



Perspectives on the Supreme Court of Canada decision on Carter vs. Canada 2015 (“Physician Assisted Death”) and a response to the November 30 final report of the “Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying.”

This statement comes from the Advance Practice Nurses of the Palliative Care Consult Service in the Calgary Zone of Alberta Health Services. As nurse consultants working with patients and families who are approaching end of life, we are part of a long nursing tradition of being present and caring for our patients during the profound experiences of their living and dying. We practice in the community, in hospices and in acute care settings, in rural areas as well as within the city. Most people who receive specialist palliative care as they approach end of life will meet and be cared for by a member of our group. While our individual beliefs vary, we are united in our fundamental understanding of palliative care as a philosophy of care which seeks to relieve suffering of patients and families, affirms life and regards dying as a normal process, and intends to neither hasten nor postpone death (WHO definition of Palliative Care). We have near unanimity for the belief that physician-assisted dying (PAD) is not part of palliative care, and should not be offered by the same service that provides palliative care.

We respect the Supreme Court decision suggesting that PAD be available to those with intolerable, unrelievable suffering. In our work, however, we have observed that intolerable, unrelievable suffering is not the experience of most people who are living with a life limiting illness. More often, the dying process presents opportunities for patients and families to grow in spirit and relationships, even as their bodies weaken. When they do suffer, we consider their suffering an invitation to offer support and to help them find the resources they need to alleviate suffering and achieve growth. While our patients often choose paths through their illness and options to relieve suffering that are not ones that we would choose, we accompany them along their path, nevertheless. We do not abandon.

We have reviewed the report of the “Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying” and we do not agree with the recommendation that PAD should be offered to people when first discussing diagnosis or advance care planning. The advisory group already recognizes that unrelievable suffering is not necessarily associated with specific life limiting diseases, and therefore to offer physician assisted dying in the context of an advance care planning discussion is to suggest that intolerable suffering is to be expected. In fact, PAD is likely to be requested in rare and unusual circumstances. The very act of a trusted health care professional offering it while delivering news of a life limiting, life threatening illness, may be construed as an endorsement of PAD, and can have a powerful, coercive effect that we find very concerning, particularly in its potential to damage the therapeutic relationships that palliative care practitioners strive to have with our patients.

Good palliative care, including impeccable pain and symptom management and the acknowledgement and alleviation of suffering, should be available to all Canadians. While it is expected that a relative few would utilize PAD as outlined in the Supreme Court decision, virtually all Canadians would benefit from good palliative care. All Canadians should be able to receive integrated palliative care in all stages along an illness trajectory, no matter where they are living. We recognize that despite national initiatives such as “The Way Forward” (Canadian Hospice Palliative Care Association, 2015), we fall well short of the goal of universal access to palliative care in our country. We want to ensure that our government remains focused on this goal, and we want to avoid the unfortunate scenario of a patient choosing PAD because of poorly managed symptoms when palliative care services were not available to them.

As advocates for our colleagues in nursing at the bedside, we want to ensure that PAD not be considered a natural extension of nursing work. Good health care is provided by a team of professionals. It is unusual for physicians to administer the medications they order. More frequently this task is given to a nurse. Nurses currently do not have the education necessary to fulfill the administering of agents to induce death. Even if such education is provided, there must be care and support offered to the nurses who take part in PAD and who are likely to pay a significant emotional cost. In general, we have grave concerns for the moral residue and complex grief of all of our colleagues, physicians, nurses and allied health professionals, and that of the families of patients, who are left behind when the act of PAD is completed. We have noticed a lack of consideration for this residue in much of the current discussion of PAD.

Thank you for the opportunity to share our perspectives on this complex issue. As nurses and as palliative care practitioners, we would welcome a role in the conversation and development of legislation and policies and procedures of PAD as it becomes part of the Canadian social landscape.

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References

Canadian Hospice Palliative Care Association, *The Way Forward National Framework: A roadmap for an integrated palliative approach to care*, The Way Forward Initiative, March 2015.