration simply renders the criminal prohibition invalid. *What follows is in the hands of the physicians' colleges, Parliament, and the provincial legislatures.* However, we note - as did Beetz J. in addressing the topic of physician participation in abortion in *Morgentaler* - that a physician's decision to participate in assisted dying is a matter of conscience and, in some cases, of religious belief (pp. 95-96). In making this observation, we do not wish to pre-empt the legislative and regulatory response to this judgment. Rather, we underline that the *Charter* rights of patients and physicians will need to be reconciled.
> [My italicization added]

[2] Y and X respectively are wife and husband. They are both in their early 80s and have been married for almost 50 years.

[3] X has stage III COPD and other medical conditions that he asserts have made him eligible for “Medical Assistance in Dying”, or MAID. That procedure, chosen by X, was scheduled to take place on July 20, 2020. It was permitted to be scheduled because it was in accordance with the Nova Scotia Health Authority’s “Interdisciplinary Clinical Policy and Procedure titled Medical Assistance in

Dying" (the MAID Policy") which became effective August 7, 2019. I attach some of the more important of those documents as Appendix "A" hereto.[2]

[4] This proceeding is an Application in Court started by Y.[3]

[5] She seeks "a permanent and interlocutory injunction enjoining the Respondents from carrying out an assisted suicide of [X]… A declaration that [X] does not meet the legal requirements to permit an assisted suicide according to

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[2] I believe this may be the first case of its kind to be disputed in Nova Scotia. In its two decisions, *Carter v Canada (Atty. Gen.)*, 2015 SCC ["*Carter 2015*"] and 2016 SCC 4 ["*Carter 2016*"] the Supreme Court of Canada agreed that sections 14 and 241(b) of the Criminal Code of Canada which prohibited such procedures were unconstitutional, and explained what fundamental requirements must be met before individuals could take advantage of such procedures, and when its suspension of the invalidity of those sections would be effective. Ultimately those sections remained effective until June 6, 2016. Thereafter, Parliament enacted amendments to the Criminal Code, effective June 17, 2016 permitting MAID: sections 241, 241.1, 241.2, 241.3, and 241.31. In summary, although anyone who counsels a person to die by suicide or aids or abets a person to die by suicide commits a criminal offence, whereas when medical assistance in dying procedures as per the MAID Policy are followed, which would thereby comply with the conditions in s. 241.2 Criminal Code, such assistance is legally permissible. The status of MAID during the Supreme Court of Canada's suspension of invalidity periods pending legislation to permit same by Parliament, was considered in a number of decisions before the effective date of the present sections 241- 241.31: see in particular those of Justice Sheilah Martin (as she then was) : *S. (H.), Re*, 2016 ABQB 121; and Justice Perell : *B.(A.) v Canada (Atty. Gen.)*, 2016 ONSC 1912; and *B.(A.) v Canada (Atty. Gen.)*, 2017 ONSC 3759; *J.(I.) v Canada (Atty. Gen.)*, 2016 ONSC 3380.

[3] Persons seeking MAID are free to choose whether to reveal to others that they are doing so. However, some very private persons may wish that information to be known only to service providers, even to the exclusion of their own family and friends. In this case, X shared his interest and then intention to seek MAID with his wife. She is now in the process of challenging his intention to do so. While it was not raised as a preliminary issue herein, and I conclude that in these circumstances Y likely has standing to request the sought after relief, the question of "who has standing?" may well be a significant consideration in other circumstances. See, for example, cases where an individual is incapable of making decisions regarding a "do not resuscitate" order (possibly absent a binding legal directive authorized by them while they were capable- although I note that in Nova Scotia the MAID policy of the NSHA states that paragraph 1.2: "note: physicians/nurse practitioners cannot act on a request for MAID: set out in a personal directive or similar document;[or] on the direction of anyone other than the capable patient.") - *Sawatzky v Riverview Health Center Inc*., (1998) 132 Man. R. (2nd) 222 (QB); *Golubchuk (Committee of) v Salvation Army Grace General Hospital*, (2008) 290 DLR (4th) 46 (Man QB); *Jin v Calgary Health Region*, (2008) 82 Alta. L. R. (4th) 36 (QB). In *McKitty v. Hayani*, 2019 ONCA 805, the parents of a neurologically deceased child challenged the constitutionality of statutory and common law approaches to defining death. The court (at footnote 1) commented that the application judge decided to proceed as though the substitute decision-makers/parents of the deceased had standing and that aspect of the judgement was not appealed. There may also be questions raised about whether those seeking to exercise their right to MAID, have a positive l*egal* obligation to advise anyone, including their family of their intentions- see for example the reasons in *(S.) H. (Re),* and *AB* 2016 ONSC 1912.

Canadian law and particularly that he does not suffer from a grievous and irremediable medical condition and that his death is not reasonably foreseeable".[4]

[6] I am satisfied that regarding this "legal" dispute, although their positions are at odds in what properly can be characterized as a "life or death" decision, both X and Y are acting with what they each sincerely believe is in the best interests of X.

[7] I am further satisfied that this is not a proper case for an interlocutory injunction that would prevent X from continuing to exercise his constitutional right to the availability of MAID.

[8] I therefore dismiss Y's motion for an interlocutory injunction.

Procedural history

[9] On July 31, Justice Campbell of this Court heard an *ex parte* motion, ordered an interim injunction forestalling re-scheduling of the MAID procedure sought by X, and set the matter for August 7 so notice could be provided to the parties

[4] As is evident from my earlier footnote, it is a misnomer to characterize "medical assistance in dying" as "suicide" – the former is lawful- and the latter is unlawful. On the other hand, in *Carter* 2015 the Court did use the descriptor "assisted suicide" in its reasons, although their use of "physician-assisted death" was more prevalent.

entitled thereto. On August 7, all the parties were present and argued fully whether the interim injunction should be continued as an interlocutory injunction.[5]

[10] This proceeding has not yet been set down for a full hearing on the merits. However, based on the present positions of the parties, and the continuing implications of Covid 19's disruption to court operations which have created great backlogs of matters (particularly time sensitive criminal proceedings) requiring hearings in the near future, I agree with counsel for NSHA that for a full hearing, (an optimistic estimate is) the earliest dates for hearing will be in the late fall of 2020, and I conclude it could be as late as early Spring of 2021 before the hearing

[5] This court's power to grant injunctions arises through a combination of the powers derived from section 43(9) *Judicature Act*, RSNS 1989, c. 240, and the common law "inherent jurisdiction" of a superior court (see Justice Bryson's statements in *Maxwell Properties Ltd. v Mosaik Property Management Ltd.*, 2017 NSCA 76, at para. 19), and our Civil Procedure Rule 41-Interlocutory Injunction and Receivership-see CPR 41.02(7). Rule 41.01 provides the following definitions – "interim injunction and "interim receivership" mean an order for an injunction or receivership effective before a motion for an interlocutory injunction or interlocutory receivership is determined; "interlocutory injunction" and "interlocutory receivership" mean an order for an injunction or receivership granted on notice of motion and effective before the trial of an action or hearing of an application to which the interlocutory injunction or interlocutory receivership relate." I bear in mind that Y's counsel has argued that generally for disputes such as those regarding whether a person has suffered a "neurological death", affected parties often resort to courts for a resolution thereof, and that courts should determine the issue based on its *parens patriae* jurisdiction which assesses the dispute from the basis of what is in the best interests of the individual (eg. see the comments of Justice Beard in *Sawatzky* at paras. 14-16 and 38 which was adopted in *Golubchuk v Salvation Army Grace General Hospital*, 2008 MBQB at para. 13; and *AM v Benes*, (1999) 46 OR (3d) 271 at para. 40 per Abella, Moldaver and Laskin,JJA ; *and Rasuoli v Sunnybrook Health Sciences Centre*, 2013 SCC 53 at para. 1-4, which was focused upon the Ontario statutory scheme for resolving such disputes by applying to the Consent and Capacity Board.

is concluded. Certainly, all of the procedural steps proposed by Y's counsel will extend when the earliest date that the hearing can take place.[6]

The requirements for an interlocutory injunction

[11] In order to obtain an interlocutory injunction, Y must satisfy the court of each of the following, namely that:[7]

1. there exists a serious question/issue(s) to be considered: is the approval of the MAID-process regarding X lawful?
   [I am so satisfied]

[6] I recognize that no Notice of Contest (s) per CPR 5.08 have been filed yet, but bearing in mind that counsel have been responded in writing to questions posed by the court based upon CPR 5.13 – motion for directions, I am able to approximate when this matter might be heard on the merits. Counsel for X responded that: "At this time, I will be representing [X] until Friday, August 14, 2020. X will not be taking an active part in this proceeding after that date." Counsel for Y responded: that a full hearing on the merits would require "including examinations and cross examinations in court, perhaps five – seven days, otherwise just one day for hearing… We seek full documentary disclosure from Health Authority and all assessors. We also require the clinical notes and records from X's practitioners including Dr [DT], [NP S] and Dr. [D]… In addition to the assessors who have produced reports in brief of Health Authority, we would seek to cross-examine John McCarthy Director of MAID program in Nova Scotia. We also seek an independent psychiatric assessment to be conducted by an independent psychiatric/capacity assessor as agreed between the parties or selected by the court, or alternatively a follow-up assessment by Dr. [D], the geriatric psychiatrist by Zoom. We anticipate to examine Dr. [D] and NP [G]… We would seek to cross-examine X, Dr.[D], NP[G], Drs. [M], [C], [M] and [H]; and John McCarthy of Health Authority and possibly Dr. [D] and/or independent psychiatric assessor." When asked by what dates at the earliest and latest does each party believe the matter can be ready for a hearing on the merits, counsel for Y responded: "I believe a hearing on the merits could be possible as early as August 24, latest date, September 14." Counsel for NSHA responded that they does not anticipate cross-examining nor discovering Y or Dr. CB. Regarding the timeline, "the NSHA does not agree with Mr. Scher's estimate of August 24 as the earliest date this matter can be ready for hearing on the merits. The NSHA believes that at the earliest it will be at least mid-to-late October 2020 before this matter could be ready for hearing on the merits and at the latest, could be towards the end of the year [2020]."

[7] As noted in *Sharpe on Injunctions and Specific Performance*, Thomson Reuters Canada Limited – Canada Law Book, looseleaf updated to November 2019 at page 2-2: "It is important to keep in mind that the principles discussed in this chapter in relation to pretrial injunctions are not applicable where the Court is asked to make a final determination after trial as to whether an injunction should be granted."

2. Y, who seeks the injunction, will suffer irreparable harm (refers to the nature of the harm suffered rather than its magnitude – which either *cannot be quantified* in monetary terms *or* which *cannot be cured*, if the injunction is not granted);

   [In her written brief at para. 47, Y puts her position as: "if the injunction is denied, [Y] will lose her husband of 48 years unduly and this application will become moot as [he] will be dead. This is the ultimate irreparable harm and mitigates strongly in favour of granting this injunction." While arguably Y could sue for wrongful death and, if successful, receive damages for her loss of X-given that X is otherwise presently constitutionally entitled to exercise his choice and schedule his MAID almost immediately, if this court concludes that the injunction should not be continued, then the dispute at issue here would become qualitatively moot, and so I am satisfied Y would suffer irreparable harm.]

3. that Y would suffer the greater harm, if the injunction is not granted, as compared with the harm X will suffer if the injunction is granted (the so-called "balance of convenience").

> [I am NOT so satisfied – I conclude that there is significant compelling evidence that X has reasonably been determined to have "a grievous and irremediable medical condition" as defined in section 241.2 (2) of the Criminal Code of Canada, and that the other eligibility conditions have been met. X is constitutionally entitled to take this course of action, and given that he has some level of ongoing dementia, which could, by itself or in addition to other phenomena such as cerebrovascular disease, render him incapable, and therefore no longer qualified to consent to his presently chosen MAID process, there is a real risk here that he will be deprived of his present choice. He has also been found by MAID assessors to be presently enduring "a grievous and irremediable medical condition and his natural death has become reasonably foreseeable, taking into account all of his medical circumstances". Further delay entails further suffering for X. I conclude he would suffer irreparable harm if the injunction is granted. On balance, the harm he would suffer is significantly greater than what his wife would suffer.]

[12] Y, who has the evidentiary and persuasive burden, has argued for a continuation of an injunction until the full merits are heard.

[13] X argues that he has complied with the MAID legislation and Nova Scotia Health Authority policy, and that he should be permitted to exercise his constitutional rights, and immediately continue that process.

Evidence before the court[8]

[14] On behalf of Y are the filed affidavits of herself, and Dr. CB.

[15] Counsel for X argues that these affidavits suffer from significant deficiencies.

[16] Our Civil Procedure Rule 39 addresses the use of affidavits:

> **Rule 39 - Affidavit**
>
> **Scope of Rule 39**
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> **39.01** A party may make and use an affidavit, and a judge may strike an affidavit, in accordance with this Rule.
>
> **Affidavit is to provide evidence**

[8] X has decided not to file an affidavit. I draw no adverse inference therefrom. He has engaged the MAID process and been approved. There is compelling evidence that he has the capacity required (in his case by multiple assessors). His eligibility is determined exclusively by the assessors and related qualified personnel once he has given his consent. The matter in dispute before me is whether an interlocutory injunction should issue to supersede the interim injunction preventing X from immediately being eligible for and exercising his right to MAID. Thus, evidence presented to me should be relevant to *that decision*. While the arguments referenced the lawfulness of X's having been found eligible for MAID, it is not my function to determine that issue at this time. Nevertheless, the evidence in the record related to X's eligibility for MAID, and his medical history, are relevant to whether there is a serious question/issues to be considered and under the "balance of convenience" analysis regarding consideration of the harm which X would suffer if the injunction is continued.

39.02 **(1)** A party may only file an affidavit that contains evidence admissible under the rules of evidence, these Rules, or legislation.

(2) An affidavit that includes hearsay permitted under these Rules, a rule of evidence, or legislation must identify the source of the information and swear to, or affirm, the witness' belief in the truth of the information.

Editing exhibit

39.03 **(1)** A party must edit out personal information not required to prove or disprove a fact in issue from an exhibit attached to, or referred to in, an affidavit to be filed by the party.

(2) A party who edits information from an exhibit must do so in such a way that the reader of the exhibit sees where text has been edited out, such as by obliterating text on part of a page, leaving a shaded blank in the text of electronic information, or inserting a note that indicates a number of pages or a quantity of text has been removed.

(3) The party must, on demand, produce the unedited document or electronic information for inspection by another party.

Striking part or all of affidavit

39.04 **(1)** A judge may strike an affidavit containing information that is not admissible evidence, or evidence that is not appropriate to the affidavit.

(2) A judge must strike a part of an affidavit containing either of the following:

(a) information that is not admissible, such as an irrelevant statement or a submission or plea;

(b) information that may be admissible but for which the grounds of admission have not been provided in the affidavit, such as hearsay admissible on a motion but not supported by evidence of the source and belief in the truth of the information.

(3) If the parts of the affidavit to be struck cannot readily be separated from the rest, or if striking the parts leaves the rest

difficult to understand, the judge may strike the whole affidavit.

(4) A judge who orders that the whole of an affidavit be struck may direct the prothonotary to remove the affidavit from the court file and maintain it, for the record, in a sealed envelope kept separate from the file.

(5) A judge who strikes parts, or the whole, of an affidavit must consider ordering the party who filed the affidavit to indemnify another party for the expense of the motion to strike and any adjournment caused by it.

Form of affidavit

39.08 **(1)** An affidavit must be entitled "Affidavit" and the title may include other words to distinguish it from other affidavits, such as including the name of the witness who swears or affirms the affidavit, the date it is sworn or affirmed, or the word "supplementary".

(2) An affidavit must contain the standard heading, and include all of the following:

(a) the opening, identifying the witness and showing that the witness is giving sworn or affirmed evidence;

(b) the witness' statement, by which the relationship of the witness to the proceeding is stated, and the witness swears or affirms that the affidavit contains only information based on personal knowledge, or hearsay with a statement of the source and the witness' belief of the information;

(c) the body, providing the main evidence, with each sentence set out separately and numbered and with references to exhibits by letter, number, or other identifier;

(d) a jurat showing that an oath or affirmation was administered, and the date and place when and where the witness personally appeared before the authority administering it;

(e) the printed name and official capacity of the authority administering the oath or affirmation.

(3) An exhibit that can be attached conveniently to the affidavit must be attached when it is sworn or affirmed, and an exhibit that cannot be

attached conveniently must be filed with the affidavit.

(4) The pages of a long exhibit must be numbered, and ten or more exhibits attached to the same affidavit must be separated by a numbered or lettered tab.

(5) An affidavit with ten or more exhibits must include, before the exhibits, a table of contents identifying each exhibit and its tab number or letter.

(6) An affidavit may be in **Form 39.08**.

Proof of exhibit

39.09 **(1)** A party who files an affidavit that includes an exhibit must ensure that the authority who administers the oath or affirmation marks the exhibit so it is clear that it is the exhibit referred to in the affidavit.

(2) An exhibit is adequately marked if the following are placed on, or attached to, the exhibit and the exhibit is signed by the authority administering the oath or affirmation:

(a) the registry number;

(b) the number, letter, or other identifier by which the exhibit is referred to in the affidavit;

(c) the name of the witness;

(d) a reference to the witness' oath or affirmation;

(e) the date the affidavit is sworn or affirmed.

(3) The writing that marks an exhibit may be in **Form 39.09**.

[17] Rule 5.17 deals with evidence on an application:

Rules of evidence on an application

5.17 The rules of evidence, including the rules about hearsay, apply on the hearing of an application and to affidavits filed for the hearing except a judge may, in an *ex parte* application, accept hearsay presented by affidavit prepared in accordance with Rule 39 - Affidavit.

[18] Counsel for X suggests that the affidavit of Y contains a great deal of objectionable hearsay.

[19] In large measure the facts recorded in Y's affidavit are matters of which she has direct or reliable indirect knowledge. Importantly, X permitted Y to be involved in the process he pursued to obtain MAID thus she has some direct knowledge of the circumstances. I bear in mind that I also have the benefit of the affidavit filed by the NSHA which confirms portions of the factual information contained in Y's affidavit.

[20] On the other hand, Y's affidavit clearly has elements that suggest she may be motivated to present only evidence that supports her position as a person who is morally opposed to "assisted suicide".[9]

[9] The evidence presented shows that Y from the beginning has consistently advocated to X that he not exercise his right to MAID. Her efforts have attracted the attention of assessors who are clearly concerned that she is unduly attempting to interfere with X's private choice to exercise his right to MAID- see eg. Dr Martell's Report ("he became upset when his wife suggested that he should pursue follow-up spirometry testing and echocardiography recommended at the time of his most recent hospitalization and became more upset when she suggested he see a psychologist… to help him manage the distress that comes with his subjective shortness of breath."); and Dr. Miller's Report: "[Y] was cordial but angry from the outset of our interaction. She used the word 'murder'… and repeatedly referenced that [NP Swinemar] is 'trying to put [X] down'… I noted that when [X] attempted to speak that she immediately responded with negative comments or rebuttals refuting his descriptions of his own experience.… She stated repeatedly 'he has not exhausted all options'… When I explained that [X] has the capacity to make his own health related decisions… she expressed that she is not accepting of this approach." She leaves the court with the sense that her factual statements may be presented in a manner that best supports her position on the issue before the court.

[21] Nevertheless, her affidavit is clearly oriented toward facts that are arguably relevant to the lawfulness of the decision to permit X to proceed with MAID-most significantly whether he has the capacity to make rational and informed decisions about his health and the question of physician-assisted death and whether his circumstances fulfil the criteria: that he has a "grievous and irremediable medical condition", and in particular whether his natural death has become "reasonably foreseeable", taking into account all of his medical circumstances, without a prognosis necessarily having been made as to the specific length of time that he has remaining.

[22] I will not strike any portions of her affidavit but will give no weight or diminished weight appropriately to those objectionable statements made by her.

[23] X's counsel also objects to the affidavit of Dr. CB.

[24] Insofar as he purports to give expert opinion, his curriculum vitae notes that he graduated from Dalhousie Medical School in Halifax, Nova Scotia and received his MD in June 1993 and that he was certified in Family Medicine as of June 8, 1995 in Canada, but it does not show him having any license to practice medicine in Canada since that time. He also questioned how much opportunity Dr. CB has

had to interact with X in person, particularly recently, other than a July 29, 2020 telephone conversation.

[25] Moreover, he is not qualified to assert that "[X] has suffered from a lifelong psychiatric disorder… He is now suffering from a powerful delusional thought process as it applies to an age-appropriate disease burden… None of these processes are likely to cause death in the reasonably foreseeable future. [X] is suffering. His desire for urgent euthanasia stems not from the above medical conditions but from a treatable psychiatric condition – hypochondriasis with severe anxiety."

[26] I accept these arguments – Dr. B is not a licensed psychiatrist, even in the United States. He is not a licensed doctor in Canada. He has very limited recent contact with X. It is entirely unclear when he last saw X in person. I give no weight to the purported expert opinion evidence contained in his affidavit. I will consider his factual evidence therein, but find it of minimal weight, particularly when contrasted with the very recent medical opinions and observations of X made by doctors licensed to practice medicine in Nova Scotia. Moreover, he has not had access to all the records regarding X that they have.

[27] NSHA has filed an extensive affidavit from the Interim Director for MAID in Nova Scotia. Therein she chronicles the MAID process which X has engaged since April 15, 2020, and attaches the NSHA's MAID Policy, effective August 7, 2019.[10]

[28] Y's counsel objects to this affidavit on the basis that it contains only hearsay factual documentation in relation to X's circumstances as he progressed through the MAID process. On the other hand, Y's counsel was quite prepared to rely on evidence therein that buttressed his client's case – he pointed to the evidence of NP Giffin and that of Dr. du Toit.

[29] I conclude that the NSHA affidavit in its entirety is admissible either as "business records" pursuant to section 23 of the *Evidence Act,* c. 154 RSNS 1989, as amended, and pursuant to the common law "business records" exception, articulated by the Supreme Court of Canada in *Ares v Venner*, or as an exception to the hearsay rule (as being necessary and reliable), captured in the recent canvas of

[10] In matters involving policies relied upon by decision-makers in the judicial review context, in Nova Scotia courts generally must find authority for those policies in legislation or subordinate legislation (regulations)- *Pratt v Nova Scotia (Attorney General),* 2020 NSCA 39 at para.91. On the other hand, in the *Christian Medical and Dental Society of Canada v. College of Physicians and Surgeons of Ontario,* 2018 ONSC 579, which involved a challenge to the (Charter of Rights based) constitutional validity of two policies of the College, Justice Wilton-Siegel was satisfied that the policies "establish limits prescribed by law that may be subject to the *Oakes* analysis" (at para. 136) because as the College argued, the policies "are norms or standards of general application for the medical profession that are sufficiently precise, accessible and binding to constitute "laws" to which section 1 of the Charter can apply."

the law articulated by Justice Beveridge in *R v Keats*, 2016 NSCA 94 at paras. 108-131.

The sections of the Criminal Code relating to MAID

[30] The following sections of the Criminal Code of Canada provide for the exemption for persons involved in rendering medical assistance in dying:

> *Counselling or aiding suicide*
>
> 241 (1) Everyone is guilty of an indictable offence and liable to imprisonment for a term of not more than 14 years who, whether suicide ensues or not,
>
> (a) counsels a person to die by suicide or abets a person in dying by suicide; or
>
> (b) aids a person to die by suicide.
>
> *Exemption for medical assistance in dying*
>
> (2) No medical practitioner or nurse practitioner commits an offence under paragraph (1)(b) if they provide a person with medical assistance in dying in accordance with section 241.2.
>
> *Exemption for person aiding practitioner*
>
> (3) No person is a party to an offence under paragraph (1)(b) if they do anything for the purpose of aiding a medical practitioner or nurse practitioner to provide a person with medical assistance in dying in accordance with section 241.2.
>
> *Exemption for pharmacist*
>
> (4) No pharmacist who dispenses a substance to a person other than a medical practitioner or nurse practitioner commits an offence under paragraph (1)(b) if the pharmacist dispenses the substance further to a prescription that is written by such a practitioner in providing medical assistance in dying in accordance with section 241.2.

Exemption for person aiding patient

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

Clarification

(5.1) For greater certainty, no social worker, psychologist, psychiatrist, therapist, medical practitioner, nurse practitioner or other health care professional commits an offence if they provide information to a person on the lawful provision of medical assistance in dying.

Reasonable but mistaken belief

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

Definitions

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

Definitions

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

medical assistance in dying means

(a) the administering by a medical practitioner or nurse practitioner of a substance to a person, at their request, that causes their death; or

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

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

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

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

Eligibility for medical assistance in dying

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

(a) they are eligible-or, but for any applicable minimum period of residence or waiting period, would be eligible-for health services funded by a government in Canada;

(b) they are at least 18 years of age and capable of making decisions with respect to their health;

(c) they have a grievous and irremediable medical condition;

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

(e) they give informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care.

Grievous and irremediable medical condition

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

(a) they have a serious and incurable illness, disease or disability;

(b) they are in an advanced state of irreversible decline in capability;

(c) that illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and

(d) their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining.

Safeguards

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

(a) be of the opinion that the person meets all of the criteria set out in subsection (1);

(b) ensure that the person's request for medical assist-ance in dying was

(i) made in writing and signed and dated by the person or by another person under subsection (4), and

(ii) signed and dated after the person was informed by a medical practitioner or nurse practitioner that the person has a grievous and irremediable medical condition;

(c) be satisfied that the request was signed and dated by the person-or by another person under subsection (4)-before two independent witnesses who then also signed and dated the request;

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

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

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

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

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

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

Unable to sign

(4) If the person requesting medical assistance in dying is unable to sign and date the request, another person-who is at least 18 years of age, who understands the nature of the request for medical assistance in dying and who does not know or believe that they are a beneficiary under the will of the person making the request, or a recipient, in any other

way, of a financial or other material benefit resulting from that person's death-may do so in the person's presence, on the person's behalf and under the person's express direction.

Independent witness

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

(a) know or believe that they are a beneficiary under the will of the person making the request, or a recipient, in any other way, of a financial or other material benefit resulting from that person's death;

(b) are an owner or operator of any health care facility at which the person making the request is being treated or any facility in which that person resides;

(c) are directly involved in providing health care serv-ices to the person making the request; or

(d) directly provide personal care to the person making the request.

Independence-medical practitioners and nurse practitioners

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

(a) are not a mentor to the other practitioner or responsible for supervising their work;

(b) do not know or believe that they are a beneficiary under the will of the person making the request, or a recipient, in any other way, of a financial or other material benefit resulting from that person's death, other than standard compensation for their services relating to the request; or

(c) do not know or believe that they are connected to the other practitioner or to the person making the request in any other way that would affect their objectivity.

Reasonable knowledge, care and skill

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

Informing pharmacist

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

dispenses the substance, inform the pharmacist that the substance is intended for that purpose.

Clarification

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

Failure to comply with safeguards

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

(a) an indictable offence and liable to imprisonment for a term of not more than five years; or

(b) an offence punishable on summary conviction.

Forgery

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

Destruction of documents

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

(a) another person's access to medical assistance in dying;

(b) the lawful assessment of a request for medical assistance in dying;

(c) another person invoking an exemption under any of subsections 227(1) or (2), 241(2) to (5) or 245(2); or

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

Punishment

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

> (a) an indictable offence and liable to imprisonment for a term of not more than five years; or
>
> (b) an offence punishable on summary conviction.
>
> *Definition of document*
>
> (4) In subsection (2), *document* has the same meaning as in section 321.

A summary of the significant evidence

[31] The key questions *ultimately* in dispute will be whether[11]

1. X has the capacity to make decisions regarding the MAID processes, and
2. he in fact suffers from "a grievous and irremediable medical condition that renders his death reasonably foreseeable" per para. 70 of Y's affidavit.

[32] Y argues that the mere fact that some of the multiple assessors who have seen X have differed on these two issues strongly suggests injunctive relief is appropriate.

[33] Y notes that X has been seen by the following assessors (X signed the first Request for and Consent to Medical Assistance in Dying form on April 22, 2020, wherein he stated he believed that he was suffering from "end stage COPD, a

[11] As noted earlier my focus must be on whether the preconditions for an interlocutory injunction have been established.

grievous and irremediable medical condition from which my natural death has become reasonably foreseeable…" which was witnessed by two persons):

[34] **NP S-**on April 22, 2020 she authored the first physician/nurse practitioner assessment and indicated he was capable of making decisions with respect to medical assistance in dying, and he has a grievous and irremediable medical condition and his natural death has become reasonably foreseeable, taking into account all of his medical circumstances.

[35] **NP G-**on April 30 she authored the second physician/nurse practitioner assessment and indicated on the form that he was **not capable of making decisions with respect to medical assistance in dying,** and that she was **not satisfied that he had a grievous and irremediable medical condition and his natural death has become reasonably foreseeable, taking into account all of his medical circumstances.** She authored a separate written report in which she elaborated that "I do not feel he is capable of making decisions regarding MAID due to dementia… He has a grievous progressive and incurable illness (dementia/COPD) but I do not feel that death is foreseeable."

[36] **Dr. Chisholm –** Psychiatrist- on May 8, 2020 authored a clinic letter in which she wrote: "was assessed today… This consultation was for an opinion on

his capacity to make a decision about MAID, as well as his eligibility for MAID…. Cognitive Impairment-he was previously assessed by Dr. D of geriatric medicine… in July 2019.… Her assessment was that he was experiencing some mild depression and she suspected mild Alzheimer disease but could not confirm the diagnosis at that time."… Past Medical History – … He has good insight into the symptoms, functional limitations, and options for treatment for his illness (COPD) and intact judgement. Cognition – cognition was assessed today using a telephone MMSE and he scored 21/23 losing two points for delayed recall. On abstraction he got 3/3.… Capacity – [he] consistently stated his choice was to have medical assistance in dying. He had a factual understanding of his illness and understood that there was no other treatment that would cure his disease or improve his symptoms that are acceptable to him. He finds it intolerable and extremely stressful to be so short of breath and fatigue throughout his day, and unable to function in the way that he wants to… He wants to avoid a painful death…

Assessment

1. Capacity – [he] does have capacity to make a treatment decision regarding MAID, based on our assessment today.
2. He does have a grievous and a remedial medical condition, and we have asked you to arrange an urgent reassessment from his

respirologist, to confirm that a natural death has become reasonably foreseeable, given the recent decline in worsening of his symptoms over the last few months.

3. Cognitive Impairment – he does have some cognitive impairment on testing today which has been present on previous testing reviewed. Although it is likely that he has a mild cognitive impairment, he does not have a major Neuro- Cognitive Disorder (Dementia). His cognitive status is not impairing his ability to consent for MAID.

4. Mood –… He is not clinically depressed. There is no evidence of any psychosis or delusional thought content either.

Plan

1. Respirology to reassess to his COPD status to provide their opinion on if his natural death has become reasonably foreseeable.

2. as long as the Respirologist's assessment is in agreement with above, we will complete the second MAID assessment."

[37] **Dr. du Toit –** Respirologist – authored a May 14, 2020 report in which he wrote: "… I have known him only for about nine months in total and met him first on 9 August 2019. Active Diagnosis: stage III COPD, chronic asthmatic with resulting COPD; severe dyslipidemia with cerebral ischemia and moderate cerebral

atrophy; number of lacunar infarcts in the caudate and lentiform nuclei… Definite dementia with a MOCH score recently calculated at 23/30… I personally think that he is depressed as well with a significant anxiety underlying component…

[38] Physical examination: He is a rather weak man of 83 years old. He gets out of his wheelchair with great difficulty and walks pretty wobbly and is unsteady on his feet due to muscle weakness… Respiratory: there is moderate to severe obstructive airflow with hyperresonance to percussion and decreased airflow in keeping with an FEV1 around 40%.…

[39] Opinion and Plan: This man's lung function over the past six years has not deteriorated with an FEV1 in 2014 was 37% and today is 37%.… I would judge his COPD at level III days with Gold Class B and I do not at this stage see him as a man who is going to die from his COPD in the foreseeable future… Unfortunately, the law regarding MAID it is rather vague stating that the person should be dying in the foreseeable future. I unfortunately have no idea what that means; although I do not see that [he] will die from his lungs in the next year. That however is never sure with the Covid 19 and other respiratory tract infections. I am willing to reassess his lung function, arterial oxygenation and six minute walk test and I will set that up and try to give you some more accurate information."

[40] **Dr. Martell** – Addiction Medicine Physician – authored a July 11, 2020 report entitled Medical Assistance in Dying Consultation. He wrote: "…[X]tired after about 20 minutes of sustained conversation and started at times to close his eyes to give responses… I did notice the fatigue. At no time did he have trouble with articulation… [X reports that] he has a constant awareness of being out of breath. This also happens suddenly at night, waking him from sleep… [X] is aware that he needs to be capable of requesting this procedure both at the time of assessment and the time of the procedure itself and that loss of decision-making capacity will halt the process… He has little interest in pursuing more diagnostic testing and does not want to explore palliative care options to help him manage his symptoms. He became upset when his wife suggested that he should pursue follow-up spirometry testing and echocardiography recommended at the time of his most recent hospitalization and became more upset when she suggested that he see a psychologist… To help him manage the distress that comes with his subjective shortness of breath. When asked about his thoughts on these options, [X] told me he would like to proceed with assisted dying.…

Summary:

1. this patient has decision-making capacity to decide to undergo Medical Assistance in Dying.

2. he has a grievous and irremediable condition, cerebrovascular disease.
3. he tells me his decision is not being coerced.
4. he is over the age of 18.
5. Medical Assistance in Dying provision is being considered and other options for care were reviewed.
6. his death is reasonably foreseeable according to his primary care provider, who knows him best [reference to NP S]. The challenge here has been to try to figure out what limits his life expectancy. His severe lung disease does not, according to his pulmonologist. From what I can tell, it is his cerebrovascular disease that is creating the behavioural and distressing symptoms that is progressing rapidly. He is not interested in trying to get more clarity on his condition and I agree that the likelihood of uncovering something reversible is very remote.

Plan:

…

7. [X's] disease process may interfere with his decision-making capacity. It seems to have already done this on one occasion, although I deem him to have capacity by my assessment today…"

[41] Dr. Martell completed the first physician/nurse practitioner assessment that same day and found X to be eligible for MAID. That is he agreed that X is "capable of making decisions with respect to medical assistance in dying" and "he has a grievous and irremediable medical condition and his natural death has become reasonably foreseeable taking into account all of his medical circumstances"

[42] On July 16, 2020 X signed a second Request for and Consent to Medical Assistance in Dying form, wherein he stated that he believed that he was suffering from "brain disease, a grievous and irremediable medical condition from which my natural death has become reasonably foreseeable", which was also witnessed by two persons. Dr. Miller noted that in each circumstance the referred to "end stage COPD" and "brain disease" was inserted by X rather than his treating providers.

[43] **Dr. Miller** – Department of Internal Medicine- On July 21, 2020 the first physician/nurse practitioner assessment was completed by Dr. Miller. She also authored a lengthy MAID Consultation Letter dated July 21, 2020. Therein, she agreed that she would not be surprised to learn that X had died naturally in the coming year if he did not have access to MAID.

[44] She stated in her report: “in terms of my capacity assessment, I am confident that [X] has the capacity to make decisions related to his own health and specifically medical assistance in dying based on multiple observations including the following…

[45] She continued: “in exploring [X’s] rationale for pursuing MAID , he recounted a precipitous decline over the past 6 to 8 months… He describes extreme suffering related to his breathlessness as it limits his activity… results in extreme fatigue… and causes him existential distress (“I have lost my sense of purpose”… due to the physical suffering). He reports that over the past several months his dyspnea has resulted in the considerable loss of his function in terms of inability to do activities previously important to him… Loss of appetite and weight… and significantly slowed mobility.… He feels strongly that MAID is the only definitive means of ending his suffering at this time. I again offered [X] further investigation to provide diagnostic clarity related to the potential that his symptoms may be related to something other than his known Gold Stage 3/severe COPD. He declined an offer and confirmed that no further investigation is acceptable to him at this point.… It took him approximately three minutes to walk that 15 m distance. When I inquired if he could have walked faster than that he stated ‘no’. He was very breathless following the walk.… He had visible increased work of breathing was

shallow breaths, accessory muscle use, and a prolonged expiratory phase. [X] was visibly fatigued throughout the assessment… Reports that he currently weighs 122 pounds on a 5'7" frame… This represents a significant loss over recent years from his lifelong baseline of 155 pounds…

[46] I explained to [X] following this comprehensive assessment that it is my impression that he meets the legal criteria for MAID. In terms of the legal requirements relating to the determination of a 'grievous and irremediable medical condition', I concluded that his progressive frailty and severe COPD meet all of the required criteria. Firstly, COPD is a 'serious and incurable disease'. Secondly, [X] is in 'an advanced state of irreversible declining capability' as evidenced by his loss of function over the past months. Thirdly, [X's] COPD related dyspnea is the cause of 'enduring physical AND psychological suffering that is intolerable to HIM and cannot be relieved under conditions that he finds acceptable.' Finally, I am confident that [his] 'natural death has become reasonably foreseeable' related to his progressive frailty that appears to be driven by his end stage COPD and associated dyspnea. I asked myself the 'surprise question' of whether …I would be surprised to learn that [X] had [not] died naturally in the coming year if he did not have access to MAID. My answer is yes.

[47] Of note, COPD prognostication is a complex endeavour. Based on my extensive experience providing hospital-based care to patients with end-stage COPD, as well as a knowledge of the prognostic literature, there is a significant variability in disease trajectory.… There is no single measure that can accurately define life expectancy, nor is an estimation of remaining lifespan a requirement in concluding that death is 'reasonably foreseeable'. One validated prognostic tool in COPD is the BODE Index. [X's] BODE Index is nine points… This constitutes the highest risk category… This objective measures only noted here to validate my global impression of [X's] severe COPD constituting 'end-stage' disease.… I therefore at the end of our visit invited [Y] to join us. I summarized the information offered to [X]… I explained to her my conclusion that he meets the legal criteria for MAID on the basis of his progressive frailty and severe COPD. I explained that although his history of cerebrovascular disease certainly contributes to his overall status, that I did not have the impression based on my assessment today that it was a major driver of his symptom burden or functional decline.… Given the complexity of the situation and specifically the medical legal threats made by [Y], I explained that we would be taking the extraordinary step of conducting a formal case review and potentially involving an additional neutral assessor.[X] was very disappointed by the ongoing delay in his ability to access the

procedure but expressed concern for all of his treating providers including asking me repeatedly ‘can she really sue you once I’m gone?’ I explained that Nicole Phinney would be in communication related to next steps in procedure planning pending the results of our case review and potentially an additional assessment.”

[48] On July 24, 2020 X completed a third Request for and Consent to Medical Assistance in Dying. He selected “progressive frailty and end-stage COPD” as the grievous and irremediable medical condition from which his natural death has become reasonably foreseeable. It was witnessed by two persons.

[49] **Dr. Holland-** Family and Emergency Medicine (as well as significant involvement with creating the clinical infrastructure for MAID in Nova Scotia and sits on the NSHA’s MAID Steering Committee. He is also the Chair of the Committee on Ethics for the Canadian Medical Association, and “played a central role in drafting the CMA’s Policy on Medical Assistance in Dying which is a central document that defines clinical standards of practice on MAID in Canada.” – Met with X on August 1, 2020 and concluded that: “[X] is eligible for MAID. Given his high degree of suffering and the lengthy process to be deemed eligible, I will work with the NSHA to make arrangements for his MAID procedure as expeditiously as possible. It is my understanding that the assessments of Dr. [Miller] will be considered as the first assessment for purposes of eligibility and

my assessment will be considered as the second assessment. I have reviewed Dr. Miller's assessment and we are in agreement."

[50] He states in his report:

> "[Dr. du Toit/the respirologist] reported that he was not able to comment on the legal criteria for 'reasonably foreseeable' which is completely understandable given that he is not had the required training or experience in interpreting of the 'reasonably foreseeable' criteria of 'grievous and irremediable condition' in the relevant MAID legislation. It is worth noting that my assessment is independent of all previous MAID assessments and the two auxiliary assessments as defined by health Canada as regards the independence of MAID assessors.… I am of the opinion that [X] meets all requirements for MAID and is therefore eligible for MAID. It is worth noting that this case is quite complicated and requires a firm understanding the legal criteria for MAID as well as a clinical appreciation of the various conditions affecting [X]. However, the fact that this is a complicated case does not mean that his eligibility is questionable or 'borderline'. After a careful review of the case, I am of the opinion that [X] clearly meets the criteria for MAID in Canada."

[51] Dr. Holland's report is extremely detailed and carefully addresses the concerns of earlier assessors. Importantly he reiterates that X is at stage III COPD with Gold Class B, and that he "has clear evidence of cerebrovascular disease and is at risk of an ischemic stroke. At his age, an ischemic stroke could be devastating and easily lead to his death."

[52] He comments:

> "Taking all of [X 's] medical conditions and his age [into account], there is no doubt that his death is reasonably foreseeable. It is also worth noting some other commonly used measures within the MAID assessment community that are used to assist in determining if a patient meets the criteria for 'reasonably foreseeable':

• one such criterion is the ‘surprise test’ where the assessor asked themselves if they would be surprised if the patient died in the next year. I can say I would not be surprised if [X] died in the next year. In fact, I would not be surprised if he died in the next month. As Dr du Toit appropriately highlights, a simple respiratory tract infection could easily lead to [X’s] death given his age and severity of his respiratory illness;

-another method of assessing ‘reasonably foreseeable’ is the ‘reasonably predictable’ measure. This method is recommended by the Canadian Association of MAID Assessors and Providers as outlined in their Clinical Practice Guideline regarding the clinical interpretation of ‘reasonably foreseeable’. As noted in their key recommendations: ‘as an aid to clarity, clinicians can consider interpreting ‘reasonably foreseeable’ as meaning ‘reasonably predictable’ from the patient’s combination of known medical conditions and potential sequalae, whilst taking other factors including age and frailty into account’

…

In accumulation of his various medical conditions, age and frailty, [X’s] death is clearly reasonably foreseeable.”

[53] Dr. Holland also carefully assesses [X’s] capacity to make a decision regarding at the moment of the MAID request and at the time of the procedure itself:

“The MAID assessment by NP Giffin states that [X] does not have capacity to make a decision regarding MAID ‘due to dementia ‘. However, she does not proceed to elucidate any other components of her capacity assessment. It is worth noting that patients with dementia can have capacity for decisions regarding a large number of medical conditions including MAID. Dementia is a spectrum of illness ranging from very mild to very severe.… Regardless, [X] also has a formal geriatric psychiatry assessment where Dr. Terry Chisholm reports he does not have dementia. Also, Dr. Chisholm highlights he does have capacity for decisions regarding MAID. I saw no evidence of dementia during my interview with [X]. As well, he clearly has capacity. However, given that this was brought into question by the MAID assessment by NP Giffin, I will document a detailed account of my capacity assessment for [X].

…

Hypocondriasis with severe anxiety:… I do not believe that [X] has [this condition] but even if he did, that would not exclude his eligibility for MAID. It is definitely possible that a component of [X’s] suffering is due to an element of anxiety or some other mental health

> condition. However, any mental health condition that may be contributing to [X's] condition is NOT impairing his capacity to consent to MAID. Nor would it change the fact that he has a grievous and irremediable condition… [X] has clearly stated he does not want to go through any more investigations to uncover further explanations of his suffering. Even once diagnosed, these conditions are very difficult to treat. Even if there is a component of psychogenic symptoms that could be diagnosed and could be treated, this would only partially treat [X's] suffering and he has stated clearly that he is not interested in this type of amelioration.… In summary, [X] clearly has the necessary understanding, appreciation, expression of choice and reasoning to make be deemed capable to make a decision regarding MAID."

Conclusion

[54] I appreciate that this is not the final hearing stage, and not all the evidence has been presented in a full and robust fashion. However, my analysis of the law and facts leads me to conclude that Y has not satisfied me that there are grounds for continuing the present interim injunction, as an interlocutory injunction.

[55] Therefore, I immediately order the interim injunction of no force and effect and decline to order an interlocutory injunction.

[56] Given the nature of this case, dealing with a novel legal issue of injunctions in circumstances where MAID is sought, I order all parties to bear their own costs.

Rosinski, J.

Appendix "A"

nova scotia health authority

INTERDISCIPLINARY CLINICAL Policy and Procedure

Title:	Medical Assistance in Dying (MAID)	Number:	CL-AP-010
Sponsor:	VP Quality and System Performance	Page:	1 of 23
Approved by:	Executive Leadership Team	Approval Date:	Mar 18, 2019
		Effective Date:	Aug 7, 2019
Applies to:	NSHA Employees, Contractors, Privileged Physicians, and Nurse Practitioners		

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PREAMBLE

1. In February 2015, the Supreme Court of Canada reached a unanimous decision that the Criminal Code provisions banning assisted dying were unconstitutional under the Canadian Charter of Rights and Freedoms.
2. On June 17, 2016, an Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying, MAiD) was passed. For this policy, it will be referred to as *the Act*.

POLICY STATEMENTS

1. Nova Scotia Health Authority (NSHA) is committed to ensuring that MAiD information, assessment, and procedure is accessible, provided in a timely way, and as close to the patient's home or requested location as reasonably possible.
    1.1. Patients and families are supported through the provision of information and patient-centered care during all phases of the MAiD process.
    1.2. Questions regarding MAiD may be directed to the VP Medicine/delegate or the Medical Affairs Advisor.
2. NSHA will review this policy within one year to evaluate its implementation and effectiveness to:
    2.1. Determine whether there are lessons to be learned that could serve to improve end of life care generally.
    2.2. Make recommendations to improve the processes and practices contained in this policy.

GUIDING PRINCIPLES AND VALUES

1. Accountability:
    1.1. The Act recognizes the need for processes to ensure accountability and oversight. NSHA, through this policy, monitors the implementation of MAiD.
    1.2. NSHA adheres to legislative regulatory requirements in relation to oversight of MAiD processes.
2. Respect for Persons:
    2.1. Respecting persons involves both respecting individuals' rights to make choices and respecting the range of values that are relevant to choices.
        2.1.1. NSHA:
            2.1.1.1. Promotes care that respects personal autonomy and fosters the person's sense of self-determination.
            2.1.1.2. Recognizes and respects that decision making may take place in the sphere of Relational Autonomy in that both the content and process of decision making may be shaped and informed in the context of relationships with others, such as family.

2.1.1.3. Ensures that a person's decision making is supported and that the person is not coerced or subject to undue influence.

3. Freedom from Stigma

3.1. Stigma refers to prejudice and discrimination towards certain groups of people or patient populations. Patients who inquire about or request MAiD should be free from experiencing negative attitudes and responses that leave them feeling unwanted or shamed, and negatively affect their relationships with others or the health system.

4. Freedom from Discrimination:

4.1. NSHA is committed to offering care that is free from judgment and discrimination on the basis of:

- age
- race
- colour
- religion
- creed
- sex
- sexual orientation
- gender identity
- gender expression
- physical disability or mental disability
- an irrational fear of contracting an illness or disease
- ethnic, national, or aboriginal origin
- family status
- marital status
- source of income
- political belief
- affiliation or activity
- individual's association with another individual or class of individuals having characteristics listed above. (See Human Rights Act Chapter 214)

5. Respect for Health Care Provider Values:

5.1. While NSHA recognizes eligible patients' right to access MAiD, and health care providers' duty to provide care, NSHA also recognizes that the care must be provided in a context that respects the values of the NSHA care provider. (See Conscientious Objection.)

5.2. No health care provider should experience stigma or disadvantage on the basis of having participated or not participated in providing MAiD.

6. Respect for Privacy and Confidentiality:

6.1. NSHA acknowledges that MAiD may require particular attention to privacy and confidentiality for both patients and health care providers who are involved with MAiD.

7. Protection for Vulnerable Persons:

7.1. This policy recognizes that protection for Vulnerable Persons is of great importance and that robust procedures and processes, in accordance with the Act, are essential to prevent harm from undue influence of others.

PROCEDURE

Note:

- Responsibilities for patient requests for MAiD information and/or assessment are found in Appendix B.
- MAiD contact directory information can be accessed on the NSHA MAiD webpage and the Related Documents section of this policy)

1. **Responsibility after receiving a request for information on MAiD or after receiving a request for MAiD**

1.1. **Interdisciplinary care team member:**

1.1.1. Provides information on the lawful provision of MAiD as per this policy and the care team members' professional college standards of practice or guidelines.

1.1.1.1. Within the context of therapeutic counselling, interdisciplinary care team members may provide information on the lawful provision of MAiD when requested by patients, including where to access this service, and ensure details of the interaction are documented in the patient file.

1.1.1.2. Directs the patient to MAiD information on NSHA's website and/or provides NSHA-developed written material, available on the NSHA website.

Note:

Counsel in the therapeutic relationship covers activities related to communication, information sharing, the provision of psychosocial support, and referrals.

Counsel in the Criminal Code means to "procure, solicit and incite." It remains a criminal offense to 'counsel' a person to die by suicide as outlined in the Criminal Code, subsection 241(1); therefore, it is important that care team members are familiar with the legislative aspects of MAiD and are able to distinguish between the word counsel as it is related to the Criminal Code and counselling within the therapeutic relationship.

1.1.2. Notifies the primary/attending physician or nurse practitioner (NP) when a request for MAiD information and/or assessment is received from a patient.

1.1.2.1. Ensures the patient is aware of the intent to communicate the information, and to whom, and documents in the progress notes in accordance with section 8 of this procedure — Responsibilities for documentation.

1.1.3. Ensures the health services manager for the unit, facility, or community setting where MAiD may occur is aware of the request for MAiD, and of any decision to schedule the MAiD procedure so that care of the patient is optimized and requirements for section 7 of this procedure — Administration.

care, and support — are actioned, including providing support to care team members.

1.1.4. Notifies manager if, as part of the interdisciplinary care team, they do not wish to participate based on Conscientious Objection.

1.1.4.1. Care team members who have Conscientious Objections will continue to provide safe, culturally competent, ethical, and compassionate care until alternative care arrangements can be made to meet the patient's needs or wishes.

1.2. **Physician or NP:**

1.2.1. Upon receiving notification that there is a request for information or assessment for MAiD, a physician or NP has an initial discussion with the patient requesting information and/or assessment for MAiD.

Note: The Medical Assistance in Dying Documentation and Procedure Checklist provides guidance on what needs to be discussed.

Note: Physicians/NPs cannot act on a request for MAiD:

- set out in a personal directive or similar document.
- on the direction of anyone other than the capable patient.

Note: If the patient has difficulty communicating, physicians and/or NPs must take all necessary measures to provide a reliable means by which the patient may understand the information provided and communicate his or her decision.

1.2.2. Confirms this request with the Office of the VP Medicine/delegate or the Medical Affairs Advisor.

1.2.3. Completes an Effective Transfer of Care for reasons of conscience (Conscientious Objection) or skill so another physician/NP can complete the MAiD assessment for the patient.

1.2.3.1. Transfer care in the manner dictated by their professional standards and guideline.

1.2.3.2. If unable to make an Effective Transfer of Care because of inability to locate a physician or NP able to pursue the request, contact the VP Medicine/delegate or the Medical Affairs Advisor.

2. **Physician's/NP's responsibility for assessment of eligibility**

2.1. Promptly assess the patient to determine if the following eligibility criteria are met:

2.1.1. The patient 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.

2.1.2. The patient is at least 18 years of age and capable of making decisions with respect to their health.

2.1.3. The patient's request for MAiD is a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure.

2.1.4. The patient must have a grievous and irremediable medical condition. This criteria is met only where the physician/NP is of the opinion that the patient meets all of the following:

2.1.4.1. Has a serious and incurable illness, disease, or disability.

2.1.4.2. Is in an advanced state of irreversible decline.

2.1.4.3. Illness, disease, disability, or state of decline that causes the patient enduring physical or psychological suffering that is intolerable to the patient and cannot be relieved under conditions that the patient considers acceptable.

2.1.4.4. Natural death has become reasonably foreseeable, taking into account all of the patient's medical circumstances, without a prognosis necessarily having been made as to the specific length of time that the patient has remaining.

2.1.5. The patient gives informed consent to receive medical assistance in dying after having been informed of the means that are available to manage their suffering, including palliative care.

3. **Physician's/NP's responsibility for assessing and arranging for MAiD**

3.1. **First Physician/NP**

3.1.1. Advises the VP Medicine/delegate or Medical Affairs Advisor of the request for MAiD and seeks their guidance, as necessary, regarding the process and required documentation. The MAID fact sheet for practitioners can be accessed on the NSHA MAiD webpage.

3.1.2. Provides information to the patient and assesses the patient's Capacity to request and consent to MAiD.

3.1.3. Provides patient with:

3.1.3.1. College of Physicians and Surgeons of Nova Scotia (NS) MAID Standards, and/or

3.1.3.2. Nova Scotia College of Nursing Medical Assistance in Dying Practice Guideline for NPs, and

3.1.3.3. Request For and Consent to Medical Assistance in Dying form to sign should they request MAiD.

3.1.4. Assesses the patient in person to determine whether the patient meets the eligibility criteria by completing the assessment required in the NSHA Medical Assistance in Dying Documentation and Procedure Checklist — First Physician/Nurse Practitioner Assessment.

3.1.4.1. If the physician/NP determines the patient meets the eligibility criteria, contact the Medical Affairs Advisor and forward the assessment form to arrange the second assessment or seek the opinion of a second physician/NP to complete an Independent assessment.

3.1.4.2. If not aware of or unable to identify the second physician/NP, discuss with NSHA VP Medicine/delegate or Medical Affairs Advisor to facilitate identification of the second physician/NP.

3.1.4.3. If the first assessor determines the patient does not meet the eligibility criteria:

3.1.4.3.1. Promptly communicate findings directly to the patient and explain the reasons for the determination.

3.1.4.3.2. Advise the patient that they can request assessment from another physician/NP. If they request assistance, contact the VP Medicine/delegate or the Medical Affairs Advisor to inform of the second request for MAiD and seek guidance, as necessary.

3.1.5. Upon reviewing the information from the second physician/NP and being satisfied that the patient meets the eligibility criteria, the first and second MAiD providers will determine which provider will complete the MAiD medication prescribing and procedure. In collaboration with the patient, determine whether one or both physicians/NPs, and possibly additional care team members, will be present at the time of the procedure.

3.2. **Second Physician/NP**

3.2.1. Must be Independent from the first physician/NP (see Appendix A for definition of Independent).

3.2.2. Assesses the patient in person, or via Tele-Health (Virtual Care) video link if available, to determine whether the patient meets the eligibility criteria by completing the assessments required in the NSHA Medical Assistance in Dying Documentation and Procedure Checklist — Second Physician/Nurse Practitioner Assessment.

3.2.3. If the second assessor determines the patient does not meet the eligibility criteria, assessor communicates to the patient in accordance with section 3.1.4.3.

3.2.4. Forwards the documentation to the Medical Affairs Advisor. Ideally, the second physician/NP speaks to the first physician/NP about the results of their assessment to determine next steps.

4. **Physician's/NP's responsibility for arranging MAiD services**

4.1. When in an NSHA facility, inform the health services manager for the relevant care location/facility of the upcoming procedure to allow time for the manager to ensure staff and equipment will be available and so that requirements for section 7 of this procedure — Administration, care, and support — are actioned.

4.2. When providing MAiD in the community, the primary health care (PHC) team facilitates treatment.

4.2.1. If there is no PHC team involved, the physician/NP must complete a referral to Continuing Care for services such as IV start, clinical/bereavement support, etc. (1-800-225-7225).

> **Note:** Please expedite referral to Continuing Care if required and/or communication with facility manager to allow coordination of staffing and equipment requirements.

4.2.2. PHC teams or community care facilities may not require referrals to Continuing Care when nursing services are part of the team.

4.3. Continuing Care requires the following documents as early as possible to ensure staffing and supplies are available for the procedure:

4.3.1. A completed Continuing Care Referral Order form, including an indication that the referral is for MAiD, with an anticipated date and time for the procedure (if known).

4.3.2. Physician/NP order form.

4.3.3. Copy of the signed Request for and Consent to Medical Assistance in Dying.

4.3.4. A copy of the completed physician/NP assessment forms so staffing and equipment requirements for section 8 of this procedure — Responsibilities for documentation — can be actioned.

5. **Responsibility of physicians/NPs when prescribing and administering medication**

5.1. There must be at least 10 clear days between the day on which the request for and consent for MAiD was signed by, or on behalf of, the patient and the day on which MAiD is provided.

5.2. If the **first and second physician/NP** are both of the opinion that the person's death or the loss of Capacity to provide informed consent is imminent, a shorter period as determined appropriate by the assessors is permitted.

5.3. Administration of the MAiD medication protocol is to be carried out by either the **first or second physician/NP**; if neither is available, a **third physician/NP** can review the documentation to ensure eligibility criteria are met. NSHA Medical Assistance in Dying Documentation and Procedure Checklist — Third Physician/Nurse Practitioner Assessment.

5.3.1. If this assessment concurs with the initial assessments, wherein the patient is found to meet the criteria for MAiD, the **third physician/NP** may administer the procedure.

5.4. The **physician/NP** who takes on the role of prescribing and administering the medication:

5.4.1. Reviews the documentation provided by the other physician/NP to be satisfied that eligibility criteria are met.

5.4.2. Completes the requirements of the Medication Protocol and ensures the waiting period has been met (See Appendix C).

5.4.3. Works collaboratively with the hospital/community pharmacist to allow for safe acquisition, administration, and disposition of all MAiD-related medications, and completes the requirements of the Medication Protocol. The pharmacist or the physician/NP provides information to the patient and the patient's support about the medications and what they can expect upon administration.

5.4.4. The physician/NP, immediately before providing MAiD, gives the patient an opportunity to withdraw their request and ensures that the patient gives expressed, informed final consent to receive MAiD.

5.4.4.1. If the patient rescinds the request for MAiD, and subsequently makes another request for it, the first **physician/NP** re-starts the process and completes all the duties of the first **physician/NP** as if the process had not been previously commenced.

6. **Patient location and responsibility for registration**

6.1. A patient who has freely and formally consented to assisted death may request for the procedure to be undertaken in an NSHA facility or in a community location (their home, care facility, relative's home, etc.). (See Policy Statement 1.)

6.2. If the patient is in a community location and will be coming in to an NSHA facility for the procedure, **Health Information Services clerks** will register them as an outpatient in accordance with Appendix D, and the health services manager/facility administrator arranges for a location.

6.3. If the patient is in the community and is undergoing the procedure at home, register them in accordance with Appendix D.

7. **Administration, care, and support**

7.1. The procedure is performed in accordance with the Nova Scotia College of Nursing Medical Assistance in Dying Practice Guidelines, the College of Physicians and Surgeons of Nova Scotia Professional Standard Regarding Medical Assistance in Dying, and the Nova Scotia College of Pharmacists Standards of Practice: Medical Assistance in Dying.

7.2. A MAiD supply list can be accessed on the NSHA MAiD webpage.

7.3. The manager offers a pre-MAiD intervention huddle/meeting and/or debriefing session to members of the interdisciplinary care team involved in the procedure. Where members wish to have a session, the manager will facilitate the coordination of the session.

Note: See Appendix D for registration procedure for in-facility and community procedures.

8. **Responsibilities for documentation**

8.1. The **physician/NP** or the interdisciplinary care team member documents in the progress notes that patient's request for information on MAiD and/or request for MAiD.

8.2. The patient, in consultation with the **physician/NP**, fills out and signs the Request For and Consent to Medical Assistance in Dying form.

8.3. The **first and second physician/NP** complete all sections of the NSHA Medical Assistance in Dying Documentation and Procedure Checklist.

8.4. The **prescribing physician/NP** completes the Medical Assistance in Dying pre-printed order form and notice to pharmacist.

8.5. The **pharmacist** completes and retains the Pharmacy MAiD Form.

8.6. **All care providers** involved in the procedure document in the patient's health record progress/interdisciplinary progress notes **and** in the interdisciplinary Progress Notes Section of the NSHA Medical Assistance in Dying Documentation and Procedure Checklist.

8.7. Place documentation forms in the patient's health record. (See Appendix D.)

8.8. Upon completion of the procedure, all documentation must be sent to the Medical Affairs Advisor.

Required documentation includes:

- First Physician/NP Assessment
- Second Physician/NP Assessment
- Request for and Consent to MAID
- Pre-procedure Documentation
- Procedure Documentation
- Post Procedure Documentation
- Death Certificate

8.9. How to complete the Medical Certificate of Death in cases of MAiD:

- **Section 13, line (A):** Write "Injection of" and identify the medication administered in the immediate cause of death.
- **Section 13, line (D):** Note the condition that led the applicant to seek MAiD as the underlying cause of death. (This will be the last item in Section 13.)
- **Section 18:** Identify the manner of death appropriate to the underlying cause of death.
- **Section 14:** Write in "MAiD" on the very last line in Section 14 of the Medical Certificate of Death.

REFERENCES

Legislative Acts

An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying), Statutes of Canada (2016, c. 3). Retrieved from the Justice Laws website: https://laws-lois.justice.gc.ca/eng/AnnualStatutes/2016_3/FullText.html

Other

College of Physicians & Surgeons of Nova Scotia. (2019). Medical assistance in dying. Retrieved from https://cpsns.ns.ca/Standards-Guidelines/Medical-Assistance-in-Dying/

Nova Scotia College of Nursing. (2017). *Guideline for nurse practitioners: Medical assistance in dying*. Retrieved from https://cdn1.nscn.ca/sites/default/files/documents/resources/MAID_NP_Guidelines.pdf

Nova Scotia College of Pharmacists. (2016). *Standards of practice: Medical assistance in dying*. Retrieved from http://eol.law.dal.ca/wp-content/uploads/2017/05/SOP_MAID.pdf

RELATED DOCUMENTS

Policies

AVH 280.001 Consent to Treatment, Procedure or Operations

CBDHA A-3-41 Consent to Treatment

CDHA CH 30-045 Consent to Treatment

CEHHA 101-003 Consent to Treatment

CHA 101-003 Consent

GASHA 3-11 Consent to Treatment

PCHA 6-c-10 Consent for Treatment

SSH-AD-110-206 Consent to Treatment

SWH 504.0 Consent

Forms

Request For and Consent to Medical Assistance in Dying Form

Medical Assistance in Dying Documentation and Procedure Checklist

Medical Assistance in Dying Pre-Printed Order

Directory

MAiD Directory

Appendices

Appendix A – Definitions

Appendix B – Medical Assistance in Dying - Policy Quick Reference Guide

* * *

Appendix A: Definitions

Adult	For the purposes of this policy, an Adult is defined as a person 18 years or older so as to be in line with the eligibility criteria identified in the legislation.
Capacity	Refer to applicable *Consent for Treatment Policy* click on **Criteria for Valid Consent**
Conscientious Objection	Conscientious Objection is the refusal to perform a legal role or responsibility because of personal beliefs. In health care, Conscientious Objection can involve practitioners not providing certain treatments to their patients. Health care providers/professionals with moral objections (conscientious objector) to specific health care services have an obligation to alert their colleagues and/or and supervisors to these objections, in the interests of minimizing disruption in the delivery of care and minimizing burdens on other providers (see definition of Effective Transfer of Care). (Adapted from The Hastings Centre.)
Effective Transfer of Care	A transfer by one practitioner in good faith to another practitioner who is available to accept the transfer, who is accessible to the patient, and willing to provide medical assistance in dying to the patient if the eligibility criteria are met.
Independent	The second medical practitioner or nurse practitioner providing the opinion are Independent if they: • Are not in a business relationship with the other practitioner, a mentor to them, or responsible for supervising their work; • Do not know or believe that they are a beneficiary under the will of the person making the request, or a recipient, in any other way, of a financial or other material benefit resulting from that person's death, other than standard compensation for their services relating to the request; • 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. (Bill C-14.)
Independent Witness	An independent witness is any person who is at least 18 years of age and who understands the nature of the request for medical assistance in dying. Anyone meeting these criteria may act as an independent witness, except if they:

- Know of or believe that they are a beneficiary under the will of the person making the request, or a recipient, in any other way, of financial or other material benefit resulting from that person's death.
- Are an owner or operator of any health care facility at which the person making the request is being treated or any facility in which that person resides.
- Are directly involved in providing health care services to the person making the request. *NSHA staff cannot act as an independent witness.*
- Directly provide personal care to the person making the request.
- Questions or concerns about witnessing forms may be directed to the Medical Affairs Advisor.

Medical Affairs Advisor	The NSHA staff member responsible for support and coordination of MAiD. Contact information for the Medical Affairs Advisor can be accessed on the NSHA MAiD webpage and related documents section of this policy.
Relational Autonomy	A description of personal autonomy that draws attention to the ways in which decision making occurs within context, particularly the ways in which relationships can legitimately affect both the process of decision making and the content of decisions.
Vulnerable Person	Any Adult who, by nature of a physical, emotional, or psychological condition, is dependent on other persons for care and assistance in day-to-day living. (Federal Department of Justice.)

Appendix B: Medical Assistance in Dying Policy Quick Reference Guide

Note: This is a **quick reference guide only** and does not substitute for reference to the policy proper.

Health Care Team

1. The primary/attending physician or nurse practitioner (NP) is notified by the member of the interdisciplinary team that receives the patient request for medical assistance in dying (MAiD). The patient can be provided written information available on NSHA website as requested and team members can answer questions on the lawful provision of MAiD.
2. If after being informed of the grievous and irremediable medical condition and being informed of the means that are available to receive their care, the patient requests MAiD, the patient is provided the Request For and Consent to Medical Assistance in Dying Form by the physician/NP. The patient upon signing the form will return the form to the physician or NP. The primary/attending physician or NP will notify and discuss this request with the VP Medicine/delegate or the Medical Affairs Advisor.
3. If the attending physician or NP does not feel they have enough experience/knowledge or is a conscientious objector, then they must complete an Effective Transfer of Care.
   3.1. See procedure section 1.2.3. for more information on making an Effective Transfer of Care.
4. Physicians and NPs may provide MAiD only where all of the eligibility criteria are met.
   4.1. See procedure section 2 for an outline of the eligibility criteria.
   4.2. The first physician/NP — First Physician/Nurse Practitioner Assessment —assesses the patient in person to determine whether the patient meets the eligibility criteria by completing the NSHA Medical Assistance in Dying Documentation and Procedure Checklist
   4.3. Once satisfied the patient meets the eligibility criteria, the physician/NP seeks out the opinion of a second physician/NP.
   4.4. The second physician/NP assesses the patient in person, or via Tele-Health (Virtual Care), to determine whether the patient meets the eligibility criteria by completing the NSHA Medical Assistance in Dying Documentation and Procedure Checklist — Second Physician/Nurse Practitioner Assessment.
5. The health services manager helps to arrange the staff and equipment requirements for the procedure when taking place in NSHA facilities. For community-based (personal residence or care facility) procedures, Continuing Care (if a referral has been made) completes the arrangements. (See Appendix E.) Primary Health Care teams or community care facilities may not require referrals to Continuing Care when nursing services are part of the team.
6. The prescribing physician/NP must complete the pre-printed order (PPO) Medical Assistance in Dying (MAiD) — Physician Administered IV Protocol including the notice to the pharmacist.

6.1. Administration of the MAiD medication protocol is to be carried out by either the first or second physician/NP; if neither is available, the administration of the MAiD medication protocol can be carried out by a third physician/NP. The third physician/NP assesses the patient in person, or via Tele-Health (Virtual Care), to determine whether the patient meets the eligibility criteria by completing the NSHA Medical Assistance in Dying Documentation and Procedure Checklist – Third Physician/Nurse Practitioner Assessment.

6.2. If this assessment concurs with the initial assessments, wherein the patient is found to meet the criteria for MAiD, the third physician/NP may administer the procedure.

7. The physician/NP performing the MAiD procedure works collaboratively with the hospital/community pharmacist to allow for the safe acquisition, administration, and disposition of all MAiD-related medications, and completes the requirements of the Medication Protocol (see Appendix C).

8. The pharmacist dispenses medications for MAiD in accordance with NSCP Standards of Practice and the NSHA interdepartmental policy and procedure. The pharmacist also documents the details of the MAiD process on the Pharmacy MAiD Form and retains this record.

9. The procedure, consent, and assessments should be documented by completing the NSHA Medical Assistance in Dying Documentation and Procedure Checklist.

Appendix C: Medication Protocol

1. At the beginning of the 10 day (or shorter if deemed appropriate by physician/NP) reflection phase the physician/NP notifies the pharmacy/pharmacy manager by phone of the forthcoming prescription.
2. In a timely manner, the physician/NP provides the pharmacist with a completed pre-printed order including:
   2.1. Protocol selected for patient's drug therapy, and
   2.2. Notice to the pharmacist that the medications are intended for MAiD and for a specific patient who meets the eligibility criteria.

> **Note:** Pre-printed orders (PPO) are intended for internal NSHA use in conjunction with NSHA policies. The NSHA-written MAiD PPO can be used as a prescription for outpatients obtaining medications from community pharmacy; however, it cannot be faxed and, in order to meet legal requirements, controlled substance/narcotic prescriptions must be written on the NS Prescription Monitoring Program (PMP) duplicate pad form. Physicians/NPs administering MAiD in a private setting should contact the community pharmacy at the earliest opportunity to confirm ability to participate and to facilitate acquisition of medications not routinely stocked in the community setting.

3. The physician/NP and pharmacist discuss:
   - Time required to order the medications
   - Date, time and location for medication release and administration
   - To whom the medication will be released; if not to the prescribing physician/NP, to a licensed health care professional designated by the physician/NP
   - Who will provide counselling to the patient and/or family members related to the MAiD medications
   - That physician/NP is aware of the preparation, stability, and storage requirements for MAiD medications
   - Procedure for secure and timely return of unused medication
4. The pharmacist is responsible for the preparation of the medications in a kit for dispensing as per departmental policy and in accordance with the Nova Scotia College of Pharmacists Standards of Practice: Medical Assistance in Dying.
5. The pharmacist shall release the MAiD medication(s) to the physician/NP or licensed health care professional pre-designated by the physician/NP on the date specified by the physician or nurse practitioner.
6. At the time of medication release the pharmacist and physician/NP or designated licensed health care professional must sign the Pharmacy Medical Assistance in Dying (MAiD) form.
7. The physician/NP provides the patient's date of death to the pharmacist for documentation on the Pharmacy MAiD Form.

8. The physician/NP confirms medications were administered and identifies unused medications. They arrange for secure return of medications to the same location where medications were dispensed to permit timely disposal.
9. Upon return of unused medication, the pharmacist and physician/NP or designated licensed health care professional signs the Pharmacy MAiD form.

Appendix D: Registration for MAiD Patients

- For all NSHA outpatients participating in MAiD, regardless of where they reside in the province or what facility/location, the physician/NP will see that the patient is registered in the NSHA Central Zone Registration System (STAR).
- Registration may be completed following the MAiD procedure. Forward your completed MAID forms by fax, available on the NSHA website, to the Medical Affairs Advisor at 902-454-0379. Information on your forms will be captured for reporting purposes and then forwarded to Health Information Services and your patient registration will be completed.
- For those performing the registration, follow the table below to select the appropriate codes based on the location where the patient is being seen and complete the STAR System Registration.
- Each patient consult and procedure performed will require a separate registration for the patient.
- The documentation supplied to complete the registration will be filed within the patient legal health record at NSHA Central Zone.
- Copies of this information will be available to care providers involved in the continuum of care for the patient by contacting Health Information Services at **902-473-6318.**

Facility	Department Locations	CUT Codes	Patient Types
Q	PHOM (patient home)	MDS	XSH
Q	IMDS (inpatient visit)	MDS	QIS
Q	OMDS (outpatient visit)	MDS	OSC

If you are completing STAR registration for a patient procedure, you will be manually required to change the discharge disposition for any expired patient to the morgue following the procedure and include the correct date and time for the change.

Documentation Requirements for MAiD Patients

- All NSHA patients participating in the MAID program, regardless of where they reside or are seen in the province, are registered in the NSHA Central Zone computer systems and the required forms are filed to the legal health record for the patient within Central zone.
- All clinicians providing direct patient care to NSHA patients participating in MAiD are required to complete the forms for the appropriate visit type as identified on the NSHA website.
- Clinicians can complete dictations for MAID patients using the NSHA Provincial eScription System.
- Instructions for system use, access and user support are included as follows.

NSHA Central Zone — Dictation Instructions for eScription

Important: Always use your own Dictation ID even if you are dictating for the attending physician. The system will create your own voice profile based on this ID. If you do not know your ID please call 902-473-2568.

1. Lift handset and dial 902-473-5300 or 1-888-940-8088 (long distance).
2. Enter your **User ID** followed by the # key.
3. If you are clinician who dictates for an attending you will be prompted for the attending's PMB#. If you are an attending staff you will not be prompted for this number, continue to step 4.

   Enter attending physician's **PMB#** followed by the # key.

   > **Important:** If you do not know the attending physician's PMB#, you will not be able to continue.

4. Enter the **Facility code (1) for QEII Health Sciences Centre** followed by the # key.
5. Enter **Worktype** followed by the # key.
6. Enter patient's **MRN** followed by the # key.
7. You will hear an intermittent tone — **press 2 to begin recording.**

   > **Note**: You will be in record mode **until** you interrupt it with a keypad function (see chart on following page).

8. When dictation on *that* chart is complete, press **8** to complete the report. Then to continue, repeat steps 3 through 6, or to complete the last report and disconnect press **5.** You will hear "goodbye" and may then hang up.

   > **Note:** When you press 8 to complete your dictation *or* 5 to complete dictation and disconnect, the system will provide you with a **Job ID #.** This is a confirmation number assigned to each individual dictated report. You should write down this # as it will be the reference number in the dictation system.
   >
   > Instead of pressing 8 to complete report then 5 to disconnect, simply press 5 to complete your final report *and* disconnect. You will be given the **Job ID#** of the last report dictated and the system will say 'goodbye'.

KEYPAD FUNCTIONS

Throughout your dictation you can use **ANY** of the following features by entering the corresponding number to assist you in completing your dictation.

1.	PAUSE	Press 1 to put dictation on hold for 15 min. If not resumed before 15 min. is up, the report will be sent through to transcription.
2.	RECORD/STOP	Press 2 to begin your dictation.
3.	SKIPBACK/PLAY	Press 3 for an incremental rewind with automatic playback. Press 2 to stop playback.
4.	FAST FORWARD	Press 4 for an incremental fast forward.
5.	COMPLETE REPORT/DISCONNECT	Press 5 to complete the last report and disconnect.
6.	STAT REPORT	Press 6 anytime after you enter worktype # and before you complete the report. The system will confirm that you have indicated that this report is a priority. Priority reports will be transcribed within 24 hours.
7.	REWIND	Press 7 for rewind then 3 for playback.
8.	COMPLETE REPORT	Press 8 to complete report *or* Press 5 to complete report and disconnect.
9.	INTERRUPT REPORT	Press 9 to put correct dictation in "holding pattern." You must complete this dictation within 24 hours or the system will automatically end the report.

MAID E-scription Work Type Selection Options for Dictation

Work Type	E-scription Report Template	Report Location in HPF
26	MAID Consultation Letter	Consultation Records
27	MAID Progress Note/Phone Consult	Progress Notes
28	MAID Death Summary Report	Discharge Summary/ Death Report

Appendix E: Continuing Care Quick Reference Guide for Physicians/NPs: MAiD in the Community

This reference guide applies to the delivery of medical assistance in dying (MAiD) in the community requiring Continuing Care services. These settings may include a patient's home, a long-term care facility, other care facility, etc.

- Screen and assess the patient and complete required MAiD documentation and process as per NSHA policy and professional practice standards.
- If the patient **lives in a care facility** in the community, contact the administrator to inform them of the request (with consent of the patient).
    - If the care facility will support delivery of MAiD in the facility and community nursing is required, send a referral to Continuing Care.
    - If the care facility will not support delivery of MAiD in the facility, discuss this with the patient and identify an alternate setting for the procedure to occur.
- If the alternate setting is in the community (e.g., someone's home) and community nursing is required, send a referral to Continuing Care.
- If the alternate setting is in a hospital, follow the procedures for the delivery of MAiD in a hospital setting.
- If the patient **lives at home** in the community and community nursing service is required, send a referral to Continuing Care.
    - Arrange for the delivery of medication to the home and for post-procedure items.
    - Arrange for the required MAiD documentation to be in the home or facility the day of the procedure (i.e., Pre-Procedure Form).

Nursing services will not be delivered if the documents are not available the day of the procedure. The complete **Continuing Care Referral Package** for the purpose of MAiD must include:

- Continuing Care *Referral Form*
- Continuing Care *Physician/NP Order Form*
- A copy of the patient's signed Request for and Consent to Medical Assistance in Dying form
- A copy of the completed *Physician/NP Assessment Forms* (First and Second).

The referral must indicate that the request is for the delivery of MAiD and include the planned date for delivery (if known). Consider providing a cell phone number to expedite communication with Care Coordination and the nursing agency, particularly if the timelines are shortened.

Referral to Continuing Care as early as possible and specifying the request is for MAiD is critical to ensure they and their contracted service providers can uphold the legal rights and professional responsibilities of their staff. Continuing Care makes every effort to expedite MAiD referrals.

Continuing Care Intake: 1-800-225-7225

Version History

Major Revisions (e.g. Standard 4 year review)	Minor Revisions (e.g. spelling correction, wording changes, etc.)
New to NSHA Aug. 7, 2019	