Position Statement

Nurses' and Nursing's Role in Supporting a Patient-Centred Approach to Physician Assisted Death

Introduction

On February 6th, 2015, the Supreme Court of Canada (SCC)[1] ruled that people suffering "a grievous and irremediable medical condition" must be allowed to seek a doctor's help to end their lives" and allowed governments one year to make the appropriate legislative changes. In January 2016, the SCC granted the federal government a four-month extension to pass assisted dying legislation. The Court also ruled that Quebec's assisted dying law which came into effect in December, can remain in effect and 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" set out in the High Court's ruling last February. This is the first time the Supreme Court has been asked to grant individual exemptions of this kind.

Although the SCC's decision was silent on the role of Registered Nurses (RNs) and Nurse Practitioners (NPs) in physician assisted death, ARNBC recognizes that many RNs and NPs have questions and concerns about this decision and are seeking guidance in relation to their role in assisted death. It is important for all RNs and NPs to be aware that neither the SCC nor the federal government have yet considered the role of nurses in this process and that without a court order, physician assisted death still constitutes an offense under the Criminal Code. ARNBC recognizes that RNs and NPs are looking for information and support about what their role will be in physician assisted death. Be assured that ARNBC will continue to monitor how this ruling will impact nursing practice and will update this Position Statement 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 about how to manage a case where physician assisted death has been requested or discussed.
- While the nursing profession will play an important role in informing policy and legislation around physician assisted death, some individual RNs and NPs may be required to support patients throughout the experience.
- While RNs and NPs have the right to conscientious objection under the CNA's Code of Ethics (2008)[2], 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 (CRNBC)[3]
    - 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." (CNA 2008)[2].

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

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

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

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- Before an individual is granted a court order for physician assisted death, there will have been substantial involvement in their case by physicians, the health authority and others. RNs and NPs will have time to seek advice and information from their health authority risk management or professional practice office, and seek legal counsel if required.
- The Criminal Code should be amended to refer to "practitioner assisted death", rather than physician assisted death. This would ensure that all Canadians, regardless of geographic location, have access to physician assisted death if they so desire. It would also ensure that all healthcare providers, such as pharmacists, nurses and others are protected under the Criminal Code.
- While the Criminal Code currently prohibits "counselling" suicide, RNs and NPs should feel confident that they can access required knowledge around the current legal implications, tools and resources when presented with a patient who is requesting physician assisted death. ARNBC has advocated for all B.C. RNs and NPs to have access to current legal advice through the Canadian Nurses Protective Society (CNPS). RNs and NPs can call CNPS at any time to confidentially discuss concerns and questions or have CNPS review court orders or other legal documents specifically related to physician assisted death.
- Nurses should, in any instance, avoid initiating a discussion about physician assisted death with a patient who has not first raised the issue because the Criminal Code contains a provision making it an offence to counsel a person to commit suicide and it is not clear to what extent this provision will still apply in reference to physician assisted death.
- Nurses have many questions, concerns and beliefs regarding physician assisted death and for this reason greater discussion regarding the implications to nursing practice, as well as the individual RN or NP, must be addressed.
- 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 advanced care planning,[4] 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
- As legislation regarding physician assisted death is drafted, legal clarity and protection for nurses needs to be achieved with regard to the nursing role in counselling and supporting patients in their decisions regarding end-of-life care.

Background

In 1993 the Supreme Court of Canada (SCC)[5] 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 v 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 Sections 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[6], the case was heard in the SCC on

4 *Government of British Columbia. (2016). Advanced Care Planning.*

5 *Canadian Legal Information Institute. (2012). Carter v Canada.*

6 *Supreme Court of B.C. (2012)*

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 physician assisted death.

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 physician can apply to a superior court in their home province for "relief in accordance with the criteria"[8] set out in the high court's ruling last February

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 notably, The Provincial-Territorial Expert Advisory Group on Physician Assisted Dying[7], released in November 2015, and the External Panel on Options for a Legislative Response to Carter v Canada[8] which was released a month later. Currently, Quebec has implemented provincial legislation and has reported one case of administered physician assisted death. The Colleges of Physicians and Surgeons in B.C.[9] and Ontario have developed interim guidelines for the provision of physician assisted death during the exemption period, which begins February 6th, 2016.

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 physician assisted death 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 physician assisted death. This relationship is an invaluable tool to provide patients and their families with meaningful end-of-life care.
- There continues to be concern that patients will choose physician assisted death in fear of the dying process or because they feel they are a burden to their family and friends without first having access to information on what palliative services are available.

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).*

9 *College of Physicians and Surgeons of British Columbia Interim Guidelines. (2016).*

- There is a concern for nurses and patients located in underserved and remote communities where specialized palliative care is unavailable, coupled with a lack of physicians. Nurses practicing in these areas 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 physician assisted death.

Legal and Ethical Implications for RNs and NPs

- The Carter decision did not comment on the role of nurses in physician assisted death. While we await clarity regarding how the Carter decision applies to nursing practice, there remains a risk of criminal prosecution of nurses who, in the normal course of carrying out their duties, provide end-of-life care to patients engaged in the assisted death process.
- There is a need for clear provincial guidelines to be developed to guide nurses' practice should their patients request physician assisted death.
- Some RNs and NPs may be apprehensive or opposed to being involved with physician assisted death. 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 physician assisted death, keeping in mind that providing patients with information is not supporting physician assisted death, 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.[10]

Need for More Education and Information

- Bolstering nursing curriculum and continuing education in symptom management, the palliative approach, advanced 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 physician assisted death on nurses and to inform the creation and development of supports and resources.
- Patients need to receive better direction around advanced care planning.[11] An advanced directive[12] 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 advanced directives. However, in the current state of end-of-life care across Canada, what remains to be decided is whether an individual can include provisions for physician assisted death within their advanced directive.

10 Canadian Nursing Association.(n.d). Respecting choices in end of life care.

11 Government of British Columbia. (2016). Advanced Care Planning.

12 Canadian Nurses Association. (1998). Advanced Directives.

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Recommendations

1. Until June 6, 2016, a court must authorize physician assisted death in individual cases. It will be possible for a court, when providing this authorization, to stipulate that nurses who participate in the process within the limits of their scope of practice will not be acting in violation of the Criminal Code. Accordingly, until June 6, 2016, the extent to which a nurse is protected from criminal prosecution may depend on the wording of a court order. In these circumstances, if approached to participate in physician assisted death, ARNBC advises nurses to contact CNPS regarding their specific situation.

   ARNBC approached the CNPS to ask if it would be prepared to advise nurses in this regard. The CNPS has confirmed that it is available to provide independent legal advice to B.C. RNs and NPs with respect to their specific circumstances, even if the situation arises before March 1, 2016. There is no additional fee to obtain this advice.

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 physician assisted death 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. registered nurses and nurse practitioners. CNPS will provide any nurse who has questions or concerns about the legal implications of being involved in a physician assisted death situation with confidential legal advice.
4. ARNBC will host a discussion forum or webinar on end-of-life care including advanced care planning, palliative care and physician assisted death.

Conclusion

The laws prohibiting physician assisted death are still in effect until June of 2016, and the role that RNs and NPs will take in the delivery of this service has yet to be determined. ARNBC will continue to watch this issue very closely in an effort to provide appropriate and timely support for the nurses of B.C. The Association remains resolute that this discussion will be focused on the needs of patients and families, and will continue to advocate for resources and legal clarity to be made available so that nurses can provide the best care possible to patients facing end-of-life decisions.

Appendix A - Key Expert Perspectives

The Canadian Society of Palliative Physicians (CSPP)[1] 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 patients' 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 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 patients, families and healthcare providers.

The Canadian Nurses Association's (CNA)[2] submission to the External Panel cites 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 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 an interprofessional healthcare team throughout the assisted death process. In a joint position statement[3] 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 has concerns with the word "counseling". This term is commonly used in 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[4] suggests there should be a clear exemption in the Criminal Code for physician assisted death.

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 has stated "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."[5] The College of Physicians and Surgeons of Ontario have echoed this sentiment.[4]

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

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

3 *Joint Position statement. (2015).*

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

5 *The External Panel on options for Legislative Response to Carter v Canada. p84. (2015)*

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" (World Health Organization, 2016).[1]

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. (Canadian Hospice Palliative Care Association, 2014).[2]

Advanced 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 (Canadian Hospice Palliative Care Association, 2014).[3] This leads to the creation of an advanced 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. (CNA, 1998)

Physician Assisted Death "means that a physician knowingly and intentionally provides 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. (Canadian Medical Association, 2014)[4]

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.

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

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

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

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

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