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Gauri Sreenivasan, Federation for the Humanities and Social Sciences director of policy and programs, looks on as Jocelyn Downie speaks about assisted dying legislation at CNA House in February.

Examining medical assistance in dying from all sides

A lot of work remains to be done before and after the June 6 deadline for Criminal Code amendments and new federal legislation

BY VIRGINIA ST-DENIS

With the fast-approaching deadline for the federal government to create and pass an amendment to the Criminal Code and new legislation around providing medical assistance in dying, CNA continues to be part of the growing discussion.

The Federation for the Humanities and Social Sciences hosted a presentation by Jocelyn Downie on what the new assisted dying legislation will mean for health-care communities. A professor in the faculties of law and medicine at Dalhousie University, Downie was a special advisor to the 1994 Senate committee on euthanasia and assisted suicide and served on the Royal Society of Canada expert panel on end-of-life decision-making, the pro bono legal team in *Carter v. Canada* and the provincial-territorial expert advisory group on physician-assisted death (PAD).

Downie started her Feb. 23 talk at CNA House with a quick history of the issues. While PAD is legal in a limited way now, she says all stakeholders have a lot of work to do, which cannot be completed by the June 6 Supreme Court-mandated deadline. The Criminal Code amendment and new legislation is only the first step. While the provinces and territories have said they prefer a harmonized system across the country, it is uncertain how that would happen. How medical certificates of death will change to reflect PAD will need to be determined. Access issues — such as allowing NPs to provide assistance in rural and remote communities — need to be addressed, with input from Indigenous communities.

Health authorities need to address access as well, including what to do when publicly funded health-care

facilities declare a conscientious objection to providing assistance; if it is determined that a facility can have a conscience.

Each of the health-care professions' associations needs to review its code of ethics around members' conscientious objection to providing such assistance. The definition of palliative care needs to be expanded to address this new end-of-life care. Clinical practice guidelines, competencies and post-secondary education need to be developed for those administering assistance and for others involved in the process.

Finally, Downie said insurance companies need to review their policies, not only for patients' medical and life insurance, but also for health-care professionals' professional liability protection or malpractice insurance. Plain language materials need to be created to explain all of this information for Canadians who may want or need to consider such assistance.

INCLUSIVE TERMINOLOGY

On Feb. 16, CNA CEO Anne Sutherland Boal took part in a *Hill Times* panel discussion on PAD. Moderated by CPAC's *Beyond Politics* host Catherine Clark, the panel also included Dr. Jeff Blackmer, vice president of medical professionalism at the Canadian Medical Association, and Maureen McTeer, medical lawyer and author of the 1999 book *Tough Choices: Living and Dying in the 21st Century*.

Nearly 80 per cent of attendees voted in favour of changing the terminology from physician-assisted death to medically assisted death. The change would acknowledge the roles other health-care professionals, such as RNs, NPs, pharmacists and social workers, will have in providing this assistance.

Sutherland Boal used an example of a nurse in a fly-in community doing a home visit with a 78-year-old man in advanced stages of ALS. The man begins a conversation about the progression of the disease. "In these settings across the country, primary care is often carried out by nurses in expanded scope who prescribe medication and provide emergency care services. These nurses do have access to medical specialists via telehealth and other means, but it would be infrequent for a physician to fly in for a specialized service such as PAD," she said. "Furthermore, it is unlikely that a patient would want to leave their community for this service."

Twenty per cent of Canadians — more than seven million people — live in rural and remote areas. Using the term *medically assisted death* (or *medical assistance in dying*, which is starting to garner support), rather than

physician-assisted death, "will avoid repeating hard-learned mistakes of the past where a simple word in federal legislation can create major barriers to access," Sutherland Boal said.

"Along with the attention to terminology, we must have a framework for PAD that ensures a consistent approach across the country, equally accessible in rural and remote settings, and universal coverage."

Blackmer agreed. "We very much want to avoid what we have been calling a patchwork provincial approach, similar to what we see with some other legislation, similar to what we are already now seeing across the provincial medical regulatory bodies," he said, "seven of whom have come out with their own final or draft regulations, which differ on some important issues, either subtly or substantively."

McTeer focused her comments on the *Carter* decision and the two sections of the Criminal Code that the Supreme Court ruled unconstitutional. She also discussed what needs to be covered in new federal legislation to ensure Canadians who fit the eligibility requirements can get access to assistance in dying from qualified physicians. ■

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