

SUBMISSION



**CANADIAN
NURSES
ASSOCIATION**®

AMENDMENTS AND REVISION OF THE CRIMINAL CODE OF CANADA PROVISIONS ON MEDICAL ASSISTANCE IN DYING

**Submission to the Ministry of Health
and Department of Justice**

January 27, 2020

The Canadian Nurses Association is a powerful, unified voice for the Canadian nursing profession. We represent nurses in all 13 jurisdictions as well as retired nurses from across the country. We advance the practice and profession of nursing to improve health outcomes and strengthen Canada's publicly funded, not-for-profit health system.

All rights reserved. Permission to reproduce is permitted without changes and for non-commercial use. Refer to www.cna-aiic.ca/en/terms-and-conditions-of-use#Copyright for all terms and conditions to reproduce.

© Copyright 2020

Canadian Nurses Association
50 Driveway
Ottawa, Ont. K2P 1E2
CANADA

Tel.: 613-237-2133 or 1-800-361-8404

Fax: 613-237-3520

Website: www.cna-aiic.ca

® CANADIAN NURSES ASSOCIATION and the CNA flame design are registered trademarks of the Canadian Nurses Association.

Introduction

The Canadian Nurses Association (CNA) has been actively involved in work related to medical assistance in dying (MAID) for several years. Nurse practitioners, physicians, pharmacists and “persons aiding practitioners” (including regulated nurses) are permitted to help those who have explicitly requested MAID. Health-care providers are in a unique position compared with five years ago. Nurses and nurse practitioners have acquired significant knowledge and experience from nearly five years of MAID in practice. In particular, ongoing research into nurses’ experiences with MAID has confirmed the existence of anticipated dilemmas while uncovering new and unanticipated challenges.

Nurses are uniquely positioned to be able to use this experience to inform impending changes to federal legislation. However, CNA and other health-care associations need adequate time to engage in meaningful and appropriate consultation with their members. CNA notes that the current federal government consultation with the public and stakeholders is not enabling a comprehensive review and feedback on proposed amendments or considerations. While we strive to be responsive, we are particularly concerned that this short timeline to amend such landmark legislation could be harmful for patients and health-care providers alike. It should also be noted that there needs to be significant, meaningful engagement with Indigenous nurses and Indigenous people alike to align with the United Nations Declaration on the Rights of Indigenous Peoples and to be responsive to the calls to action from the Truth and Reconciliation Commission.

CNA understands that in light of recent court rulings in Quebec, the federal government has committed to moving forward in a responsible way with legislation that responds to the court case. This current consideration on expanding the criteria for MAID has implications for the nursing workforce.

In December 2019, CNA met with staff from Health Canada and the Department of Justice to start a conversation on how nurses’ knowledge and experience could inform potential amendments and revision to the Criminal Code of Canada’s provisions on MAID.

Despite the short timeline, CNA committed to being responsive to the government’s request, agreeing to provide a submission that would include key findings from the first two years of a three-year Canadian research study on nurses’ experiences with MAID. In addition, CNA reached out through our Canadian Network of Nursing Specialties to



identify regulated nurses who have participated in supporting patients, families and health-care providers and who agreed to work with us to inform our response. CNA, in collaboration with the Canadian Nurses Protective Society (CNPS), hosted a series of small group calls to engage with nurses who have had experience with MAID in some capacity. CNA has summarized the findings from those calls and, as a result, made recommendations. CNA wishes to express gratitude to CNPS for their partnership on work related to MAID and assistance in proposing legislative wording in response to key informant suggestions.

This submission contains the following:

- ▶ [Summary of research](#)
- ▶ [Key informant interviews with nurses](#)
- ▶ [CNA's recommendations](#)
- ▶ [Appendix A: Canadian nurses' experience with MAID](#)
- ▶ [Appendix B: Summary of CNA's previous responses and recommendations](#)



Summary of research

This section contains a high-level summary of research findings and recommendations. A more comprehensive summary can be found in [Appendix A](#).

OVERVIEW OF CANADIAN NURSES' EXPERIENCE WITH MAID

A team of Canadian nursing research and policy leaders, led by Barbara Pesut, RN, PhD, and supported by an international group of co-investigators, began a three-year Canadian Institutes of Health Research-funded study (2017-2020) of Canadian nurses' experience with MAID. The research team began by producing three knowledge synthesis reports focusing on extant international literature on the ethics, practice and policy implications, as well as a review of Canadian nursing regulatory policy documents related to MAID. They then interviewed a wide diversity of registered nurses and nurse practitioners from both urban and rural settings, across provinces, and with various experiences around engaging with patients considering, applying for, awaiting and/or undergoing MAID, as well as families coping with caregiving, support and bereavement associated with a medically assisted death.

In the study, 59 nurses were interviewed in-depth and provided frank reflections on their thoughts, experiences and perceptions with MAID. These nurses had diverse opinions about MAID informed by different levels of engagement with cases. Some nurses were conscientious objectors, trying to work out how to provide care for patients who had chosen MAID; other nurses actively supported their patients' decisions.

This evidence from Pesut and her team offers an important window into the phenomenon as the federal government is committed to responding to the Quebec court's Truchon decision before the March 11 deadline. The experience of Canadian nurses is evolving, particularly around the ethics and moral complexities associated with care provision and patient support, the technical and practical implications of real-life situations, and the subtle and nuanced communication expertise that is essential to relational engagement with patients and families in this delicate decision-making and implementation process.

KEY FINDINGS

The practice of nursing has been profoundly affected by the availability of MAID in Canada and the moral ambiguities it creates within the world of clinical practice. Nurses have emotional and intuitive responses to the idea of MAID and need to make sense of



those responses within the context of their professional practice standards and ethical commitments. Most nurses view MAID in relation to their fundamental values and their practice mandate to not “play God,” but rather do all that can be done to support life and health until death is inevitable. Nurses therefore use various processes of reasoning to explain their moral positioning in this new context, including changes within this that may occur as they confront new complexities in their practice. From their experience, we have learned how nurses’ moral decisions are contextually and relationally mediated and how nurses seek to guard patient vulnerability, even at the cost of their own emotional well-being.

This research has resulted in several recommendations, many of which have been incorporated in CNA’s recommendations. Additional recommendations can be found in Appendix A.



Key informant interviews with nurses

CNA worked with its partners at the Canadian Nurses Protective Society to host a series of facilitated group calls. We posed focused questions to identify challenges and potential solutions related to three key areas of the legislation: [eligibility](#), [safeguards](#) and [advanced requests](#). (We also found other important [additional issues](#).) CNA sought representation from all categories of regulated nurses (licensed/registered practical nurses, registered psychiatric nurses, registered nurses and nurse practitioners). A total of 24 nurses were involved, representing various specialty areas, care settings and patient populations, including, but not limited to, rural/remote, urban, public hospitals, facilities with religious affiliation/MAID objections, long-term care, Indigenous health, mental health, hospice and palliative care, and ethics. It should be noted that while these calls did garner quite a bit of information, CNA does not consider this effort a comprehensive consultation of nurses. In addition, CNA has a partnership accord with the Canadian Indigenous Nurses Association and, as such, works together on a variety of issues.

ELIGIBILITY

Themes that emerged around eligibility criteria for MAID:

- ▶ Nurses are expressing concern and moral distress about persons opting to proceed with MAID earlier than they would have chosen, because of fear of losing capacity and later being deemed ineligible for an intervention, which they have previously consented to.
- ▶ That, should it remain in the legislation (though unlikely given the Truchon ruling), “natural death be reasonably foreseeable” needs further specificity. *What would we categorize as “reasonably foreseeable”?*
- ▶ Nurses face ethical dilemmas when it is not the patient’s illness that makes natural death reasonably foreseeable, but instead the patient’s chronological age.
- ▶ That, should “natural death be reasonably foreseeable” be removed from the legislation, several issues may arise:
 - There may be far more individuals seeking MAID than providers available, thus resulting in an issue of decreased system capacity and patient access. This could result in additional delays in assessment and



persons unable to obtain the intervention, thus potentially experiencing prolonged suffering.

- Strong statements of concern that MAID providers may experience moral distress around providing the service for those where natural death is not reasonably foreseeable, and thus may opt to no longer provide it. This could result in an issue of decreased system capacity and patient access.
- ▶ Nurses expressed concern around the criteria that a patient “give informed consent after they have received all of the information they need to make their decision, including their medical diagnosis, available forms of treatment, and available options to relieve suffering, including palliative care.” Nurses’ concerns include the following:
- The term “receive” is less appropriate than noting that a patient should be able to not only receive information, but also convey understanding. This requires that the provider and team (where teams exist) take into consideration culture, language, cognition, literacy, and ability to communicate, among other factors. While it can be argued that “informed consent” covers this requirement for understanding, nurses articulated that there were still concerns that patients may not fully understand the information presented to them, and that steps should be taken to ensure comprehension.
 - This condition requires persons to have explored all options, including options to which they may not be open, in order to satisfy the legal requirements.
 - There is inadequate access to available forms of treatment and available options to relieve suffering, including palliative care. This theme emerged across several questions/categories. Respondents were clear that at present, access to treatment and palliative care needs to improve. Should MAID be broadened to remove eligibility criteria, access to treatment and palliative care will absolutely need to be scaled up. No person should opt for MAID because they cannot access other components of quality end-of-life care.



SAFEGUARDS

Themes that emerged around safeguards related to MAID:

- ▶ Safeguards, like the requirement for two independent witnesses, can be a barrier to access in some rural and remote settings where finding witnesses can be challenging. There needs to be careful balancing of safeguards with considerations around access to care.
- ▶ Consideration of adding a requirement for psychiatric evaluation was discussed as a means to alleviate burden that may lie on a sole provider. This was further supported as a requirement when discussing if MAID were to be expanded to patients where psychiatric illness is the sole diagnosis. Conversely, there were concerns voiced again that this additional layer of approval/assessment could be an additional barrier.
- ▶ Consideration that a clinician with expertise in the patient's condition be involved in the assessment of persons requesting MAID. Again, there was discussion that this would need to be balanced with ensuring access.
- ▶ Significant discussion occurred across all calls related to the safeguard where a patient must expressly confirm their consent immediately before receiving MAID. Concerns included the following:
 - The need for clarification around what was meant by "immediately."
 - That the 10-day period is an arbitrary amount of time. Nurses articulated that there have been situations where patients who were deemed eligible subsequently lost capacity and thus were unable to obtain MAID.
 - That patients are opting for MAID sooner than they would have originally wished, due to fear of losing capacity. The example of Audrey's Amendment was raised, which was created following the case of a Halifax woman with terminal metastatic breast cancer; she had been approved for MAID and opted to receive it earlier than planned because she felt she was losing mental capacity. This issue can lead to significant distress for patients, families, MAID providers and the care team.
 - That persons who have been approved, then lose their capacity to provide consent prior to receiving MAID, are unable to have their wishes and care plan respected. This causes significant distress to patients, families, and care providers.



- Situations where persons have been approved, but MAID is not available where they are, either because of religious objection of a facility, or because of location of services. At times, due to the advanced stage of illness, patients need to be transferred to obtain MAID.
 - This transfer, particularly when it is not the first choice of the patient, is in and of itself disruptive to a person's end-of-life care. It results in distress for patients, families and care providers, where therapeutic relationships need to be ended at one facility and reinitiated at another.
 - Transfer and access to MAID is further complicated when persons in advanced stages of illness need to be sedated for transport, but then lose capacity to consent. We are hearing of situations where patients are transferred out to obtain MAID, then unable to die as they wish due to inability to consent immediately prior to the procedure.
- ▶ Moral distress experienced by nurses when someone is approved for MAID, has lost mental capacity, but articulates that they do *not* want MAID immediately prior to the procedure.

ADVANCED REQUESTS

For more on advanced requests, see our recommendations pertaining to [special populations](#).

ADDITIONAL ISSUES

Amendments to the law clarify that health-care providers are permitted to raise the issue of MAID

- ▶ Nurses had divergent opinions on this. Many supported that it would be reasonable to allow regulated nurses and nurse practitioners to bring up the topic of MAID. Some, however, felt this should only be done when spoken of in the context of all treatment and end-of-life options, including palliative care.
 - Nurses spoke of situations in which they felt it would have been helpful for patients to have information about MAID. These nurses said MAID was not raised in these situations because of how the law is currently written and they subsequently felt that they were not offering *all* available options to their patients.



- ▶ Some nurses spoke of negative experiences they, or colleagues, have experienced, where patients *did not* receive the information well and found it to cause them significant distress.
- ▶ Nurses and health-care providers are in a position of power and, as such, need to recognize that patients and families put significant value on treatment suggestions offered by their providers.
- ▶ While legal interpretation from our partners at the Canadian Nurses Protective Society is such that there is nothing in the Criminal Code at present that would indicate that nurses cannot initiate discussions about MAID — so long as they are not actively encouraging it — clarity in the Code would be beneficial to nurses who find the law as it is written to be unclear.

MAID for persons whose sole diagnosis is psychiatric illness

- ▶ Significant concerns exist around expanding MAID for persons for whom psychiatric illness is the sole diagnosis.
 - Significant concerns voiced that providers and care teams do not feel ready to expand to this.
 - It should be noted that, as previously mentioned, CNA does not consider these calls to represent a comprehensive consultation, and as such, additional consultation is necessary.
- ▶ Significant discussion was had around the ongoing need for access to palliative care.
- ▶ When considering the potential removal of the eligibility criteria that natural death be reasonably foreseeable, it was noted that not only will palliative care need to be scaled up, but also access to other treatment and care. This will help ensure that people are not accessing MAID due to lack of access to acceptable alternatives. There is no point in questioning patients on whether they have explored other options, including palliative care, when we know well that those patients cannot access that care.

Appropriate access to other types of care

- ▶ MAID providers are also concerned with focusing on MAID and overlooking other needs in our health-care system. Example of other pressing issues include: the needs of equitable care across rural and remote communities or within vulnerable groups; and access to specialized care (palliative care, geriatricians, mental health and addictions services etc.).



CNA's recommendations

GENERAL

- ▶ **Allow for an additional review period beyond the one five-year period currently stipulated**, particularly in light of impending work to amend the current legislation. An additional review period will provide an opportunity for more comprehensive review and consultation, as well as an option to examine issues that may occur as a result of amendments. CNA further recommends that consideration be given to another subsequent review period, should the legislation be broadened upon the next review.
- ▶ **That subsection 241(5.1) of the Criminal Code be amended to stipulate that this exemption applies notwithstanding that the health-care professional may have initiated the discussion about the lawful provision of MAID.** As suggested by our partners at CNPS, the revised provision could read as follows:
 - (5.1) For greater certainty, no social worker, psychologist, psychiatrist, therapist, medical practitioner, nurse practitioner or other health-care professional commits an offence if they provide information to a person on the lawful provision of medical assistance in dying, **whether or not the health-care professional initiates the discussion.**

ELIGIBILITY

- ▶ **That Section 241.2 (1) be amended to provide clarity regarding “irremediable” and “incurable” condition, and to prevent interpretation that a person must exhaust all treatment options,** CNA recommends adding the following language to 241.2 (1) (c): *“they have 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 and where ‘irremediable’ does not require the person to undertake treatments that are not acceptable to the person”.*

SAFEGUARDS

- ▶ **That, in line with recommendations from CNPS, and from what we heard on our key informant calls, there be established a new, specialized, independent body, comprised of health-care professionals and other**



representatives that would include for instance one or more psychiatrists or psychologists, a neurologist, palliative care specialists, representatives of the public, etc., as needed, with the authority to

- waive the requirement for reasonably foreseeable death, in circumstances where the other eligibility criteria have clearly been met, it is not necessary to protect the person having requested MAID as a vulnerable person and the application of that requirement would result in undue hardship to that person;
 - implement other reasonable safeguards, or reduce or waive the reflection period, where the requirement for reasonably foreseeable death has been waived; and
 - determine if the eligibility conditions have been met at the request of a patient, if MAID has been denied, or at the request of a MAID assessor, where there is uncertainty as to whether a patient would meet the eligibility criteria.
- ▶ **Harmonize the implementation of MAID.** CNA called for a pan-Canadian harmonized approach to support patients in receiving accurate information and knowledge of options/alternatives to MAID. Although data collection and monitoring for MAID is included in the final legislation, a harmonized implementation across provinces and territories has not been legislated.
- ▶ **That consideration be given to waiving the requirement for express consent immediately before the provision of MAID, if sufficient safeguards are in place.**
- These safeguards could include: the person requests the waiver in writing; the person is prepared to appoint a delegate to decide on their behalf when MAID will be provided; and provision is made for circumstances where the person refuses to submit to MAID or the loss of capacity appears to have brought about a change in circumstances such that the person no longer appears to experience intolerable suffering.
 - This should be permitted only when it is realistically contemplated that the patient could lose capacity during the waiting period.
 - The patient should have to expressly waive the requirement in writing or by way of a legally acceptable alternative for persons who may lack the ability to consent in writing.



- Consider that there should be a mechanism in place to decide when MAID would be administered, if the patient lost capacity to make that decision.
 - Consider that the law should indicate what to do in the case where the patient has lost capacity but refuses MAID at the time of administration.
- ▶ **Provide counselling and/or spiritual support offered to patients considering MAID.** To ensure patients and families were fully supported, CNA advocated for counselling and/or spiritual support to be offered to patients considering MAID.
 - ▶ **In Section 241.2 (6) (c), remove wording that stipulates that the independent practitioner does not “know or believe that they are connected to the other practitioner.”**

SPECIAL POPULATIONS

- ▶ **Permit time to properly consider the inclusion of advanced requests, mature minors, and cases where psychiatric illness is the sole diagnosis.** Additional work and considerations is required to define the processes around patients representing these three special populations. A team of experts that includes nurses, physicians, social workers, among others, will need to map out the procedure for patients making advanced requests, mature minors, and patients whose sole diagnosis is psychiatric illness. Multiple aspects need to be considered such as time, written criteria, accountability and responsibilities. This should not be done piecemeal across provinces and territories and should not be done after the legislation is in place.
 - CNA understands that there are some nurses in Canada who have concerns that *not* making MAID available as an option for persons where psychiatric illness is the sole diagnosis may be discriminatory. Additional consultation is required.

NURSES, NURSE PRACTITIONERS AND HEALTH SYSTEMS

- ▶ **Continue to develop palliative care options and accessibility** for all Canadians approaching end of life. In addition, we recommend enhancing palliative approaches to care for all who are living with chronic and life limiting conditions.
- ▶ **Ensure appropriate supports and resources are built into care systems, practice supports and research efforts.** Doing so would recognize the moral



and emotional work of nurses who work with patients considering or undergoing MAID.

- ▶ **Fund ongoing research** into both patient/family experience and the experience of nurses and others closely involved with MAID care.
- ▶ **Harmonize regulatory frameworks, policies, and practice supports for nurses across Canada.** Doing so would ensure that all nurses have access to a robust and viable set of guidelines that is consistent with nursing practice standards, even as these evolve over time with developments in legislation, public expectations, and the body of available evidence.
- ▶ **Give due consideration to the significant barriers experienced by patients,** especially their tremendous physical and emotional pain, when patients are unable to access MAID due to religious objections of a care facility. Create a reporting structure for patients unable to access MAID in a timely manner due to facility objections, so that the scale of the issue can be further determined and reasonable solutions presented.



Appendix A

CANADIAN NURSES' EXPERIENCE WITH MAID

This appendix contains a summary of the findings and recommendations from an ongoing report (2017-2020) of a team of Canadian nursing research and policy leaders led by Barbara Pesut. Their work, which is being supported by an international group of co-investigators, is funded by the Canadian Institutes of Health Research.

HEALTH-SYSTEM FINDINGS

Failure to provide adequate palliative care influences nurses' sense of providing good ethical care. Many nurses believe that palliative care services in Canada are inadequate. While excellent palliative care is available for some Canadian patients (particularly those with relatively predictable dying trajectories in larger urban settings), there are many sectors of the population for whom it is much less available. This includes those with multiple chronic conditions (such as congestive heart failure, chronic obstructive pulmonary disease, end-stage renal disease, issues associated with frailty), and those who reside in rural, remote, community, or long-term care settings. Nurses experience moral distress when they perceive that a patient's decision to pursue MAID has been influenced by the lack of quality palliative care supports, including support for palliative caregivers.

- ▶ **Recommendation: Nurses strongly support the advancement of palliative service availability across the system as a necessary pre-condition for the safe and ethical development of MAID in Canada.**

Practice supports are critical to ensuring high-quality care in MAID. In addition to accessible palliative care, nurses identify other conditions that are necessary to ensure that they are not legally and morally at risk in relation to their care of patients considering or undergoing MAID. These include a knowledgeable health-care team, practice supports (including guidelines, regulatory frameworks and policies), and adequate time in the workplace to address the complex patient and family issues that arise in the context of MAID. When nurses attempt to provide the compassionate care consistent with such a momentous moment in patients' lives, without suitable supports, they find themselves caught in an untenable moral quandary.



- ▶ **Recommendation: Provide nurses involved in MAID care with a knowledgeable team, comprehensive practice supports, and adequate time to address the complexities of MAID practice.**

Skilled leadership is required to create workplace climates that can successfully negotiate the moral divisiveness of MAID practice. Nurses shared stories of difficult collegial relationships that arose as a result of MAID, which in turn affected their work climate. Leaders who took the position that only one response to MAID was acceptable (e.g., either for or against) created difficult environments characterized by conflict and perceived stigma. Of particular concern in the study were leaders who wrote MAID responsibilities into pre-existing job requirements or who screened applicants for nursing jobs based upon their willingness to participate in MAID. Such a climate makes it difficult to guard the rights of nurses who are conscientious objectors. A number of participants in the study knew of nurses who had chosen to retire or resign as a result of the implementation of MAID in their work context. However, some leaders had created exceptionally supportive climates in which those nurses who expressed a range of moral responses to MAID could still work effectively together. In these workplaces, leaders took a more neutral approach and set up systems and procedures that supported all of their staff.

- ▶ **Recommendation: Coach health-care leaders to create workplace contexts in which nurses' moral differences can be accommodated and negotiated.**

Nurses who assist with, assess for, or provide MAID in isolation are at risk. Nurses in this study described feeling responsible to assist with, or provide, MAID because no one else in their context would do so. Soon, others would learn of their willingness to perform this role and would send other cases their way until they were doing multiple subsequent provisions of MAID. Although their commitment to patient access to MAID was laudable, it was often at great personal cost. These nurses shared difficult emotional journeys in these interviews. In regions where there are insufficient numbers of health-care providers willing to participate in MAID, mechanisms should be created for support such as access to MAID teams outside of the area or virtual collaborative communities. Robust regulatory frameworks are necessary to balance risk, safety and competent practice. The availability of clear and robust regulatory policies to support nursing practice around MAID differs among provinces and territories and between provincial/territorial and health region jurisdictions. Nurses in this study described a degree of uncertainty about what they could and could not do in relation to MAID. Further, frameworks that over-emphasized risk, without proportionately robust guidelines, failed to provide nurses with the guidance required for the complexities of MAID practice.



- ▶ **Recommendation:** Ensure that nurses in all provinces, territories, and health regions have robust and accessible policies to guide nurses' MAID-related practice.

Evidence-based practice guidelines support high-quality MAID care. Nurses require evidence-based guidance on what constitutes "good practice" within the variability that constitutes MAID practice in Canada (e.g., clinical judgments determining eligibility, jurisdictional variabilities in procedures). It is important to emphasize that there is not, as yet, available guidance as to what constitutes "gold standard" practice in care of patients undergoing MAID; without this, it becomes difficult for individual nurses to know how to benchmark their own practice. In this study, nurses described what they were learning of person-centred practice in the context of MAID that entailed establishing effective relationships with patients and families, communicating skillfully, planning and orchestrating the MAID death with meticulous attention to detail, and supporting family to understand and cope with this new form of bereavement experience. Nurses were further learning of tools and resources to support complex MAID eligibility assessments.

- ▶ **Recommendation:** Ensure continued development of knowledge from the nursing perspective about this evolving area of nursing practice and establish national evidence-based guidelines.

PROFESSIONAL AND PERSONAL FINDINGS

MAID presents as a very different death and this different death is emotionally impactful. Nurses describe being ill-prepared for the rapid and stark transitions between life and death that is characteristic of MAID. This emotional impact is compounded by the reality that death comes through the administration of a health-care-delivered intervention. Many nurses describe not knowing how to understand or attenuate this emotional impact. Further, the trajectory of the impact is unpredictable over time. It may abate or escalate. Support from colleagues who are familiar with the experience is the most effective intervention to offset this emotional impact.

- ▶ **Recommendation:** Ensure that every nurse who directly participates in a MAID death has access to collegial support from others who have participated in MAID.

Nurses' decisions to participate in MAID, or not, are multi-faceted and evolving. Nurses acknowledge that their decision whether to participate in MAID is influenced by family and community, professional experience, colleagues and the interplay between professional and personal values. Many nurses have embraced the MAID option



relatively easily, based on their professional experiences of being unable to alleviate patients' physical and existential suffering. Other nurses choose not to commit to a stance until they find themselves caring for a patient and family determined to take this path.

- ▶ **Recommendation: Create systems within health care that recognize that nurses may not be able to declare their willingness to participate in MAID without some direct experience of the process.**

Taking a stance of conscientious objection does not preclude the ability of the nurse to provide high quality and compassionate care. Nurses who are conscientious objectors and/or who are employed within health-care organizations that do not support MAID are continuing to reflect on how best to provide care for patients inquiring about, considering, or deciding to pursue MAID. We heard many accounts of remarkably comprehensive and supportive care enveloping the patient and family through this process, even among those who prefer not to participate in the act itself.

- ▶ **Recommendation: Rather than viewing conscientious objection as antithetical to MAID accessibility, there is an opportunity to learn of these new approaches individuals and organizations are using to develop a compassionate response to suffering.**

Nurses rely on a number of common "moral waypoints" to make sense of their willingness to participate in MAID. These waypoints include their understandings about patient choice, control and certainty; about staying with and serving patients in their suffering even amidst differing values and beliefs; about the moral differences in common ways to alleviate suffering; and about how MAID fits with their views of life after death. The gratitude of patients and families, and the peacefulness of the MAID death itself, buffered this moral uncertainty. However, this moral sense-making could be critically disrupted under difficult patient and family circumstances, forcing nurses to revisit their decision to participate, or not, in MAID.

- ▶ **Recommendation: Offer opportunities for student nurses and nurses to engage in experiences that support their abilities to reflect on, and have conversations about, MAID and other morally contentious practices in palliative care (e.g., voluntary stopping eating and drinking, palliative sedation).**

Nurses require unique communication skills to negotiate the complex process leading to a MAID death. While much of the public and policy attention has been paid to the assessment and administration of MAID, what nurses are confronted with extends far beyond those time-delimited events. As the health-care providers who work most



directly with patients, nurses often receive patient inquiries about the available options. And for many patients, wondering about these options begins long in advance of the MAID act. Many patients express impatience with the dying process, but this does not necessarily mean they are requesting MAID. Nurses described patient communication that is often covert, subtle and nuanced in ways that take time for nurses to understand and interpret. Such a complex communication landscape requires both skill and time. Only then can nurses be assured that patients have had the opportunity carefully weigh their available options, and ultimately, to make the decision that is best for them and their family in light of their unique circumstances.

- ▶ **Recommendation: Expand available resources for nurses to learn and practice the communication skills required of conversations in the context of MAID.**



Appendix B

SUMMARY OF CNA'S PREVIOUS RESPONSES AND RECOMMENDATIONS

CNA has been actively engaged in the consultations on MAID legislation following the 2015 Supreme Court of Canada decision in *Carter v. Canada*, up to the release of *Bill C-14: An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*. In appearances before and submissions to the legislative committees studying medical assisted dying in Canada and developing proposed legislation, CNA has advocated for safeguards to protect the rights of the patient and the nurse, as well as for system-level changes including access to palliative care and accountability mechanisms. CNA has put forward three written submissions:

- ▶ [Physician-Assisted Death: Brief for the Government of Canada's External Panel on Options for a Legislative Response to Carter v. Canada \(2015\)](#) (October 2015)
- ▶ [Suggested Amendments to the text of Bill C-14: Brief for the Standing Senate Committee on Legal and Constitutional Affairs](#) (May 2016)
- ▶ [Suggested Amendments to the text of Bill C-14: Brief for the House of Commons Standing Committee on Justice and Human Rights](#) (May 2016)

