This issue is not one of life or death. The issue is what kind of death, an agonized or peaceful one. Shall we meet death in personal integrity or in personal disintegration? Should there be a moral or demoralized end to mortal life? medical ethicist (Fletcher, 1954)

“Legalization of assisted dying is a societal prerogative. It is a done deal. But we still have an opportunity to help shape what it will look like in practice.”
Dr. Jeff Blackmer, CMA Vice-President, Medical Professionalism., July 20, 2015
June 17/16– did Canada open Pandora’s Box?

- In Greek mythology, Pandora opened a box & all the evils of the world flew out. This left her with only “hope.” Accordingly, the phrase “to open Pandora’s box” means to perform an action that may seem small or innocent, but has wider unintended consequences. Two thousand years on this story is still informative. It is not enough to “hope” that we get MAID right: it requires frank debate, lengthy commitment, clearer guidelines, and wider engagement.  

Dr. Jeff Blackmer, CMA Vice-President, Medical Professionalism,. July 2015
Don’t want versus Do want

- Legislation and societal acceptance on what we *don’t* want
  - Very Clear

- Legislation and societal acceptance on what we *do* want
  - Clear moral conflict and disagreement
History and Background

- Prior to recent changes, the Criminal Code of Canada prohibited the provision of any form of assistance in dying.

- In the early 1990s, Sue Rodriguez, a woman suffering from ALS challenged the constitutionality of these statutory provisions.

- Ms. Rodriguez’s argument was that the prohibitions on assisted-suicide violated her rights under s. 7 of the Charter.
History and Background

- Section 7 guarantees the right to life, liberty and security of the person

- She took this challenge all the way to the Supreme Court of Canada in 1993.

- The Court ultimately held that the prohibition on assisted-suicide was constitutional, and the Criminal Code provisions remained in place.
History and Background

- Thus the Court held there was no constitutional right to assisted dying.

- It was a tight decision: 4 versus 5 Judges

- More than 20 yrs later, in 2015, the Supreme Court unanimously overruled Rodriguez in the Carter decision.
Carter Decision

- The Court ruled that the Criminal Code provisions at issue “infringe s. 7 of the Charter and are of no force or effect to the extent that 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.”
Carter Decision

- The Court gave the Federal Government 1 yr to introduce legislation that was compliant with its decision.

- Bill C-14 received Royal Assent and came into force June 17, 2016
Medical Assistance in Dying is defined as:

(a) the administration 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
CLPNNS & CRNNS

- Guidance on Nurses’ Roles in MAiD
- Summarizes many of the key aspects of Bill C-14
- Provides recommendations and guidance
Statement of Nursing Values & Responsibilities per the 2017 CNA Framework (Core Values)

A. Providing safe, compassionate, competent and ethical care
   i. Nurses adhere to and remain current on the state of the law and its implications for their professional practice.
   
   iii. Nurses aid in the provision of MAID with reasonable knowledge, care and skill and in accordance with any applicable provincial laws, rules or standards.

B. Promoting health and well-being
   
   i. Nurses support persons in achieving their highest level of health in ways that are meaningful and acceptable to those persons.
   
   ii. Nurses strive for excellence in end-of-life care options including palliative care and natural death or MAID.
Statement of Nursing Values & Responsibilities per the 2017 CNA Framework (Core Values)

C. Promoting & respecting informed decision-making
   i. Nurses recognize, respect and promote a capable person’s right to be informed and make decisions about their health and end-of-life care options including MAID.
   
   ii. Nurses respect the wishes of capable persons who request information about MAID.
   
   iii. 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.
   
   iv. Nurses support a capable person’s right to withdraw their request for MAID at any time.

D. Maintaining privacy and confidentiality
   i. Nurses respect the privacy of persons who inquire about or request MAID and protect the privacy and confidentiality of sensitive information about diagnosis and cause of death.
   
   ii. Nurses adhere to current legislation, professional regulatory standards & employer policies regarding MAID, including IT security safeguards that protect & preserve the privacy of the person, as well as that of his or her family and the health-care professionals involved.
Statement of Nursing Values & Responsibilities per the 2017 CNA Framework (Core Values)

E. Preserving dignity

i. Nurses work with the person inquiring about or requesting MAID, & with family members, groups & communities, in accordance with the person’s consent while respecting the person’s values, beliefs and decision.

ii. Nurses work to prevent or eliminate discrimination toward all those involved — persons, family members, health-care staff — in end-of-life care decisions & provisions, including MAID.

iii. Nurses listen actively to persons’ concerns, experiences and requests for information to identify opportunities for clarifying their goals of care, education needs, alterations in care and access to resources.

iv. Nurses foster comfort and support a dignified death.

v. Nurses provide support for the family during and following the death.

vi. Nurses treat each other and all members of the health-care team respectfully, whether or not they choose to be involved in providing or aiding in MAID.
F. Promoting justice

i. Nurses contribute to the development of processes and practices that enable persons to access information on and request MAID.

ii. Nurses refrain from judging, labelling, demeaning, stigmatizing or humiliating persons who request MAID or who provide or aid in MAID (including each other), whether or not they have a conscientious objection to MAID.

iii. When a person requests MAID, nurses make fair decisions about the allocation of resources within their control based on the needs of the person.

iv. Nurses strive for sufficient resources that enable persons to access palliative care and MAID.
Nursing Role in MAiD – What can you do?

Consider the following:

- Counseling
- Client eligibility
- Statutory safeguards
- Administration of medication
- Privacy and confidentiality
- Documentation
- Witnessing a written request

Section 241.2(7) of the Criminal Code requires that MAiD be provided with reasonable knowledge, care & skill and in accordance with applicable provincial laws, rules or standards.
Nursing Role in MAiD – What about CO?

- Counseling (IF a client asks):
  - Explore reasons for request BUT in context of ALL OTHER end of life care options (e.g. palliative care).
    - IMPORTANT: It is still a CRIMINAL offence to counsel a person to commit suicide. Therefore MUST NOT encourage or recommend MAiD.
  - Provide information about MAiD & answer questions – keep it patient centered.
  - May refer inquiries to MD/NP who know more
  - Must continue to provide care that supports client’s rights to make informed decisions & end of life needs
  - Promptly inform the client’s primary care provider/team members of client’s request & document in client record
Nursing Role in MAiD – What about CO?

**Client Eligibility**
- Not permitted to determine client’s eligibility BUT you MUST:
  - Discuss client’s request for MAiD with other members of Health care team
  - *Review client record & client’s written request for MAiD*
  - Follow any employer policies
  - If you know OR reasonably believe the client DOES NOT meet eligibility criteria you must immediately raise your concerns

**Statutory Safeguards**
- Must know the safeguards outlined in Criminal Code & by employer
  - Written request, signed & dated with 2 independent witnesses
  - Another NP/MD has provided written opinion that client meets eligibility
  - At least 10 days between day request signed & provision of MAiD**
  - Immediately before MAiD NP/MD must give option to withdraw & re-consent
Nursing Role in MAiD – What about CO?

- **Administration of MAiD**
  - RNs/LPNs not permitted to administer the meds that cause the client’s death, even if requested by NP/MD/client
  - *May assist with:*
    - Inserting of IV line that will be used later for MAiD
    - Be present during MAiD to provide holistic nursing to support client/family
    - *If client is self-administering – passing of the meds AS LONG AS client asks for your assistance***

- **Privacy & Confidentiality**
  - The same as will all other aspects of nursing practice
Nursing Role in MAiD – What about CO?

**Documentation**
- There is a general documentation guideline for LPNs
- *Identity of persons present*
- *Name of provider that administered medication, where applicable*

**Witnessing a Written Request for MAiD**
- You may act as a witness as long as you:
  - Are aware that the document is a formal request for assisted dying
  - *NOT directly involved with providing health care services or personal care/services to the client*
  - Are not OR reasonably believe that you are not a beneficiary under the client’s will or will receive a financial or other material benefit from the client’s death
  - Not the owner or operator of the facility where MAiD will occur
Nursing Role in MAiD – What about CO?

But what if you conscientiously object?

Note: Nothing in the Criminal Code compels a nurse or NP to participate in MAiD....
MAiD and Conscientious Objection

- Health care providers are often faced with conflicts between their personal values and their professional duty to provide care.

- In these situations, it is usually expected that professional obligations will be prioritized over personal values.

- What is different about a situation in which a health care provider may choose to conscientiously object to providing care?

- What is the same & different between Duty to Care & Conscientiously objecting
  - SARS versus MAiD
  - Purposefully chose a career where you are around sick people; Did not choose a career where you killed people
  - Physical harm to self versus harm to moral integrity
What is conscientious objection?

- Conscientious objection in the health care context:

  When a health care professional

  (1) Refuses to provide a legal service that falls within his/her professional competence; and

  (2) Justifies the refusal by claiming that it is conscience-based

  (Wicclair, 2014)
Refusal is conscience-based *if and only if*:

- the agent has **core moral beliefs** (ethical or religious)
- providing the service is incompatible with her core moral beliefs
- the agent’s refusal is based on her core moral beliefs

What are ‘core moral beliefs’?

- ‘beliefs that matter most to the agent’; ‘beliefs that are integral to the agent’s understanding of who she is’; ‘the central moral core of her character’

(Wicclair, 2014)
Other reasons for refusal that are *NOT* conscience-based

- Self-interest: e.g. concerns about personal safety (abortions, contagious disease)

- Professional integrity: refusals based on clinical considerations, e.g. treatment not medically indicated, not in patients’ best interest

- Different from civil disobedience – goal is to secure legal exemptions
What does legislation permit?

- Legislation typically permits individual health care professionals to refuse participation in certain medical procedures:
  - End-of-life care: ending life-sustaining treatment, palliative sedation, physician assisted suicide
  - Reproductive health care: Abortion, sterilization, assisted reproduction, dispensing (emergency) contraception
Why protect the right to conscientious objection?

- Protect the moral integrity of health professionals
- Tolerance of moral diversity
- Epistemic modesty
- We want health professionals who are capable of exercising judgment, not just ‘follow the rules’
Limitations on the right to conscientious objection

- No absolute moral right to act on one’s conscience
  - Refusal to accept a patient may not be based on invidious discrimination (e.g. race, religion, sexual orientation)

- The medical professions’ obligations to society
  - Patient’s right to health care
  - No blanket approval or general right: CO should be considered in relation to specific clinical services.
Patients’ interest need to be protected

- Health care providers may not refuse to accept patients in medical emergencies

- The conventional compromise:
  - CO must not undermine access to services
    - HCPs required to provide information and/or referral
  - CO must not impose undue burden on patients
    - What counts as undue burden? (harm versus mere inconvenience)
  - Patients may be affected unequally by CO (special concerns for the poor, otherwise vulnerable groups)
  - Geography-relative right to CO (urban versus rural)
What does my College say about CO?

- If MAiD is in conflict with your moral beliefs & values, you may decline to participate in any aspect of client care connected with it.

- If you choose not to participate you MUST:
  - Promptly inform either your employer or your client IF you are a self-employed nurse
  - Continue to provide safe, competent, ethical and compassionate care until alternative arrangements can be made
  - Provide nursing service in a professional, non-judgmental & non-discriminatory way.
  - Not express your PERSONAL opinions
Amy and Holly

- Amy is a 69-yr-old woman diagnosed with Amyotrophic Lateral Sclerosis (ALS) 3 & a half yrs ago.
- She is wheelchair bound & receives 4 hrs of homecare support a day. Increasingly, she has been having difficulties breathing & performing basic ADL’s, including dressing, toileting, & showering.
- She has been prescribed medication for pain management.
- Amy lives in the same rural community she grew up in but has no existing family members (she was an only child. Her husband passed 2 yrs ago and they were unable to have children of their own). She also has few remaining friends as most have passed or moved to live with children.
- Amy was recently admitted to her rural hospital (7 beds) secondary to breathing difficulties
- While admitted she mentions to her nurse, and long time friend, Holly, that she has heard about MAiD in the news. She states that she knows as her illness progresses she will eventually lose the ability to speak & communicate. She knows she will be all alone. The thought of this terrifies her & causes her to have increasingly frequent panic attacks. She tells Holly that she is ready to die.
- Holly tells Amy that she does not believe that she has reached the stage where MAiD is a reasonable option & that in addition, she cannot participate in a process leading to ‘premature death’ as a matter of personal conscience, claiming that causing a patient’s ‘premature death’ is morally wrong. Everyone in the hospital feels the same way.
Amy and Holly

- Holly tells Amy not to worry though. The team is committed to providing her with more pain medication, & actively looking into additional home care, or other supportive care options.

- Holly further states that while the physician covering today does not believe in MAiD she knows that he has referred patients onto different physicians who support MAiD if this is something she ‘really wants.’

- Amy declines because she feels ashamed for having brought it up.

- Amy worries that this conversation may have damaged her relationship with Holly and the only care team she has ever known. What will Holly tell others about their conversation? She is worried about whether she will continue to receive good medical care.

- Amy does not speak to any other healthcare professionals about her wish to die, although her desire to access MAiD persists.

- 4 months after speaking with Holly, Amy loses the ability to speak, her breathing becomes much more difficult, she experiences frequent aspiration & pain control is an ongoing challenge. She no longer has the ability to communicate & lives with intractable pain. Three months ago she was admitted to a hospital with a palliative care unit an hour & foury-five mins away from her home town, where she continues to reside. In the last 3 months she has had 2 visitors.
Case Discussion

- What was done well?

- What values are in conflict between Amy and Holly?
  - Value Examples: Fidelity to role, beneficence (to do good,) non-maleficence (to do no harm,) patient autonomy, personal integrity, justice (in terms of access to care), you might have others....

- Did we fail Amy? If so, how?

- Discuss the elephant in the room – Rural MAiD
  - What are your biggest concerns?
MAiD in a Rural Setting

- What is good about MAiD in a rural setting?
  - The option of dying:
    - At home or
    - In the hospital with a medical team you know and trust
  - Increases possibility that family and friends can be present or at minimum say goodbyes
  - Reduce stress, burden or cost of travel
  - Provides patient with the autonomy, control and dignity of having some say in their passing
MAiD in a Rural Setting

- What is difficult about MAiD in a rural setting?
  - Facilitating a CO to “opt out” can be more difficult to support
    - What if there is no one to take your place?
    - What if there is not enough time to bring someone else in?
  - Skills & abilities – may have never done before
  - Everyone knows – In the grocery store – daily reminders
    - I will be the person who killed “grammy”
    - I will be the person who helped “grammy” pass even though it went against everything I believe in
  - Is it ethical that the type of setting in which providers practice may influence their ability to CO to providing care?
MAiD in a Rural Setting

- Currently, do you feel that we can meet the College’s recommendations around conscientious objection in rural Nova Scotia?
  - Why?
  - Why not?
- How do our urbanites feel?
MAiD: Not always so black and white

- What about you as an individual specifically...
  - Do you conscientiously object to ALL aspects of MAiD?
  - Under what circumstances, if any, do I think medical assistance in dying is acceptable?
  - What are the absolute no’s in your mind?
  - Are you able to take part in any of the process?
    - Could you provide facts if a patient was simply asking about it and not having expressed a desire yet, but just wanted to know what was involved?
    - Could you continue to provide other care/services to a patient or would you need to hand them off completely?
  - What is your line? When does your gut go wonky?
MAiD: Not always so black and white

- Manitoba College of Nurses Document on MAiD and Co:
  1. How do I feel about participating in ending the life of another human being?
  2. Under what circumstances, if any, do I think medical assistance in dying is acceptable?
  3. If I started the IV that was used for the end of life, could I live with my decision?
  4. Do I know where to get help if I experience moral distress?
  5. Could I help end the life of another human being whose suffering was unbearable?
  6. If I conscientiously object to participating, can I still offer support to colleagues who chose to participate?
  7. Do I believe people have a right to access medical assistance in dying?
  8. Am I prepared to provide care that will lead to an individual’s death?
  9. Am I prepared to leave my position or health-care facility if I have a moral objection to medical assistance in dying?
MAiD in a Rural Setting – We don’t have all of the answers, but....

- What preventative measures could we put in place to try to avoid difficult conscientious objection situations?
  - Forums like this one where people get to explore their thoughts on both MAiD and conscientious objection
  - Having a safe place team discussions on your approach to MAiD
    - One that honours both those who CO and those willing to provide service
  - Really figuring out what your role could be and communicating that both verbally and in writing to your organization
  - Develop a plan with management on how this could be managed within your care area
  - Knowing where to get help if you experience moral distress
    - Did you know we have ethics support in NSHA?
  - Advocate for the province to develop a provincial infrastructure to support MAiD in rural areas
Questions?

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