Position Statement

Nurses' and Nursing's Role in Supporting a Patient-Centred Approach to Medical Assistance in Dying

Introduction

Medical Assistance in Dying (MAiD) has been debated in Canada since the early 1990s, when British Columbian ALS sufferer, Sue Rodriguez argued for the right to end her own life by physician-assisted death.[1] While the issue has remained in the public discourse, it wasn't until February 2015 when the Supreme Court of Canada heard the case of Lee Carter and struck down the *Criminal Code* prohibiting physician-assisted death, giving the Federal Government one year to make appropriate legislative changes.

There have been significant developments with Medical Assistance in Dying (MAiD) since the February 2015 decision. Legislation on MAiD, known as Bill C-14, was tabled during the Spring 2015 Session of Parliament and received Royal Assent on June 17th 2016, making it law throughout Canada.

The College of Registered Nurses of British Columbia (CRNBC) has published standards, limits, and conditions for Registered Nurses (RNs) and Nurse Practitioners (NPs) within the context of MAiD. However, ARNBC recognizes that many RNs and NPs continue to have questions and concerns, and are seeking guidance in relation to their role in MAiD. ARNBC continues to monitor the developments related to the MAiD legislation and its impact on nursing practice. This Position Statement has been updated to reflect the most current state of MAiD within the context of nursing, and will continue to be updated as needed.

ARNBC Position:

- Death is an inevitable part of life, and nurses are often an important part of a patient's end-of-life experience. RNs and NPs want to be well-informed and confident in how to manage a case where MAiD has been requested or discussed.
- Patients have the right to choose what is best for them and their families regarding all available end-of-life care options.
- RNs and NPs spend a considerable amount of time assessing and understanding their patients' needs, and are well positioned to:
    - Engage in conversations surrounding advance care planning, in order to promote autonomy and choice.
    - Be part of the assessment process in determining a patient's capacity to make informed decisions related to end-of-life care.

- While RNs and NPs have the right to conscientious objection, they must still:
    - Be knowledgeable about the different options within the continuum of end-of-life care, in order to meet the ethical standard of 'recognizing, respecting and promoting the client's right to be informed and make informed choices', as set out by the College of Registered Nurses of British Columbia.[2]

1 *Judgments of the Supreme Court of Canada. (2016). Carter v. Canada- Attorney General.*

2 *College of Registered Nurses of British Columbia (CRNBC). (2016). Ethical Practice.*

  - Ensure there is no abandonment of a patient by recognizing their responsibility of "providing for the safety of the person receiving care, until there is assurance that other sources of nursing care are available", as indicated in the Canadian Nurses Association (CNA) *Code of Ethics*.[3]

- RNs and NPs should feel confident that they can access required knowledge around legal implications, tools and resources when presented with a patient who is requesting MAiD. ARNBC advocated for all B.C. RNs and NPs to have access to current legal advice through the Canadian Nurses Protective Society (CNPS) as of March 1, 2016.
- ARNBC believes that RNs and NPs will gain greater clarity around their role in MAiD with the new standards, limits and conditions[4] established by the CRNBC, and encourages RNs and NPs to become familiar with this information.
- ARNBC recognizes the need for additional research to examine the legal, medical and ethical questions around MAiD within the context of mature minors, people who suffer from mental illness only, and advance requests for MAiD to be carried out when individuals are no longer able to make healthcare decisions and express their wishes.
- MAiD should not be the default choice for British Columbians as a result of a lack of accessible palliative care. There must be greater efforts among all health professions and government to work towards ensuring that there is more comprehensive and accessible palliative care in order to ensure all British Columbians have a viable range of options available to them.
- RNs and NPs continue to have many questions, concerns and beliefs regarding MAiD, and for this reason, greater discussion regarding the implications to nursing practice, as well as the individual RN or NP must continue to be addressed.

Background

In 1993 the Supreme Court of Canada (SCC) by a narrow margin denied B.C. resident Sue Rodriguez the right to end her own life by physician assisted death . Nearly ten years later, in June 2012, *Carter vs Canada* was heard in the Supreme Court of British Columbia bringing forward an argument against the section of the *Criminal Code* prohibiting physician assisted death, by stating that it was inconsistent with Section 7 and 15 of the *Canadian Charter of Rights and Freedoms*. The judge ruled in favor of the plaintiffs and suspended the declaration of invalidity for one year. Following a number of court proceedings[5], the case was heard in the SCC on February 6, 2015. The SCC again struck down the *Criminal Code* prohibiting physician assisted death and the declaration of invalidity was suspended for an additional year to offer the Federal, Provincial and Territorial Governments time to respond with legislation that would govern the process of assisted dying.

In January 2016, the SCC:

- Granted the federal government a four-month extension to pass assisted dying legislation.
- Ruled that Quebec's assisted dying law, which came into effect in December, can remain in effect.
- Stipulated that, in fairness to Canadians outside Quebec, those wishing to exercise their right to die with the help of a doctor can apply to a superior court in their home province for "relief in accordance with the criteria"[6] set out in the High Court's ruling last February.

3 *Canadian Nurses Association. (2008). Code of Ethics.*

4 *Judgments of the Supreme Court of Canada. (2016). Carter v. Canada- Attorney General.*

5 *The Canadian Legal Information Institute. (2012). Carter v. Canada (Attorney General), 2012 BCSC 886 (CanLII).*

6 *Special Joint Committee on Physician Assisted Dying. (2016). Medical Assistance in Dying: A Patient Centred Approach.*

Prior to the January 2016 SCC ruling, a number of reports were released by expert panels and special interest groups weighing in on what they believe the government legislation should entail. Most notablyy, The Provincial-Territorial Expert Advisory Group on Physician Assisted Dying report,[7] released in November 2015, and the External Panel on Options for a Legislative Response to Carter v. Canada report[8], which was released a month later.

Along with counterparts such as CNPS and CNA, ARNBC supported amending the term "Physician Assisted Death" to "Medical Assistance in Dying," as indicated in the proposed legislation, Bill C-14. The intent behind this was to ensure that all Canadians, regardless of geographic location, would have access to this service. It also ensures that all healthcare providers, such as pharmacists, nurses and others are protected under the *Criminal Code*. We are pleased that this was taken into consideration in the development of C-14.

MAiD Key Dates

February 2016: The Special Joint Committee on Physician-Assisted Dying presented a report "Medical Assistance in Dying: A Patient Centred Approach." This committee put forward recommendations for a legislative framework, including amending the *Criminal Code*, procedural safeguards and oversight.

April 2016: The first court exemption was granted in British Columbia. The court's ruling exempted the physician involved, as well as two un-named registered nurses and registered pharmacists from being prosecuted under the *Criminal Code*.

Mid-April 2016: Proposed legislation for MAiD (also known as Bill C-14) was drafted and tabled.

June 2016: Bill C-14 did not pass into law by the anticipated deadline of June 6th 2016 and continued to be debated at the Federal level. *Carter* remained in place.

June 8th 2016: The B.C. Criminal Justice Branch issued guidelines for prosecutors dealing with MAiD. The Justice Branch recognized that MAiD would require the involvement of various healthcare professionals such as nurses. Consequently, the Justice Branch stated that decisions set out by *Carter* should not only be applied to physicians, but to other healthcare professionals involved in carrying out or providing information about MAiD.

June 10th 2016: Based on support from the B.C. Criminal Justice Branch, CRNBC published standards, limits and conditions for the role of RNs and NPs in MAiD, as well as revised Duty to Provide Care practice standards, based upon the language in *Carter*. The roles of both RNs and NPs were limited to aiding in the provision of MAiD. CRNBC also encouraged RNs and NPs to contact independent legal advice through CNPS when needed.

June 17th, 2016: Bill C-14 received Royal Assent and became law.

7 *Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying. (2015).*

8 *The External Panel on Options for Legislative Response to Carter v. Canada. (2015).*

June 23rd, 2016: Consistent with Bill C-14, CRNBC again revised its standards, limits and conditions to reflect the role of RNs in aiding in the provision of MAiD. At this time, the role of NPs in B.C. continued to be limited to aiding in the provision of MAiD while CRNBC worked with the College of Pharmacists of B.C., College of Physicians and Surgeons of B.C. and Health Authorities to revise standards, limits and conditions to reflect the role of NPs as written in Bill C-14.

July 29th 2016: CRNBC's Board approved and put into immediate effect revised standards, limits and conditions relating to the role of NPs in both determining eligibility for, and providing MAiD.

Discussion

In consultation with RNs and NPs across the province, a number of common themes and key areas of concern have emerged. ARNBC will continue to investigate and consult with various experts and advisors in order to develop tools to help RNs and NPs understand more clearly the implications to their practice. The majority of concerns raised by B.C. RNs and NPs are focused around the needs of patients and their families, rather than the potential impact MAiD may have on the individual nurse. Further, improving access to high quality palliative care, regardless of the context, has been a major theme raised by many throughout the consultation process.

Concern for Patients

- Nurses are well positioned to support patients in finding personal understanding that would guide end-of-life decisions, including the decision to seek MAiD. This relationship is an invaluable tool to provide patients and their families with meaningful end-of-life care.
- There continue to be concerns that patients will choose MAiD in fear of the dying process or because they feel themselves a burden to their family and friends, without first having access to and about education on what palliative services are available.
- Nurses and patients located in underserved and remote communities, where specialized palliative care is unavailable may not be able to access the resources and supports they need to provide specialized palliative care, while a lack of physicians can create barriers in responding to requests for MAiD.

Legal and Ethical Implications for RNs and NPs

- There is a need for clear provincial guidelines to be developed to guide nurses' practice, should their patients request MAiD.
- Some RNs and NPs may be apprehensive or opposed to being involved with MAiD. In cases such as these it is important for nurses to know their role as care providers and how the CNA Code of Ethics guides and supports their practice. It is important for all nurses to explore their comfort level with MAiD, keeping in mind that providing patients with information is not supporting MAiD, it is respecting a patient's right to choose what is best for them and their families. The CNA has prepared a paper that may assist nurses to explore end-of-life issues from an ethical perspective.[9]

9 Canadian Nurses Association.(n.d). Respecting choices in end of life care.

Need for More Education and Information

- Bolstering nursing curriculum and continuing education in symptom management, the palliative approach, advance care planning, and end-of-life care of both families and patients is prudent and necessary.
- Further research must be conducted to assess the implications of MAiD on nurses, and to inform the creation and development of supports and resources.
- Patients need to receive better direction around advance care planning. An advance directives gives individuals autonomy to decide what the focus of their care will be and under what circumstances. Nurses play a critical role in supporting and educating patients about advance directives.

Recommendations

1. ARNBC encourages all RNs and NPs to familiarize themselves with the CRNBC's current standards, limits and conditions for MAiD, as well as changes within the Duty to Provide Care practice standard.
2. ARNBC will support the development of an interprofessional provincial action plan to support nurses in understanding their role in end-of-life care including the full range of options possible. The plan should include:
    - Information on how to communicate MAiD with patients.
    - Increased resources and training to enable RNs and NPs to have difficult end-of-life conversations with patients.
    - Legal clarity to ensure RNs and NPs are clear on what they can and cannot discuss with patients.
    - Specific direction for rural nurses and patients whose needs and accessibility may be vastly different.
    - Increased consultation with NPs around the NP role in end-of-life care.
    - Opportunities for interprofessional education and communication among healthcare providers to understand both shared and unique roles.
3. ARNBC will continue to partner with and promote the services of the CNPS to all B.C. RNs and NPs. CNPS will provide any nurse who has questions or concerns about the legal implications of being involved in a MAiD situation with confidential legal advice.
4. ARNBC will host a discussion forum or webinar on end-of-life care including advance care planning, palliative care and the developments of MAiD.
5. ARNBC, in collaboration with stakeholders, will further study the legal, medical and ethical questions around MAiD in relation to mature minors, people who suffer from mental illness only, and those with advance directives, within the context of nursing values and practice.
6. ARNBC will explore opportunities to work with the Canadian Nurses Association to support equitable access to palliative care approaches in the context of MAiD, through provincial educational and policy initiatives in B.C.

Conclusion

Developments in MAiD continue to change rapidly, and ARNBC will continue to watch this issue very closely in an effort to provide appropriate and timely support for the nurses of B.C. With the passing of Bill C-14, the establishment of standards, limits and conditions by the CRNBC, and support from CNPS, ARNBC is confident that B.C. nurses will be able to carry out their duties, with greater clarity and support.

ARNBC will continue to study the complex issues not addressed in the legislation, and will work collaboratively with stakeholders to provide the necessary tools to support nurses in providing the best care for their patients.

Appendix A - Key Expert Perspectives

The Canadian Society of Palliative Physicians (CSPP)[10] has raised a number of concerns with the pending implementation of physician assisted death. They are concerned that patients will choose hastened death (CSPP's preferred term) in fear of uncontrolled suffering and excessive family burden. The CSPP feels that universal high quality palliative care would stem the majority of patient's desire to hasten death. The CSPP also advocates strongly that physician assisted death not be included in the suite of services that is offered by palliative care physician and programs. Concerns have been raised that patients will not seek out or utilize palliative care if they believe that assisted death is a service they provide. CSPP would like to see the creation of an independent provincial service that would operate parallel to palliative care. The service would function as a hub for physician referrals, and counselling services for patient, families, and healthcare providers.

The Canadian Nurses Association's (CNA)[11] submission to the External Panel sites the need for comprehensive education to be made available for nurses in order for them to properly care for patients and their families, while respecting professional, legal and personal boundaries.

Further, the CNA recognizes that informed consent is an imperative and stresses that all members of the care team respect and promote a person's right to be informed and make independent decisions. They highlight the unique relationship that can develop between nurses and their patients, and call for the involvement of interprofessional health-care team throughout the assisted death process. In a joint position statement[12] with the Canadian Hospice Palliative Care Association, and the Canadian Hospice Palliative Care Nurses Group, the CNA advocates for the expanded use of the Palliative Approach to end-of-life care. The palliative approach to care is focused around dignity, hope, comfort, quality of life, and relief of suffering.

The Canadian Nurses Protective Society[13] has concerns with the word "counseling". This term is commonly used in the medical settings to mean providing information or having a discussion. In the context of the *Criminal Code* "counseling" is defined as procuring, soliciting or inciting. The discrepancy in meaning leaves nurses open to possible litigation. The CNPS submission to the external panel suggests there should be a clear exemption in the *Criminal Code* for MAiD.

Dr. Douglas Grant, President of the Federation of Medical Regulatory Authorities of Canada and Registrar of the College of Physicians and Surgeons of Nova Scotia "Any time there's care delivered in any medical setting, there are other ancillary health professionals involved, and I would hope the amendments to the *Criminal Code* contemplate the roles of other health professionals." The College of Physicians and Surgeons of Ontario echoed this sentiment.[14]

10 *The Canadian Society of Palliative Physicians. (2016). Submission to Special Joint Committee on Physician-Assisted Dying.*

11 *Canadian Nurses Association. (2015). Brief for the Government of Canada's External Panel on Options for a Legislative Response to Carter v. Canada.*

12 *Canadian Nurses Association, Canadian Hospice Palliative Care Association & Canadian Hospice Palliative Care Nurses Group. (2015). Joint Position Statement: The Palliative Approach to Care and the Role of the Nurse*

13 *Canadian Nurses Protective Society. (2016). Canadian Nurses Protective Society Submission on Physician Assisted Death.*

14 *The Department of Justice. (2016). Consultations on Physician-Assisted Dying - Summary of Results and Key Findings.*

Appendix B - Definitions

Palliative Care is "an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual".[15]

The Palliative Approach is an approach to care that focuses on meeting a person's and family's full range of needs – physical, psychosocial and spiritual – at all stages of a chronic progressive illness. It reinforces the person's autonomy and right to be actively involved in his or her own care.[16]

Advance Care Planning is the process of thinking about one's values with respect to their health, and communicating to their loved ones, substitute decision makers and healthcare providers their healthcare wishes and choices, in an event that they cannot speak for themselves. This leads to the creation of an **advance directive**, which is a document used to communicate a person's preferences regarding life-sustaining treatment in the event that they become incapable of expressing those wishes for themselves.[17]

Physician Assisted Death "means that a physician knowingly and intentionally providing a person with the knowledge or means, or both, required to [end their life], including counselling about lethal doses of drugs, prescribing such lethal doses or supplying the drugs.[18]

***Medical Assistance in Dying** is the term proposed by the Special Joint Committee to be used in any future legislation on the topic of assisted death in order to "reflect the reality that healthcare teams, consisting of nurses, pharmacists, and other healthcare professionals are also involved in the process of assisted dying."[19]

End-of-life Care is both a term used to describe the care provided during the final hours or days of a person's life, as well as the continuum of care available to those with a terminal illness or terminal disease condition that is progressive and incurable.

15 *World Health Organization. (2016). WHO Definition of Palliative Care.*

16 *Canadian Hospice Palliative Care Association. (2014). Lexicon of terms of related to the integrated palliative approach to care.*

17 *Canadian Nurses Association. (1998). Advance Directives.*

18 *Canadian Medical Association. (2014). Euthanasia and Assisted Death.*

19 *Special Joint Committee on Physician Assisted Dying. (2016). Medical Assistance in Dying: A Patient Centred Approach.*

Position Statement

References

- Canadian Hospice Palliative Care Association. (2014). Lexicon of terms of related to the integrated palliative approach to care.
- Canadian Medical Association. (2014). Euthanasia and Assisted Death.
- Canadian Nurses Association. (1998). Advance Directives.
- Canadian Nurses Association. (2008). Code of Ethics.
- Canadian Nurses Association, Canadian Hospice Palliative Care Association & Canadian Hospice Palliative Care Nurses Group. (2015). Joint Position Statement: The Palliative Approach to Care and the Role of the Nurse.
- Canadian Nurses Association. (2015). Brief for the Government of Canada's External Panel on Options for a Legislative Response to Carter v. Canada.
- Canadian Nurses Association. (n.d). Respecting choices in end of life care.
- Canadian Nurses Protective Society. (2016). Canadian Nurses Protective Society Submission on Physician Assisted Death.
- The Canadian Society of Palliative Physicians. (2016). Submission to Special Joint Committee on Physician-Assisted Dying.
- College of Registered Nurses of British Columbia. (2016). Medical Assistance in Dying: Scope of Practice Standard for Registered Nurses.
- College of Registered Nurses of British Columbia. (2016). Scope of Practice for Nurse Practitioners.
- College of Registered Nurses of British Columbia (CRNBC). (2016). Ethical Practice.
- Judgments of the Supreme Court of Canada. (2016). Carter v. Canada- Attorney General.
- Special Joint Committee on Physician Assisted Dying. (2016). Medical Assistance in Dying: A Patient Centred Approach.
- Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying. (2015).
- The Canadian Legal Information Institute. (2012). Carter v. Canada (Attorney General), 2012 BCSC 886 (CanLII).
- The Department of Justice. (2016). Consultations on Physician-Assisted Dying - Summary of Results and Key Findings.
- The External Panel on options for Legislative Response to Carter v. Canada. (2015).
- World Health Organization. (2016). WHO Definition of Palliative Care.

Further Reading

- Department of Justice. (2016). Medical Assistance in Dying

Association of Registered Nurses of British Columbia