JNP

Medical Assistance in Dying in Canada: Focus on Rural Communities

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ABSTRACT

The 2015 *Carter v Canada (Attorney General)* case radically changed end-of-life care in Canada. This groundbreaking decision legalized physician-assisted suicide for competent adults who meet certain clinical criteria and who consent to their termination of life. The federal government then passed its legislative response, Bill C-14, to change the Criminal Code and legalize medical assistance in dying. Since Bill C-14 was enacted, the health care community has struggled to ensure that its implementation occurs in a legally compliant, patient-centered manner. This article focuses on the challenges of this new law for nurse practitioners, especially those in rural and remote communities.

Keywords: Canada, medical assistance in dying, physician-assisted suicide, remote, rural

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Until 2015, Canadian law prohibited physician-assisted suicide (*Rodriguez v British Columbia [AG]*[1]). However, in 2015, the Supreme Court of Canada (SCC) decided *Carter v Canada (Attorney General)*,[2] which radically changed Canadian end-of-life care. The plaintiffs in the case included the British Columbia Civil Liberties Association; Gloria Taylor, a woman who had suffered from amyotrophic lateral sclerosis and initiated the original British Columbia (BC) court application but then passed away before it reached the SCC; and the family of Kay Carter, a woman who had suffered from spinal stenosis and received physician-assisted suicide in Switzerland in 2010. This groundbreaking SCC decision legalized physician-assisted suicide for competent adults in certain clinical circumstances. The SCC held that those sections of the Criminal Code that prohibited physician-assisted suicide were invalid because they infringed on the Canadian Charter of Rights and Freedoms.[3] In response to the *Carter* decision, the Canadian federal government introduced Bill C-14, An Act to Amend the Criminal Code and to Make Related Amendments to Other Acts (Medical Assistance in Dying),[4] in April 2016; with minor amendments, Bill C-14 was passed into law that June. Given that this particular statute is still commonly referred to in Canada as Bill C-14, it will be referred to as such in this article.

Bill C-14 legalized medical assistance in dying (MAiD), the term used in the legislation rather than physician-assisted suicide, for individuals who meet certain criteria. This article will address some of the significant issues resulting from the passage of Bill C-14 and with which the Canadian health care system is now grappling. There will be a particular focus on nurse practitioners (NPs) and the challenges of implementing the MAiD legal framework in the many rural communities that exist across the country.

It is important to note that this article is not meant to be a compare and contrast of legislative frameworks around the world but instead will focus on the new Canadian legislation. To explore physician-assisted suicide on a more global level, articles such as those by Castro et al[5] and Dyer et al[6] may be helpful.

RELEVANT LEGISLATION

Bill C-14 modified the Criminal Code, which contains a prohibition on aiding and abetting someone to commit suicide. This prohibition is contained in the following sections of the Criminal Code[7]:

1. s. 14 No person is entitled to consent to have death inflicted on them. . .

2. s. 241(1) Everyone is guilty of an indictable offence and liable to imprisonment for a term of not more than 14 years who, whether suicide ensues or not, (b) aids a person to die by suicide.

In the *Carter* decision, the above prohibition was found to violate s. 7 of the Charter, which guarantees the right to life, liberty, and security of the person; however, the SCC determined that this violation only existed if the situation involved physician-assisted suicide for patients in certain clinical circumstances. Therefore, although the general prohibition on aiding and abetting suicide remains in the Criminal Code, the *Carter* case permitted an exception for physician-assisted suicide.

The phrase *physician-assisted suicide* was used by the SCC in its *Carter* decision but was not chosen for use in the actual legislation that followed. The change in terminology represents more than mere semantics; instead, it denotes a significant philosophical shift. It recognizes the health care reality that a team comprised of different professionals including, but not limited to, physicians, pharmacists, and nurses is often required to implement a procedure of this complexity.[8] Simultaneously, the name change also captured the fact that NPs were authorized to have a significant role in the Canadian MAiD framework. This is crucial in not only recognizing the broad scope of practice of the NP role but also in increasing safe access to MAiD in a country experiencing a doctor shortage that is particularly pronounced and concerning in its rural areas.[9]

Furthermore, although many Canadians assumed that those physicians already involved in palliative care would also be willing to participate in MAiD,[10,11] many palliative care physicians have already expressed that they have no intention of doing so. This position appears to arise primarily out of a belief that palliative care and MAiD should not both be available as part of a single palliative care medical practice.[10,12] It is worth noting that the perspective of NP involvement in this procedure has not been similarly canvassed in the literature, but it is possible that similar concerns may be expressed by some NPs as well.

Bill C-14 enshrined MAiD by carving out an exception to the general assisted suicide prohibition in the Criminal Code, but only for those patients who meet all of the following criteria:

1. eligible for health care services in 1 of the provinces or territories in Canada;
2. at least 18 years of age and capable of making their own health care decisions;
3. have a grievous and irremediable medical condition;
4. have made a voluntary request for MAiD; and
5. have provided informed consent to MAiD (s. 241.2[1] of the Criminal Code as implemented through Bill C-14).

The phrase *grievous and irremediable medical condition* has been the subject of significant controversy in both health care and patient advocacy communities. It is defined in Bill C-14 as requiring all of the following components:

1. a serious and incurable illness, disease, or disability;
2. an advanced state of irreversible decline in capability;
3. that illness, disease or disability, or state of decline is causing enduring and intolerable physical or psychological suffering; and
4. that natural death has become reasonably foreseeable (s. 241.2[2] of the Criminal Code as implemented through Bill C-14).

RURAL ACCESS TO HEALTH CARE SERVICES IN CANADA

The Canada Health Act[13] enshrines 5 key principles that all provincial health care insurance plans must meet in order to be eligible for federal funding. One of these foundational principles, accessibility, has traditionally been more difficult to ensure in a country with such broad geographic expanse and numerous small, remote communities dotting its landscape. Almost 18% of the Canadian population lives in a rural area,[14] but they are served by only 8% of the physicians in Canada[15] and only 11% of registered nurses, including NPs.[14] Governments have supported an increase of NPs in those communities where medical access is an issue.[16] Although there are not yet enough NPs in practice to ensure adequate health care access for all rural patients, the trend is moving in this direction. Across the country, NPs are being encouraged to work to their full scope of practice and to be full, contributing members of the health care team for the benefit of their patients.[17] This is particularly important in rural communities where an NP may be the sole provider

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