

Medical Assistance in Dying: Guidelines for Nurses in Alberta

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of Alberta

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Members of the above regulatory bodies should contact their respective organizations if they have any questions about this document or wish to seek practice guidance about this topic.

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Purpose

On June 17, 2016, the federal government enacted legislation allowing for the provision of medical assistance in dying in certain circumstances in Canada. As a result, the amendments to the *Criminal Code of Canada* (RCS 1985, c. C-46) sets out the circumstances when medical assistance in dying will not be considered a criminal offence.

This amended *Criminal Code of Canada* outlines the following:

- A physician or a ***nurse practitioner***¹ (NP) may determine eligibility and provide medical assistance in dying in accordance with the *Criminal Code of Canada* without facing criminal prosecution.
- A person may aid a physician or NP in providing medical assistance in dying in accordance with the *Criminal Code of Canada* without facing criminal prosecution.

In this document the term ***nurse(s)*** refers to registered nurses (RNs), licensed practical nurses (LPNs) and registered psychiatric nurses (RPNs). NPs have a very specific role and responsibilities in medical assistance in dying and are therefore addressed in a separate document. The standards and guidelines for NPs on medical assistance in dying can be found on the CARNA website at nurses.ab.ca.

The purpose of this document is to provide:

- information to nurses on the new federal legislation allowing the provision of medical assistance in dying;
- guidance on the nursing role and accountabilities for nurses that are:
 - ◆ able to aid a physician or NP in the provision of medical assistance in dying,
 - ◆ not able to aid a physician or NP in the provision of medical assistance in dying;
- support for nurses as they work with ***clients***, families and the inter-professional health-care team in the legal provision of medical assistance in dying.

¹ Bold italicized words or phrases are listed in the glossary. They are displayed in bold italics upon first reference.

Introduction

Following a Supreme Court of Canada ruling, the *Criminal Code of Canada* has been amended to allow a person to request and receive, under limited circumstances, a substance intended to end their life. For more information on the background of this decision and the amendments to the *Criminal Code of Canada*, please see Appendix A.

The *Criminal Code of Canada* outlines that only two forms of medical assistance in dying are permitted:

- The administration of a substance to a person, at their request, to cause their death.
- The prescription or provision of a substance to a person, at their request, so that they may self-administer the substance.

The amendments to the *Criminal Code of Canada* do not allow for medical assistance in dying requests to be made through advanced directives, by persons under the age of 18 or by persons where mental illness is the sole underlying medical condition. The federal government has contracted an independent body to review the possibility of including these situation within the scope of the law in the future.

Medical assistance in dying is not to be confused with **palliative sedation** or the **withdrawing or withholding of life-sustaining interventions**.

Eligibility and Provision of Medical Assistance in Dying

Only physicians and NPs can assess a client's eligibility for and provide medical assistance in dying. The criteria required for the eligibility of medical assistance in dying and the safeguards that must be met are outlined in the *Criminal Code of Canada*.

Eligibility for Medical Assistance in Dying

A person may receive medical assistance in dying only if they meet **all** of the following criteria:

1. They are eligible (or, would be eligible after a minimum waiting period) for health services funded by a government in Canada.
2. They are at least 18 years of age and **capable** of making decisions with respect to their health.
3. They have a grievous and irremediable medical condition.
4. They have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure.

5. 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

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

1. They have a serious and incurable illness, disease or disability.
2. They are in an advanced state of irreversible decline in capability.
3. 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.
4. 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

The *Criminal Code of Canada* states that before a physician or NP provides a person with medical assistance in dying, they must:

1. Be of the opinion that the person meets all of the eligibility criteria.
2. Ensure that the person's request for medical assistance in dying was:
 - made in writing and signed and dated by the person (or if unable to sign, signed and dated by another person on his/her behalf as outlined in the Criminal Code of Canada) and
 - signed and dated after the person was informed by a physician or NP that they has a grievous and irremediable medical condition.
3. Be satisfied that the request was signed and dated by the person before two independent witnesses who also signed and dated the request.
4. Ensure that the person has been informed that they may, at any time and in any manner, withdraw their request.
5. Ensure that another physician or NP has provided a written opinion confirming that the person meets all of the eligibility criteria.
6. Be satisfied that they and the other physician or NP providing the written opinion are independent.

7. 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. A shorter time frame can occur if certain criteria are met (the physician or NP providing medical assistance in dying and the physician or NP who provided the independent written opinion both agree that the person's death, or the loss of their capacity to provide informed consent, is imminent).
8. Immediately before providing the medical assistance in dying, give the person an opportunity to withdraw their request and ensure that the person gives expressed consent to receive medical assistance in dying.
9. If the person has difficulty communicating, take all necessary measures to provide a reliable means by which the person can understand the information that is provided to them and communicate their decision.

Provincial Requirements

Alberta Health (AH), Alberta Health Services (AHS), the College of Physicians and Surgeons of Alberta (CPSA), the Alberta College of Pharmacist (ACP) worked together to develop a regulatory framework that is aligned, legally sound, safe and consistent with the *Criminal Code of Canada*. This regulatory framework includes additional provincial safeguards and professional standards for consistency and client safety.

Alberta Health implemented the following:

- A Ministerial Order directing the establishment of the Medical Assistance in Dying Regulatory Review Committee.
- A Ministerial Order directing the establishment of a provincial care coordination Service by AHS that is available to support clients and all health-care professionals in the province when a request for medical assistance in dying is made.
- Mandatory provincial medical assistance in dying standards of practice for both physicians and NPs. These are Orders in Council under the authority of the Minister of Health and are as follows:
 - ◆ *Medical Assistance in Dying Standards of Practice for the College of Physicians and Surgeons of Alberta* (Alberta. Minister of Health, 2016).
 - ◆ *Medical Assistance in Dying Standards of Practice for Nurse Practitioners* (Alberta. Minister of Health, 2016).

Additional regulatory guidance to support physicians and NPs that are determining eligibility or providing medical assistance in dying is available:

- Physicians - *Advice to the Profession: Medical Assistance in Dying* (CPSA, 2016).

- Nurse practitioners – *Medical Assistance in Dying: Guidelines for Nurse Practitioners* (CARNA, 2017).

Guidelines for Nurses

There are important legal, ethical and professional aspects of medical assistance in dying that nurses need to understand and apply. These guidelines provide guidance and information to nurses when contemplating their response to questions about medical assistance in dying, when having conversations with clients about medical assistance in dying or when contemplating aiding a physician or NP in the provision of medical assistance in dying.

Nurses are responsible for safe, competent and ethical practice. Medical assistance in dying is a new legal choice for Canadians and nurses need to reflect on their own personal values and beliefs. Self-reflection and engaging in dialogue with other nurses, their team and health-care providers are essential components of ethical nursing and will assist nurses to develop a plan of how to approach medical assistance in dying in practice. Nurses are also encouraged to access self-assessment and decision support resources and tools. For example, *Medical Assistance in Dying: Values-Based Self-Assessment Tool for Health Care Providers* (Alberta Health Services, 2016) or *Ethical Decision Making for Registered Nurses* (CARNA, 2010).

Nurses respect their own values and moral beliefs while at the same time respect the values and moral beliefs of others. Nurses do not impose their own views and values onto others nor use their position to influence, judge or discriminate against others whose values are different from their own. For more information and team communication and respect in relation to medical assistance in dying, please see Appendix B.

The Nurses Role

The *Criminal Code of Canada* allows nurses to aid in medical assistance in dying **only when under the direction of a physician or NP**. It is essential for nurses to understand that they will have a limited role in medical assistance in dying. Only a physician or NP can assess eligibility for medical assistance in dying and only the physician or NP can administer the substance that causes the death.

Although there is nothing in federal legislation prohibiting a **graduate nurse** from aiding a physician or NP with medical assistance in dying, this role does require competencies in **end-of-life care** specific to medical assistance in dying. These competencies are currently beyond the entry-to-practice level and should not be performed by a graduate

nurse unless they have the appropriate additional knowledge, skill and ability and they have support from the employer. The graduate nurse can contact their regulatory college for more information.

Communication with the Client and Family

Many complex factors may be involved when a client begins a discussion on medical assistance in dying. The client's choices may involve factors such as their religion, the medical condition, the nurse-client relationship, perceptions of quality of life, supports available and other psychosocial circumstances. If a client wants to know more about medical assistance in dying, it is important to acknowledge their request for information in a timely, competent and compassionate way. Know that the client's request for additional information or further consultation on medical assistance in dying is their constitutional right and nurses that are able, can support the clients access to accurate and objective information so that they may make an informed decision about their care. If nurses are unable to provide accurate, objective information to clients, they need to refer them to someone that can.

Good communication strategies such as using open-ended questions and statements is essential. A request for information on assisted death may also be a way for the client to engage in a meaningful conversation about health issues or end-of-life care and support. Open communication is a vital part of end-of-life decision making.

The *Criminal Code of Canada* creates an exemption from criminal prosecution for health-care professionals who aid physicians or NPs in the lawful provision of medical assistance in dying.

Section 241(5.1) of the *Criminal Code of Canada* (R.S.C. 1985, c. C-46) states:

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.

The provision of objective information is not prohibited by the *Criminal Code of Canada*. However, nurses must be mindful that subsection 241(a) of the *Criminal Code of Canada* will continue to make it a criminal offence to "counsel" a person to commit suicide. For the purposes of the *Criminal Code of Canada*, "counsel" means encourage, solicit or incite. Due to the criminal significance of the word "counsel," nurses must be mindful not to encourage or incite a client to seek medical assistance in dying (Canadian Nurses Protective Society, 2016).

Nurses who provide information about medical assistance in dying should ensure that the information is objective and is correct before it is provided and should not guess or speculate. Where unsure, the nurse should consult with reliable sources of information and consider an early referral to authoritative sources of information such as the AHS Medical Assistance in Dying Care Coordination Service (MAID.CareTeam@ahs.ca) or the primary care provider. Nurses should also endeavor to remain as neutral as possible and refrain from advocating for or against medical assistance in dying.

Guideline 1: Nurses provide objective, accurate information on the lawful provision of medical assistance in dying.

Whether or not a nurse chooses to participate in a client's request for medical assistance in dying, they have an obligation to:

- effectively listen to the client's concerns, unmet needs, feelings, and desires about their care with empathy, respect and compassion,
- refer the client to their primary care provider or to the AHS Medical Assistance in Dying Care Coordination Service (MAID.CareTeam@ahs.ca) as necessary, and
- continue to provide safe, compassionate, competent, ethical nursing care and reassure the client that their care needs will continue to be addressed.

As part of their role, nurses:

- work to relieve pain and suffering through effective symptom and pain management, including fostering comfort and advocating for adequate relief of discomfort,
- ensure that clients in their care receive all of the information they need to make informed decisions related to their health and wellbeing including medical assistance in dying,
- collaborate with the health-care team as required,
- introduce palliative and end-of-life care as an option to consider, if appropriate, to support symptom management (see Appendix C),
- provide psychosocial support and refer to additional supports as needed,
- follow the organizational policies that detail who to alternately contact for this specific query,
- ensure the client understands all additional supports available to them and is not seeking medical assistance in dying due to lack of supports, and

- document the care provided and any request for information on medical assistance in dying in the client record according to organizational policy and professional standards.

Guideline 2: If a client asks about medical assistance in dying, the nurse engages in meaningful communication to clearly understand the client's health needs.

Knowledge Based Practice

Nurses are responsible for understanding and complying with medical assistance in dying legislation and understanding how it might apply to their nursing practice, setting and role. If a nurse elects to aid a physician or NP in the provision of medical assistance in dying, they need to review and understand:

- the principles of the *Criminal Code of Canada* provisions,
- any provincial legislation and/or direction,
- any guiding documents from their regulatory body,
- the employer's position in permitting medical assistance in dying in the employment setting and any applicable policies, guidelines, procedures and/or processes in place, and
- any professional or employer legal advice.

Guideline 3: Nurses ensure that their practice is in accordance with the *Criminal Code of Canada*, other applicable laws, rules, standards, policies and guidance on medical assistance in dying.

Nurses continually acquire and apply knowledge and skills to provide competent, **evidence-informed** nursing care and service. Nurses ensure that they utilize resources and complete any required education in relation to medical assistance in dying. For example, the *Medical Assistance in Dying Overview for Non-Physician Providers* (Alberta Health Services, 2016).

Guideline 4: Nurses ensure that they have the competence to do the required interventions (e.g. providing education or starting an intravenous line).

Aiding with Medical Assistance in Dying

The *Criminal Code of Canada* allows nurses to aid in medical assistance in dying **only when under the direction of a physician or NP**. Only the physician or NP can assess eligibility for medical assistance in dying and only the physician or NP can administer the substance that causes the death. This means that nurses could aid by initiating IV access but they cannot administer the substance that causes death pursuant to an order or prescription.

In situations where a physician or NP has prescribed an oral substance to the client to self-administer to cause death, the client would have to be the one to physically take the substance. With the client's explicit request, the nurse can pass the oral substance to the client or with the physician's or NP's explicit request, can pass the prepared syringe to the physician or NP. However, nurses refrain from activities that may be viewed as the actual administration of the substance, such as placing the oral substance in the client's mouth or inserting (pushing) the substance into the client's intravenous line or feeding tube or preparing or altering the substance to ease ingestion such as mixing the substance with food or liquid. The nurse is NOT responsible to prepare, dispense, retrieve, administer or return any of the lethal substances prescribed and administered by the physician and/or NP for medical assistance in dying.

Guideline 5: Nurses do not administer the substance that causes death in medical assistance in dying.

Guideline 6: Nurses aiding a physician or NP in the lawful provision of medical assistance in dying may perform activities such as client education, providing support or comfort care to clients and family, or inserting an intravenous line.

The *Criminal Code of Canada* requires that medical assistance in dying is provided in accordance with "reasonable knowledge, care and skill and in accordance with any applicable provincial laws, rules or standards." (CNPS, 2016). Prior to aiding a physician or NP in the provision of medical assistance in dying, nurses ensure that they are aware of the eligibility parameters, safeguards and requirements for medical assistance in dying and have a reasonable objective basis to support that the physician or NP providing medical assistance in dying has met all requirements as set out in legislation. This needs to be done through reliable sources of information.

This may include:

- a. Reviewing the clients chart and signed written request form for medical assistance in dying.

- b. Reviewing or discussing the assessment of eligibility and second opinion with the physician or NP.

It would be important for the nurse to carefully document in the client's chart the steps taken to verify the determination that the eligibility criteria and safeguards have been met. Nurses need to document according to employer policies and professional standards.

If the nurse has questions about the eligibility criteria, safeguards or requirements for medical assistance in dying, they need to directly ask their questions to the physician or NP providing the medical assistance in dying. If any questions remain unanswered, the nurse needs to notify their supervisor or the care coordination team immediately and discuss next steps.

Guideline 7: Nurses ensure that they are aware of the eligibility parameters, safeguards and requirements and have a reasonable objective basis to support that they are acting appropriately with respect to a client who is requesting medical assistance in dying.

Nurses considering aiding in medical assistance in dying under the direction of a physician or NP can contact the following resources with any questions, concerns or for practice advice:

- **CARNA:** Email practice@nurses.ab.ca for practice advice and/or call the Canadian Nurses Protective Society at 1-800-267-3390 for legal advice.
- **CLPNA:** Email info@clpna.com or call 780-484-8886 or toll free 1-800-661-5877.
- **CRPNA:** Email crpna@crpna.ab.ca or call 780-434-7666 or toll free: 1-877-234-7666.
- AHS Medical assistance in dying tools and resources and resources: albertahealthservices.ca.

No Obligation to Aid with Medical Assistance in Dying

The amendments to the *Criminal Code of Canada* do not impose any obligation for nurses to aid in medical assistance in dying.

Nurses are not obligated to aid a physician or NP in medical assistance in dying. Nurses who are asked to aid in any aspect of lawful medical assistance in dying and choose not to participate at any time due to personal moral beliefs and values, lack of skill or other reasons, must immediately:

- a. assure the client that they will not be abandoned and continue to provide care that is not related to activities associated with medical assistance in dying,
- b. notify their employer so that alternative care arrangements can be made, and
- c. refer the client to their primary care provider or to the AHS Medical Assistance in Dying Care Coordination Service via email at MAID.CareTeam@ahs.ca.

Nurses are required to follow the Code of Ethics of their profession. If nursing care is requested that is in conflict with the nurse's personal moral beliefs and values but in keeping with professional practice, the nurse provides safe, compassionate, competent and ethical care until alternative care arrangements are in place to meet the client's needs or desires. If nurses can anticipate a conflict with their conscience, they have an obligation to notify their employers or, if the nurse is self-employed, persons receiving care in advance so that alternative arrangements can be made.

Reassure the client that they will not be abandoned in the care they need. No personal moral judgments about the beliefs, lifestyle, identity or characteristics of the client should be expressed by the nurse. Until an alternate person is found or care is transferred, a nurse continues to provide nursing care, as per the client's care plan, that is not related to activities associated with medical assistance in dying.

If you have any questions about this, members are encouraged to contact their respective regulatory college.

Guideline 8: Nurses are not obligated to aid a physician or NP in medical assistance in dying. Nurses who are asked to aid in any aspect of lawful medical assistance in dying and choose not to participate at any time due to personal moral beliefs or values, must immediately:

- a. assure the client that they will not be abandoned and continue to provide care that is not related to activities associated with medical assistance in dying,
- b. notify their employer so that alternative care arrangements can be made, and
- c. refer the client to their primary-care provider or to the AHS Medical Assistance in Dying Care Coordination Service via email at MAID.CareTeam@ahs.ca.

Independent Witness

The *Criminal Code of Canada* requires that a person's request for medical assistance in dying must be made in writing, signed and dated, and witnessed by two independent witnesses, who also sign and date the request. In order to be an independent witness, a witness cannot know or believe to be a beneficiary under the will of the person making

the request, cannot be an owner or operator of a health-care facility where the person making the request is being treated, cannot be directly involved in providing health-care services to the person making the request and cannot be directly involved in the provision of personal care to the person making the request.

Nurses involved in providing health-care services or personal care (or who may become involved in care in the practice area) to the person making the request for medical assistance in dying, cannot act as an independent witness. The nurse can only act as an independent witness if they are not involved in providing health-care services or personal care to the person making the request for medical assistance in dying. This means that nurses that have documented health-care services they have personally provided in the client's health record would not be suitable to act as a formal witness to this request.

The role of the independent witness is to confirm the identity of the client requesting medical assistance in dying and attest to the client's apparent understanding of the request being made.

Guideline 9: Nurses involved in providing health-care services or personal care to the client making the request for medical assistance in dying, cannot act as an independent witness.

Documentation

Nurses accurately document medical assistance in dying conversations and the nursing care they provide in a timely, factual, complete and confidential manner. A nurse who is aiding a physician or NP in the provision of medical assistance in dying should document:

- any request for information on medical assistance in dying directed to the nurse and the information provided,
- any nursing actions in relation to the aid they provided to the physician or NP prior, during or after the medical assistance in dying procedure including the objective information that was used to verify that the legal requirements for medical assistance in dying have been satisfied.

Nurses must be aware that there are criminal offences with serious penalties for forgery or destruction of documents related to medical assistance in dying (RSC 1985, c. C-46, s241.4).

Guideline 10: Nurses document their nursing care appropriately in accordance with the standards of practice of their regulatory college and the policies/processes of their employer.

Reflections for Nursing Practice: When Aiding a Physician or NP in Medical Assistance in Dying

Despite the authorization to provide nursing care in medical assistance in dying, nurses must always restrict themselves to activities which they are competent to perform and that are appropriate to their area of practice and the procedures being performed. Below are some other considerations for nursing practice in regards to medical assistance in dying.

Route of administration

- If the substance is to be delivered via intravenous route, what is the volume of substance(s)? Is a secondary IV required? What is the appropriate gauge of IV catheter?
- If oral administration of the substance, are there any requirements to establish an IV as a secondary route of administration?
- If a client self-administers the substance, will the client be able to take the oral substance independently?

Supports available

- What supporting information is needed for the clients and family?
- What supporting information is needed for the care team that may encounter questions about or be involved in medical assistance in dying?
- Does the client, family and staff have what they consider to be adequate social, psychological and spiritual supports in place? If there is presence of conflict, are there supports in place?
- Are the family or others going to be present during the medical assistance in dying process? What support will be needed?
- Are the family and/or client informed about the process, what they may see and experience before, during and after?
- Are arrangements in place following the death of the client?
- What are the medical examiners requirements for care of the body? Are there policies or protocols in place for how to care for the body?

- Is a debriefing process required for the care team providing medical assistance in dying? What supports may be required for the care team following Medical Assistance in Dying? Has the AHS medical assistance supportive review process been contacted?
- Has it been considered whether appropriate employee/family assistance program has been contacted?

Environment

- Consider the resources available for the different environments where medical assistance in dying can take place (i.e. home, inpatient unit, hospice).
- Consider the necessary positioning of the client for substance administration and comfort.

Competency

- Assess competencies for end-of-life care:
 - ◆ assessment and management of pain, physical symptoms, and psychosocial and spiritual needs;
 - ◆ ability to attend to the end-of-life needs of the client and family.
- Awareness of own responses to suffering and death and seek support as needed.
- Seek out relevant education for competence and lifelong learning in end-of-life care.

Glossary

Advance care planning – A process that can assist all Albertans in making healthcare decisions at any time which could be now and in the future (AHS, 2014).

Capable – Being able to understand and appreciate the consequence of various options and make informed decision about one's own care and treatment (Canadian Nurses Association, 2008).

Client – The patient, resident or individual who is the recipient of nursing services.

End-of-life care – The care provided to clients and their families when they are approaching a period of time closer to death, which may be exemplified by an intensification of inter-disciplinary services and assessments such as anticipatory grief support, and pain and symptom management (AHS, 2014).

Evidence-informed – The ongoing process that incorporates evidence from research, clinical expertise, client preferences and other available resources (CNA, 2010).

Graduate nurse – Either a graduate of an approved or recognized entry-level nursing education program or an internationally educated nurse (IEN) applicant who is eligible for a temporary practice permit to begin employment as a graduate nurse (CARNA, 2009).

Nurse – In this document refers to registered nurses, registered psychiatric nurses and licensed practical nurses.

Nurse practitioner – 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 client (RSC 1985, c. C-46, s. 241.1).

Palliative care – Aims to improve the quality of life for patients and families facing the problems associated with a life-limiting illness through the prevention and relief of suffering by means of early identification, comprehensive interdisciplinary assessments and appropriate interventions. (AHS, 2014)

Palliative sedation – The use of sedative substances for clients who are terminally ill with the intent of alleviating suffering and the management of symptoms. The intent is not to hasten death although this may be a foreseeable but unintended consequence of the use of such substances (Canadian Medical Association, 2014).

Withdrawing or withholding life-sustaining interventions – Interventions that are keeping the client alive but are no longer wanted or indicated (CMA, 2014). For example; artificial ventilation, nutrition or cardiac pacing devices.

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Appendix A

Background of the Legal Framework

The past five years have seen unprecedented development in Canada's approach to choice in end-of-life decisions. Evidence of change is present in the wider context of public opinion as well as in legal and social policy development (CNA, 2017). The following significant events have contributed to and formed the current Canadian legal framework for medical assistance in dying.

Carter v. Canada

On Feb. 6, 2015, the Supreme Court of Canada (SCC) made its decision in *Carter v. Canada*. The SCC unanimously ruled that Criminal Code sections 241(b) and 14 violated section 7 of the Charter of Rights and Freedoms in so far as they prevented the two applicants, Kay Carter and Gloria Taylor and persons in like circumstances from lawfully obtaining assistance from a doctor in ending their life. The SCC set out the conditions which would make a person eligible for what they referred to as physician-assisted death. Initially, the Court suspended the operation of its judgment for one year to allow the federal government, the only level of government empowered to amend the Criminal Code, time to decide upon legislative amendments as a result of this judgment. After the Court granted the federal government a four-month extension, the operationalization of the Carter decision became law on June 6, 2016.

Bill C-14

The House of Commons and Senate established a special joint committee which convened a consultation process in January 2016. The committee heard overwhelming support for a collaborative and client centered approach. The special joint committee recommended that the term medical assistance in dying be used and the Criminal Code be amended to allow medical assistance in dying by physicians and NPs, and to protect health professionals who assist them. On April 14, 2016 *Bill C-14: An Act to amend the Criminal Code and to make related amendments to other Acts* (medical assistance in dying) was tabled in Parliament. On June 17, 2016, Bill C-14 received royal assent, making it possible for eligible people to receive medical assistance in dying in Canada. The amended *Criminal Code of Canada* establishes safeguards for clients alongside the minimum conditions required for avoiding criminal liability. The Code also offers legal protection to health professionals who provide medical assistance in dying, or assist in the process, in accordance with the law.

Alberta Regulatory Framework

Alberta Health (AH), Alberta Health Services (AHS), the College of Physicians and Surgeons of Alberta (CPSA), the Alberta College of Pharmacist (ACP) have worked together to develop a regulatory framework that is aligned, legally sound, safe and consistent with the amended *Criminal Code of Canada*. This regulatory framework includes additional provincial safeguards and professional standards for consistency and client safety.

Alberta Health has directed the following:

- The establishment of the Medical Assistance in Dying Regulatory Review Committee.
- The establishment of a Provincial Care Coordination Service by AHS that is available to support clients and all health-care professionals in the province when a request for medical assistance in dying is made.
- The development of mandatory physician and nurse practitioner standards of practice to provide medical assistance in dying (in conjunction with the regulatory colleges) through an Order in Council.

Appendix B

Team Communication and Respect

The societal context in which nurses work is constantly changing and can be a significant influence on nursing practice (CNA, 2008). Conversations on medical assistance in dying raises many ethical considerations and generates great differences of opinion. Clients may make choices that challenge or conflict with the ethical or moral values of health professionals who care for them. Nurses are responsible for the ethics of their practice and must conduct themselves ethically in what they do and how they interact with clients and their care team. Nurses treat each other, colleagues and other members of the health-care team with respect and confidentiality. For additional support, members can refer to their profession's Code of Ethics for guidance on ethical responsibilities, behaviors and nursing practice (CNA, 2008).

Nurses who choose to participate, as well as those that choose not to participate in medical assistance in dying will have deeply held values regarding end-of-life issues. It is important to recognize the rights of persons with conflicting views. Nurses can respect their own values and moral beliefs while at the same time can respect the values and moral beliefs of others. Nurses do not impose their own views and values onto others nor use their position to influence, judge or discriminate against others whose values are different from their own.

Nurses recognize the importance of privacy and confidentiality and safeguard personal, client, family and team information obtained in the context of medical assistance in dying. It is important for nurses to:

- Be knowledgeable about federal and provincial regulations, professional regulatory college standards and guidelines and organizational policies on medical assistance in dying.
- Participate in conversations on medical assistance in dying with their team to promote understanding of the processes utilized to provide this service if applicable and how privacy and confidentiality will be maintained within the team.
- Contact their regulatory college with any questions.

Appendix C

Palliative and End-of-Life Care

Palliative and end-of-life care (PEOLC) is both a philosophy and an approach to care that enables all individuals with a life-limiting and/or life-threatening illness to receive integrated and coordinated care across the continuum (AHS, 2014). This care incorporates client and family values, preferences and goals of care, and spans the disease process from early diagnosis to end of life, including bereavement. Throughout the continuum of PEOLC, health-care teams utilize an interdisciplinary approach to meet the individualized needs of clients, their families and/or caregivers. The interdisciplinary team addresses physical, emotional, spiritual, practical and social concerns that arise with advanced illness for individuals at all ages and developmental stages of life.

Palliative care starts at the time of diagnosis of a life limiting illness. If **advance care planning** has not been done this is a good time to engage individuals and their families in advance care planning.

When people have access to PEOLC services, they report fewer symptoms, better quality of life, and greater satisfaction with their care. The health-care system reports more appropriate referrals, better use of hospice care, fewer emergency room visits and hospitalizations, and less use of ineffective intensive interventions in the last days of life (CHPCA, 2013).

Access to PEOLC is the right of all Canadians and is an essential aspect of health-care. PEOLC nursing practice happens in many practice settings and recognizes the importance of a person's choices, dignity and respectful treatment. Access to comprehensive services that address pain relief and other symptom management practices needs to be reflected in the care plan and is inherent to providing quality care and dignity in life and death. Nurses and NPs need to be aware of, advocate for and offer such options.

Medical assistance in dying should not be the default choice for clients as a result of a lack of accessible PEOLC. There must be greater efforts among all health professions and government to work towards ensuring that there is more comprehensive and accessible PEOLC. Nurses need to assume a leadership role in facilitating the coordination and implementation of effective PEOLC services. Nurse's contribution to palliative care is vital as they have the knowledge, education and skill to provide effective PEOLC nursing to people and their families. For more information on the nursing role in palliative care, please see CARNA's *Position Statement on Hospice Palliative Care* (CARNA, 2011). For information about PEOLC in Alberta for clients and

families and health care providers please check out the provincial PEOLC website at <https://myhealth.alberta.ca/palliative-care>.