

Medical Assistance in Dying: The Role of the Nurse Practitioner

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BSN, Langara College, 2009

A CULMINATING PROJECT SUBMITTED IN PARTIAL
FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF

MASTERS OF NURSING- NURSE PRACTITIONER

In

THE FACULTY OF GRADUATE AND POSTDOCTORAL STUDIES

(School of Nursing)

THE UNIVERSITY OF BRITISH COLUMBIA

Vancouver

February/2018

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Abstract

Medical Assistance in Dying (MAiD) is the Canadian response to the enduring debate over euthanasia. Canada is the first country to permit Nurse Practitioners (NPs) to provide these services. This culminating project addressed the problem of limited overall knowledge of MAiD and provided evidence-based arguments for the increased role and need of NPs providing MAiD services. A scoping literature review was completed, and results were evaluated utilizing the Joanna Briggs Institute critical appraisal tools. Results provided an overview of the historical, legal and procedural related background of MAiD. Despite thousands of years of legal, medical, philosophical, and theological deliberations, euthanasia remains a controversial and unresolved concept. An objective outline on the main contentious ethical issues such as mental illness, mature minors, contentious objection and advanced directives was provided. Barriers were looked at such as geography and compensation for MAiD, alongside accompanied solutions. Procedural details were summarised including documentation and medications. Lastly, the role of nurse practitioners was discussed providing evidence that their skills and knowledge suits the provision of MAiD services.

Medical Assistance in Dying (MAiD) is the Canadian response to the enduring debate of euthanasia. MAiD simply defined is the administration of a prescribed substance that intends to cause the death of a person whom meets specific eligibility criteria (Canadian Nurses Association [CAN], 2017). Upon inspection there are numerous technicalities, debates, and nuances that require careful open dialogue and continuous reflection. Interestingly, Canada is the first country to allow Nurse Practitioners (NPs) to provide these services (Stokes, 2017). Patients are requesting MAiD assessments at a rate that health care providers cannot sustain (Larsen, 2017). Concurrently, the number of available MAiD providers is drastically reducing as the demand for MAiD provisions increases (Larsen, 2017). This culminating project addresses the problem of limited overall knowledge of MAiD and provides evidence-based arguments for the increased role and need of NPs providing MAiD services. One could contend that increasing overall knowledge of the topic could increase the number of providers, thereby reducing barriers to accessing MAiD. This project aims to increase the knowledge base of NPs on the topic of MAiD.

This literature review provided an overview of the historical, legal and procedural related background of MAiD. A discussion on several of the main ethical implications was included. The role of the NP was discussed, alongside arguments as to the suitability of the NP role for MAiD provisions. Subsequently, an outline of several of the main barriers to implementing MAiD were examined alongside accompanied potential solutions. Lastly, guidance on currently available resources was presented followed by a dialogue on ideas for future practice. Terminology surrounding medically assisted deaths is convoluted and therefore an appendix has been attached with definitions of relevant terms for the purpose of clarification and ease of reading.

Description of Project

The purpose of this project is to increase NP's general knowledge on all aspects of MAiD. In order to achieve this goal, I have prepared two projects: firstly, I have completed a scoping literature review on MAiD to be published within University of British Columbia's (UBC) cIRcle digital repository and secondly, a manuscript was created with the intent for publication to the Journal of Nurse Practitioner, a peer reviewed journal. By providing two formats to address this knowledge gap, I aim to reach a wider audience. UBC Circle "is an open access digital repository for published and unpublished material created by the UBC community and its partners. Its aim is to showcase and preserve UBC's unique intellectual output by making content freely available to anyone, anywhere via the web" (UBC, 2017, para 1). This medium targeted those persons with a general interest in MAiD of whom had knowledge of the digital repository. In order to reach a wider audience to obtain my goal of increasing knowledge on MAiD, I submitted a review of the literature for publication that would provide readers with a general overview on the topic.

MAiD is a relatively new area of nursing practice and research. This literature review is therefore timely and needed. A limitation to this project included the limited ability for a student written literature review to gather enough interest in publication from a peer reviewed journal. Another limitation was both lack of time and access for NPs to read and learn via peer reviewed journals. Reasoning and evidence for my selection of a literature review are described within the next paragraph.

Medical and nurse practitioners' barriers to accessing and utilizing evidence-based practice has been extensively studied with consistent results indicating the lack of time and enormous amounts of literature available (Majid et al., 2012). Literature reviews provide concise,

detailed, and condensed information that practitioners can use to quickly and effectively increase their knowledge base (Garrard, 2017). Medical and nurse practitioners have shifted from obtaining knowledge from an “emphasis on authoritative opinions to an emphasis on data extracted from prior research and studies” (Menear, Grindrod, Clouston, Norton, & Légaré, 2012, p. 623). Access to such information is often through peer reviewed journals. The format of my culminating project, therefore utilized this important and effective learning format.

Literature Review

A thorough literature review was conducted using various databases that included the Cochrane Library, Cumulative Index to Nursing and Allied Health, Google Scholar, Web of Science, and Pub Med. Key search terms used in the search included a combination of the following: medical assistance in dying, physician assisted suicide, physician assisted dying, euthanasia, assisted suicide, medically assisted death, nurse practitioner role, history, end of life care, ethics, and Bill C-14. Articles were screened by reviewing the abstract in relation to the clinical question, and articles from 2001- present day were included. Next, articles were assessed for quality utilizing the Joanna Briggs Institutes (JBI) critical appraisal tools. The JBI is a globally recognized non-profit organization with the overall goal of promoting evidence-based literature within healthcare (JBI, 2016). They provide easy to use, step by step checklists for the novice health care researcher to establish the quality of a research article (JBI, 2016). Results were excluded if they did not pertain to the clinical question, were appraised as low quality, or were solely opinion pieces.

History

Despite thousands of years of legal, medical, philosophical, and theological deliberations, euthanasia remains a controversial and unresolved concept (Emanuel, 1994). Minimal new

ethical advancements have been discovered surrounding euthanasia (Papadimitriou et al., 2007). It is thereby important to look back at historical debates before moving forwards to understand new legislation (Papadimitriou et al., 2007). The following paragraphs provide a brief overview of ancient, early modern, recent, and Canadian history of euthanasia.

Ancient

Euthanasia discussions date back to ancient Greece and Rome, as evidenced by personal letters, recorded theological and philosophical debates, and preserved government documents. (Emanuel, 1994; Papadimitriou et al., 2007). Such debates did not focus on the action of hastening death, but rather focused on improving the inevitable process of dying (Porter, 2005). To reduce pain during death, the herb Hemlock was typically administered (Porter, 2005). Euthanasia was an everyday reality and life in Rome, until the Hippocratic school of medicine started to reject the action and was further supported by the new Christian religion (Ezekiel, 1994; Porter, 2005). Due to increasingly dominant religious influences on society, ideas such as euthanasia that contradicted Christian and Catholic values became unpopular and began to receive little attention (Ezekiel, 1994; Porter, 2005).

Early Modern

The end of the middle ages gave rise to the early modern era. This pre-industrial revolution time period between the late 15th century and the late 18th century was characterized by a shift from primarily religious influences towards advances in science, travel, and printing technology (Emanuel, 1994). Therefore, the word of scholars and writers became more accessible to the public (Emanuel, 1994). With new ideas and communication modalities circulating, once again the debate of euthanasia resurfaced. The first popular reference in favor of euthanasia was found in Sir Thomas Moore's famous novel *Utopia*, a fictional story about an

island with near perfect societal values (Emanuel, 1994). Throughout 17th Century various philosophical and medical debates surfaced discussing the thought that euthanasia should be legal, however, religious influences remained dominant, thereby blocking any legislative revolutions (Emanuel, 1994).

The development of anesthesia in 1846 was soon followed by discussions of its use to mitigate the agonies of death (Emanuel, 1994). An essay in 1870, by writer Samuel Williams, was the first time in modern medicine that hypodermic morphine was suggested to be used to end life with the patient's permission (Emanuel, 1994). This opinion received much public attention (Emanuel, 1994). Soon after, public debates commenced that interestingly echoed modern arguments against medically assisted deaths, which were mostly centered on concerns that the procedure could be abused (Emanuel, 1994). Eventually the debate was settled with allowing anesthesia to be used in order to "soften suffering, but not to hasten death" (Emanuel, 1994, p. 795). Intriguingly, such debates lead to the undermining of the profession of medicine, which was just becoming a formal more recognized paradigm, resulting in further alienation of debates in favor of euthanasia (Emanuel, 1994). Overall, after hundreds of years of relative silence, the modern era brought attention and consideration to the euthanasia debate, but failed to bring legislative change.

Modern

The 19th century gave rise to industrialization, individualism, and Darwinism. Self-determination became a focus, alongside fierce capitalism (Emanuel, 1994). These values and cultural shifts re-ignited the debate for euthanasia, providing new insights that had an economical focus (Emanuel, 1994; Grue, 2008). In turn, those outside the realm of medicine and philosophy entered the debate. Lawyers and politicians began to publically argue for or against euthanasia,

which led to the first attempts at legislative changes in both the United States and Britain (Emanuel). World War II and the subsequent discoveries of Nazi death camps and the atrocious medical experiments (such as state sponsored euthanasia) during Nazi Germany's reign basically eliminated all discourse around euthanasia (Emanuel, 1994; Grue, 2008). It was not until the 1970's and 80's that debates again became part of popular media, usually centering around highly publicized personal cases such the stories of Terri Shiavo, Robert Latimer, and Jack Kevorkian (Grue, 2008). Cultural shifts towards a more individualized society that promoted personal choice led to the re-instatement of euthanasia as a political and social movement.

Rise of Legislative Changes

Within the longstanding debate surrounding euthanasia, MAiD is a relatively new development (Amies, 2017). Societal values, scientific advancements, and public court cases have all played a role in the demand for MAiD (Amies, 2017). Notably, values have shifted from physicians having full authority and trust, towards a model of patient centered care. This has resulted in patients who are often better informed and thus demanding of more options. (Porter & Johnson, 2005; Bradley, 2016). Concurrently, numerous advances in medicine have allowed people to live longer and survive diseases that were previously fatal (Porter & Johnson; Bradley, 2005). Within a relatively sudden timeframe death has become the enemy rather than an inevitable reality of life (Emanuel, 1994). Amid a sicker, older, and better-informed population grew a demand for end of life care along with the right to end one's life when suffering was deemed to be personally intolerable (Porter & Johnson, 2005). Canada was not experiencing these cultural shifts in isolation. Although it is beyond the scope of this paper to detail all other national interests of legalities surrounding euthanasia, is important to note that certain forms of passive euthanasia or physician assisted suicide have been legalized in Switzerland (1980's),

certain US states (1997), Netherlands (2002), Belgium (2002), Sweden (2010) and Colombia (2014) (Alchin, 2017). Interestingly Canada developed the only law in the world that allows for active euthanasia. Essentially, after numerous court cases the public demanded legislative changes that lead to Bill C-14, otherwise known as MAiD.

Canadian Legislative History

Before the criminal code was eventually amended to allow for MAiD, numerous attempts at passing bills within the Canadian legislature were attempted (Alchin, 2017). Led by the honorable Francine Lalonde three bills in 2005, 2008, and 2009 were targeted at amending the criminal code to allow for physician assisted dying (PAD) (Alchin, 2017). Neither bill was passed, but interestingly Lalonde's passion for the project was driven by her own personal cancer diagnosis (Alchin, 2017). After her death, the honorable Steven Fletcher, likewise inspired by his own personal health as a quadriplegic, attempted to pass a similar bill in 2014, again without success (Alchin, 2017). Lastly, the honorable Nancy Ruth attempted one more bill in late 2014, which was also rejected. On June 17, 2016 Canadian parliament amended the criminal code and passed Bill C-14 which allows for medical and nurse practitioners to assist their patients wishing to have a medically assisted death (Alchin, 2017).

Canadian Court History

Legislature changes did not occur in isolation from the courts. Attempts to challenge the law in Canada date back to 1985 which were typically dramatized by public court cases (Alchin, 2017). Most notably are the cases of *Rodriquez v. British Columbia, R. v Latimer*, and *Carter v. Canada*. Sue Rodriquez suffered from Amyotrophic Lateral Sclerosis (ALS) (Alchin, 2017). In 1993, she argued to the courts that the law prohibiting physician assisted dying discriminated against those with disabilities who were physically incapable of committing suicide (Alchin,

2017). Stating their need to protect the vulnerable, the majority voted against her claims (Alchin, 2017). Subsequently followed the *R. vs Latimer* case in which the father of an Cerebral Palsy afflicted child complicated with uncontrolled seizures and chronic pain, ended his daughter Tracy's life stating he desired to end her suffering (Alchin, 2017). The courts argued that he should be acquitted of his first-degree murder charges due to the crime being committed as an act of mercy (Alchin, 2017). His charges were later reduced to second-degree murder (Alchin, 2017). Lastly, the case of *Carter v. Canada* in which the BC Civil Liberties Association represented Kay Carter and Gloria Taylor, suffering from Spinal Stenosis and ALS, respectively (Alchin, 2017). This case won, effectively lifting the prohibition on PAD, triggering the legislature to create the monumental Bill C-14. Unfortunately, neither Kay Carter or Gloria Taylor survived to witness their victory.

In the time period between the *Carter* Decision and the passing of Bill C-14, a well-appointed and diverse committee was created to come to a consensus on eligibility, safeguards, procedures, and standard protocols (Alchin, 2017; Canada. Parliament, 2016). Although not all committee recommendations were represented within Bill C-14, overall the legislation passed reflects the committee's report (Amies, 2017). The decisions both within the courts and the legislature provided adequate background to create a law that would become the backbone for MAiD in Canada.

Overview of Problem

Current Statistics

MAiD law passed in 2016 within a relatively fast period of time. This meant the Provinces and Territories needed to quickly create the infrastructure and policy required to implement the law. Resultantly the statistical data available on MAiD is widely varied and some

provinces and territories have not reported any data, stating confidentiality reasons (Robertson et al., 2017). However, Health Canada (2017) has completed the 2nd interim report which has compiled the most recent and detailed statistics to date. Excluding the Yukon, Northwest Territories, and Nunavut, since Dec 10, 2015 there have been 2 149 MAiD deaths in Canada, which constitutes 0.9% of all deaths annually (Health Canada). Majority of the procedures have taken place in either the home or the hospital setting (44.6%, 38.4%) (Health Canada). There have been only 5 reported deaths from self-administration, with an overwhelming majority requesting clinical administration of the drugs (Health Canada). The average age of the patients was 73 years old and the most common cited reasons for the procedure was cancer related (63%), circulatory or respiratory illness (17%), and neuro-degenerative diseases (13%) (Health Canada). The Health Canada report also referenced the role of NPs in providing MAiD; they reported low percentages of MAiD procedures being provided by NPs, but acknowledged their participation (Health Canada). As stated previously, there has been a lack of systematic and uniform gathering of statistics, but as the law ages, more detailed statistical analysis is becoming available.

Legal Overview

Substantive Safeguards

Substantive safeguards are summarized as those put in place to prevent infringement on persons rights and liberties (Oligvie & Oliphant, 2016). To outline, those who are currently eligible for MAiD must be over the age of 18, have the ability to give informed consent, be mentally competent, suffer from a grievous and irremediable medical condition, be eligible for Canadian health services, and provide the consent voluntarily without external coercion (CNA, 2017). Grievous and irremediable medical condition is further defined as: a serious and incurable

illness, disease or disability, are in advanced state of irreversible decline, find their state to cause enduring physical or psychological suffering that is intolerable and not relieved under acceptable conditions, and their natural death has become reasonably foreseeable (CNA, 2017). The grievous and irremediable medical condition does not have to be terminal nor fatal (CAN, 2017). These terms have led to additional debates and ethical concerns which will be discussed further within this paper. Informed consent involves ensuring the patient is competent, has been made aware of feasible alternatives, and is aware of the risks of the procedure (College of Physician and Surgeons of British Columbia [CPSBC], 2017). If there are any concerns in regard to the patient's competence, the provider or assessor can refer to a specialist in competence, such as a psychiatrist (CPSBC, 2017). These safeguards act to protect vulnerable citizens while enabling those who legitimately require MAiD services to do so in a safe and consistent manner.

Procedural Related Safeguards

In order to protect vulnerable individuals from erroneously accessing MAiD, numerous procedural safeguards were also embodied within the law. Procedural related safeguards include: two independent medical or nurse practitioners must determine eligibility, the request for MAiD must be provided in writing and signed by two independent witnesses, patients have the right to withdraw at any point during the process, mandatory waiting period of 10 clear days before the administration of MAiD, and the consent must be provided at the time of medication administration (CNA, 2017). The medical or nurse practitioners are defined as independent from each other if they are not in a mentorship relationship, will not knowingly benefit from the patient's death, and are not connected to each other in any way that would affect objectivity (CSPBC, 2017). It is important to note that the 10-day waiting period does not include the day of

request approval, nor the day of the procedure (CNA, 2017). The assessments from the practitioners must be provided in writing, however, the assessor can contribute via telemedicine (CSPBC, 2017). Likewise, the independent witnesses must also not knowingly benefit from the patient's death, be a direct health care or personal care provider to the patient, nor own the health care facility in which the patient resides (CSPBC, 2017). The prescriber must also pick up the medications directly from the pharmacy, and either witness the self-administration or administer the drugs themselves, and remain with the patient until their death (CNA, 2017). To prevent wrongful exclusion based on the patient's inability to write or to endure the 10-day reflection period, exceptions are allowed at the discretion of the practitioners (Amie, 2017). A proxy may be selected to sign on behalf of the patient at their explicit consent, this proxy cannot be one of the two witnesses required to sign the patient's request, and must sign in the presence of the patient (CNA, 2017). Overall, despite concerns for placing vulnerable individuals at risk, the committee stated, "properly designed and administered safeguards was capable of protecting vulnerable people from abuse and error" and that a "carefully designed and managed system is capable of adequately addressing them" (Canada. Parliament, Section 1.3, para 4). Despite these safeguards, there remains a substantial divide between those who find the law too restrictive, and those who have determined it to be dangerous.

Reasonably Foreseeable Clause

After the release of Bill C-14, there was much confusion and debate within the medical community around the term "reasonably foreseeable" in relation to the eligible patient's natural death (Amies, 2017). "Reasonably foreseeable" is not a medical term, yet medical professionals are required to interpret and practice within that interpretation for what is arguably one of the

most important decisions of their patients' lives (Amies, 2017). Downie and Chandler (2017) who are both lawyers and medical practitioner's provide insight into how health care providers can interpret this clause, and why it was written in such an interpretable manner. They stated that the law was crafted to allow for maximal flexibility for the medical providers to decide eligibility (Downie & Chandler). Rather than using the stricter terms such as "beyond a reasonable doubt" and applying a temporal limit, the law can be adapted and adjusted to each patient within the safeguards provided (Downie & Chandler). In summary, "reasonably foreseeable" is a clause that allows for the health care provider who knows the patient to determine eligibility, which reduces the risk of denying patients who should be considered eligible (Downie & Chandler).

Procedure

After substantive safeguards are established, procedural guidelines must be followed to ensure patient safety and MAiD provider legal security. Despite the federal government amendment to the criminal code, it remains the responsibility of the provinces and territories (and thus regional health authorities) to provide procedural related guidelines (CNA, 2017). The following guideline is related to the province of British Columbia, but is not inclusive of all health authority's procedural differences. Therefore, it is imperative to ensure each health care provider is aware of their own health authorities guidelines and follows them accordingly.

Within the medical record of the perspective MAiD patient, there should be the following documents: any relevant medical records pertaining to diagnosis and prognosis, all written and oral requests for MAiD from the patient, document that confirms the patient was offered ability to withdraw request, and both the prescriber and assessor's documentation that substantive requirements were met (CNA, 2017). Before the procedure, the provider must have completed the formal written request for MAiD (see Appendix B), signed by both the patient and the two

independent witnesses, a record of the prescriber and assessor's assessment (See Appendix C & D), and the pre-printed medication order form from the pharmacy (CNA, 2017). Subsequently, the prescriber must pick up the prescribed medications from the pharmacy themselves (CNA, 2017). Of note, all unused substances must be returned to the pharmacy by the prescriber within a reasonable timeframe (typically 48 hours) (CNA, 2017; CSPBC, 2017). Directly before administering the dispensed medications to the patient, the prescriber must ask if the patient would like to continue (CNA, 2017). The patient must remain of sound mind with full abilities to provide informed consent at the time of medication administration (CNA, 2017). During the procedure, the prescriber must remain with the patient until their death has been confirmed (CNA, 2017). Afterwards, the following paperwork must be completed and faxed to the BC Coroner's office: patient request form, prescriber and assessor's assessment forms, completed medical certificate of death, BC Coroner's office MAiD form (Appendix E), and the medication administration record (CNA, 2017). See attached Appendix F for the complete checklist. In regard to the medical certificate of death, section 1 (a) the reason must be written as MAiD and section 1 must be filled out with the underlying illness as the reason, and the cause of death signified as natural (CPSBC, 2017). Again, it is important to note that all health care providers must refer to their employers or health authority's guidelines, as they can vary greatly.

Medications

Each health authority has its own pre-printed orders for the administration of medications for the MAiD procedure. These pre-printed orders are not intended for public knowledge, but a general outline will be provided within this paper. Permission has been provided by the Providence Health Authority to provide these general procedures. Overall, there are two routes of administration for the patient to choose: oral medications or intravenous medications. Each

route has its own set protocol that must be followed, alongside with contingency plans in case of failure. Again, this paper will discuss the general outline of both the oral or intravenous (IV) medication procedure, but specific details such as dosages within the pre-printed orders must be followed. Registered nurses may not prepare or administer medications for the patient.

Oral Route

The oral route of medication administration consists of three main parts: gastric motility agent, anxiolytic agent, and the coma inducing preparation (Providence Health Service Authority [PHSA], 2017). Intravenous access is still required in case of failure of oral agents (PHSA, 2017). Firstly, an hour before the coma inducing agent is intended, gastric motility agents, including metoclopramide, ondansetron, or haloperidol are required (PHSA, 2017). This is intended to reduce the nausea that is a common side effect of the coma inducing preparation (PHSA, 2017). Secondly, about 5-10 minutes before the coma inducing agent is intended, lorazepam is administered to reduce anxiety (PHSA, 2017). If this is not effective, the dosage can typically be repeated (PHSA, 2017). Lastly, the coma inducing preparation, which consists of a mixture of phenobarbital, chloral hydrate, and morphine is taken by the patient (PHSA, 2017). This preparation is compounded by the pharmacist, is stable for 72 hours, should be taken with a non-fat, non-carbonated drink, and is typically around 120mls to ingest (PHSA, 2017). On average patients are deceased within 2 hours, but it can be expected to take up to 4 hours (PHSA, 2017). The main side effects include nausea and vomiting (Gather & Vollman, 2013). The oral medications will come prepared by a pharmacist in a sealed kit, alongside with two IV route kits for back-up purposes (PHSA, 2017). Education is required for both the patients and the family members on the medication plan of action and contingency plans. Informed

consent involves the patient being aware that the oral route of medication administration might result in delayed death, or may even not result in death (Gather & Vollman, 2013).

IV Route

Intravenous route of medication administration involves four parts: anxiolytic, local anesthetic, coma inducing agent, and a neuromuscular blocking agent (PHSA, 2017). Before administration it is recommended that two IV lines are established (PHSA, 2017). Likewise, the plan of action, expected timeline, and contingency plan should be discussed with the patient and family. Of note, two sealed pre-prepared kits will be given to the prescriber from the pharmacy. Firstly, midazolam, an anxiolytic agent should be slowly pushed through the IV over two minutes, which should then be flushed with a normal saline (NS) solution (PHSA, 2017). If the first dose is ineffective, it may be repeated. Next, a lidocaine solution should be administered into the IV over 30 seconds, again followed by a NS flush (PHSA, 2017). The reasoning behind the local anesthetic is to reduce the discomfort associated with IV administration of Propofol (PHSA, 2017). Subsequently, a coma inducing agent such as Propofol or phenobarbital is slowly administered into the IV over five minutes (PHSA, 2017). Family can expect the patient to become unconscious and should be told that snoring is an expected finding (PHSA, 2017). Lastly, a neuromuscular blocking agent, such as rocuronium is injected over one minute, in which the patient can be expected to cease breathing by the end of the injection time (PHSA, 2017). Soon afterwards, cardiac function will cease and the patient can be pronounced dead. In order to simplify the procedure and reduce risk of error, medications are all prepared and labelled by a pharmacist, and should be removed from the kit and laid out in a time order sequence manner (PHSA, 2017). Likewise, a visible timer should be made available to the prescriber. As

discussed previously within the procedure section of this paper, consent must be obtained (by signing proof of confirmation section of patient request record, see Appendix B) (PHSA, 2017). Directly before the initiation of the procedure, and the patient must be asked if they wish to continue. The IV route of medication administration for MAiD is the most commonly requested, therefore NPs should be comfortable and knowledgeable with the above procedure.

Decision Making Framework

The Alberta Health Services (AHS) (2017) team created an expert panel to help create a framework that describes the stages of a patient contemplating MAiD. According to this framework, there are five stages that provide structure and delineate potential learning needs throughout the process: pre-contemplative, contemplative, determination, action, and after death (Alberta Health Services). Each stage is clearly outlined and could provide a useful framework for care providers discussing and or providing MAiD to their patients (AHS). Firstly, the pre-contemplative stage is characterized by the patient asking basic questions about MAiD. The health care provider at this time can support the patient by either providing general information, or referring to more capable resources (AHS). Secondly, the patient enters the contemplative stage, where more serious and specific questions regarding MAiD are being asked, such as patient eligibility (AHS). The willing health care provider can assist patients and their families during this stage by helping them determine eligibility, and referring them to their health authorities care coordination services (AHS). It is important to note that it is illegal to counsel persons to choose MAiD, and during these stages it is imperative the medical or nurse practitioner provide objective facts and information, not personal opinion. Next, the patient enters the determination phase, in which the patient has decided to go ahead with the procedure, and numerous planning points are being discussed (AHS). Supportive care during this phase

becomes more action orientated: the medical or nurse practitioner completes appropriate assessments and paperwork, discusses options for the procedure, and creates an aftercare plan with the family (AHS). Next, the patient enters the action phase, where together with the care provider and the family, the action plan is solidified, back up plans are discussed, numerous education points are reviewed, and the provision of the MAiD procedure takes place (AHS). Lastly, the final phase is the after-death phase. Here, the family after care plan is implemented. MAiD is a complex and profound procedure for patients, families, and care providers. Therefore, having a theoretical framework on which to guide decision-making, supportive care, and education is a helpful tool for MAiD providers.

Ethics

The debate for or against medically assisted death has been largely unchanged over the last few centuries (Emanuel, 1994). Although the language has changed over the years, the central themes remain the same (Emanuel, 1994). It is beyond the scope of this paper to outline and detail every argument, however I have outlined the general themes that provide an overview of the main arguments.

General in Favor

Those who reason in favor of MAiD state that it is a human right, and reflects the ethical principles of autonomy and self-determination (Emanuel, 1994; Morrison, 2017). If one is to follow the ethical principles of beneficence and non-maleficence, a medically assisted death ought to be permissible (Emanuel, 1994). This is contended in terms of pain relief, on the basis that a medically assisted death is less painful and harmful than remaining alive in a state of suffering (Bradley, 2016; Emanuel, 1994). Those in favor also dispute that the medical system is already regularly and routinely completing euthanasia when they withdraw life-sustaining

treatment (WLST) or provide palliative sedation (Morrison, 2017). Arguments that have a basis within the “slippery slope” are stated to be not valid and substantiated with factual evidence (Amies, 2017). In other words, there is no data supporting the argument that if medically assisted deaths are legally permitted, that there will be an increase in reports of persons not willing or not eligible being submitted to the procedure (Amies, 2017). Nor is there any factual evidence that the legality of medically assisted deaths leads to further expansion of the laws to include non-consenting persons (Amies, 2017). This is evidenced by numerous other countries legalizing medically assisted deaths without reports of the incidents stated above.

General Against

On the other side, the arguments of those against euthanasia generally state that allowing medical assisted deaths will make practitioners more willing to stop treatments (Emanuel, 1994; Morrison, 2017). Likewise, allowing MAiD could lead to the undermining of the entire medical profession, where patients would lose trust in their provider’s intentions, and fear being euthanized when not desired (Emanuel; Otte, Jung, Elger, & Bally, 2016). Instead agreeing that WLST is similar to euthanasia, those against medically assisted deaths argue that the intention behind an act is significant (Morrison, 2017). The principle of double effect is the main agreement behind these statements, citing that the intention of the act to do good has superior moral relevance than potential side effects, such as respiratory depression (Porter, 2005). Furthermore, they argue that there are many negative consequences to legalizing MAiD such as potential abuse, requesting the procedure to relieve the burden on the patient’s family, and that it may undermine the trust of the profession (Amies, 2017; Bradley, 2016). Legalizing MAiD might also send the message to those who are disabled, elderly, or chronically ill that their lives are not worth living (Amies, 2017).

Palliation

There are numerous ethical concerns that have created a divide between palliative care providers and MAiD (Morrison, 2017). Rather than offering the two end of life therapies concurrently and symbiotically, most palliative care providers have veraciously objected to MAiD being included within their scope of practice (Morrison, 2017). Several reasons are cited, such as: offering MAiD might cause some patients to avoid palliative care altogether for fear of being euthanized, that it contradicts the basic principles of palliative care, and that MAiD is a failure of the health care system to provide funding and access to palliative care (Morrison, 2017). Viewing palliative care as a human right expands these arguments of which providers should be providing MAiD to a wider lens of social injustice and access to a dignified death (Reimer-Kirkham et al., 2016).

Public opinion differs in relation to the stance that palliative care providers have taken (Morrison, 2017). The public has reported they would prefer to have palliative care and MAiD provided concurrently (Morrison, 2017). In response to palliative care basic principles, the World Health Organization states that palliative care is “an approach that improves the quality of life of patients and their families facing the problems associated with life threatening illness” (Morrison, 2017, p. 10). However, most palliative care organizations mandate their goal is neither to hasten nor prolong life, although they routinely practice WLST (Morrison, 2017). Again, it comes down to the ethical implication of conscientious objection of individuals rather than wards and facilities. If a palliative care provider objects, they can transfer their patient’s care to another provider, without having to transfer a dying patient off of their ward. MAiD could be used as a “measure of last resort within palliation, rather than an alternative to it” (Morrison, 2017, p. 12).

Ethically, there are valid concerns in regard to funding, access and education for palliative care. There have been longstanding inequities for patients to access palliative care: speciality providers and bed availability are limited in a time where demand is ever increasing (Vogel, 2017). Likewise, a recent survey on the education provided to medical students reported variable, fragmented, and minimal focus on palliative care (Vogel, 2017; Li et al., 2017). However, education on MAiD is quickly being standardized and implemented in most health care education programs (Vogel, 2017; Li et al., 2017). Likewise, health authorities have been quick to provide staffing and training on MAiD (Li et al., 2017). This leaves one asking how can we demand a right to access MAiD but not palliative care (Vogel, 2017). Concerns around lack of funding for palliative care are valid, but most areas within healthcare lack funding and equal access, and this does not necessarily justify not providing other services.

Alternatively, viewing palliative care as a human right, creates a different perspective by shifting the focus from the question of whether society should be providing MAiD services, to an assumption that each citizen has the right to die the way they want to (Reimer-Kirkham et al., 2016). Within Canada, despite our universal health care system, there is great disparity in the care we provide to the dying (Reimer-Kirkham et al., 2016). This goes beyond the structural barrier of rural versus urban populations, which will be discussed later within this paper. Rather, when applying a social justice lens to palliative care, we can see that not everyone has equal access and opportunity to a peaceful and dignified death (Reimer-Kirkham et al., 2016). Each inequity within the social determinants of health, alongside with structural inequities such as geography, can constrain a persons' access to palliative care or MAiD services (Reimer-Kirkham et al., 2016). Those who are more vulnerable are at increased risk of dying alone, dying in poorer conditions, or accessing services late within their dying process (McNeil,

Guirguis-Younger & Dilley, 2012). As such, this critical lens expands the argument from an individual or medical speciality taking ownership of MAiD to society as a whole reducing inequity, so each person has the equal right to die in the manner they choose. When reduced to the level of persons not being able to die in a dignified manner due to their life circumstance, the argument of ownership of MAiD becomes secondary. Instead, we should be working together on both macro and micro levels in order to reduce inequities to ensure equal access to a dignified death, whether that be in the form of MAiD or palliative care (Reimer-Kirkham et al., 2016).

Mental Illness

The issue of persons with mental illness applying for MAiD remains contentious. Within *Carter v. Canada* neither of the complainants suffered from mental illness, leading to a lack of precedent within this area (Oligvie & Oliphant, 2016). Questions are difficult to answer in terms of persons with mental illness being able to provide fully informed consent and whether or not their illness is irremediable (Oligvie & Oliphant, 2016). The Special Joint Committee on PAD provided expert witnesses that argued both for and against the inclusion of persons with mental illness for MAiD (Oligvie & Oliphant, 2016). Overall their conclusions stated that it would be unjust to conclude that all individuals with mental illness are incompetent, and that mental suffering is not less than physical suffering (Oligvie & Oliphant, 2016). However, it is imperative to proceed with caution, especially in cases where mental illness is the sole underlying condition triggering the request. Important to note, that those with mental illness applying for MAiD must still satisfy all of the other criteria in order to become eligible (Oligvie & Oliphant, 2016). An often-cited example is a patient suffering from anorexia nervosa, who has attempted and failed other treatment modalities (Oligvie & Oliphant, 2016). Such a patient could

be determined to be competent, whilst suffering from a grievous and irremediable mental health condition. Bill C-14 does not solely exclude persons with mental illness for eligibility for MAiD (CNA, 2017). We can expect within the near future, court cases that challenge the restrictive nature of mental health conditions when applying for MAiD (Oligvie & Oliphant, 2016). However, at this time, without precedent and limited data, the contentiousness of this issue will remain.

Minors

Similar to the inclusion of persons with mental illness, the inclusion of minors or mature minors remains locked in great debate. The Netherlands and Belgium are currently the only countries that allow inclusion of minors within their MAiD laws (Oligvie & Oliphant, 2016). Adamantly against the inclusion of minors is the Canadian Pediatric Society, citing lack of evidence and social consensus and that the over 18 age-limit was not selected arbitrarily (Oligvie & Oliphant, 2016). On the other hand, the Supreme Court of Canada stated that they have a right “to a degree of decision making autonomy that is reflective of their own evolving intelligence and understanding” (Oligvie & Oliphant, 2016, p. 20). Again, as with mental illness, mature minors would still have to meet all other inclusion criteria. In summary, the Special Joint Committee recommended that only those over the age of 18 be eligible, which reflects the current law (CNA, 2017; Oligvie & Oliphant, 2016). However, they also ruled that this issue be reviewed within three years of the passing of Bill C-14, allowing time to gather more evidence and reflect upon prospective adjustments (Oligvie & Oliphant, 2016).

Consent / Advanced Directives

In the context of an aging population, the rates of neurocognitive dementias are expected to rise annually, with 25 000 new cases diagnosed annually in Canada (Alzheimer’s Society

Canada, 2017). With these statistics, it will become more common for patients diagnosed to inquire about their eligibility of MAiD (Dresser, 2017). Currently the law does not allow for advance directives that allow for patients to legally request for MAiD when they deteriorate past a point where they can provide ongoing consent, such as in the case of dementia (Gather & Vollman, 2013; Dresser, 2017). Patients requesting MAiD must be able to provide informed consent at the time of the procedure thereby excluding patients who will lose such capacity within their illness trajectory (Gather & Vollman, 2013). Permissibility of advanced requests was one of the recommendations that was included within the joint committee's expert recommendations, but excluded from the current law (Amies, 2017; Canada. Parliament, 2016). A recent 2016 survey reported that the public opinion is that majority of the population is in favor of MAiD in circumstances such as dementia (Dresser, 2017; Gather & Vollman, 2013). However, arguments both for and against the inclusion of advanced directives must be considered.

Exploring the allowance of advanced directives within MAiD legislation directly balances the protection of vulnerable patients with patients right to autonomy and self-determination (Dresser, 2017; Gather & Vollman, 2013). In order to provide fully informed consent, patients must be able to have full decision-making capacity, adequate understanding, and voluntary choice (Gather & Vollman, 2013). Neurocognitive dementias are incurable, progressive, and currently lack effective treatments (Gather & Vollman, 2013). Even within mildly cognitive impaired persons, level of decision making capacity and ability to understand is expected to fluctuate (Gather & Vollman, 2013). Therefore, it remains a reasonable assumption that at times they may be able to understand such a momentous decision as MAiD, but on the other hand, it becomes increasingly difficult to determine capacity within such a state (Gather &

Vollman, 2013). The Dutch currently allow cognitive decline as a reason for PAD, however they ensure capacity is assessed by more skilled professionals, such as psychiatrists (Dresser). Very rarely do they honor advance directives (Dresser, 2017). As stated previously, in order to provide fully informed consent, patients must be free from coercion (Gather & Vollman, 2013). This becomes a more alarming concern in cases of dementia, where caregivers typically experience increased physical, financial, and emotional burdens. Another valid argument presented by Dresser (2017) was that those newly diagnosed with dementia may lack an accurate objective opinion on the realities of living with dementia. Currently there is no standardized validated method to feasibly determine capacity to consent in context of persons living with dementia (Gather & Vollman, 2013). Consequently, it seems a reasonable first step to proceed with caution in regard to allowing advanced directives for MAiD.

Conscientious Objection

Although the law allows for practitioners to provide medically assisted deaths, it does not force any health care provider to participate (CNA, 2017). Opting out of participating is known as conscientious objection. It is important to note that objecting NPs are required by their professional standards to refer the MAiD requesting patient to another practitioner who provides the service (CNA, 2017). This transfer of care must remain respectful and not compromise patient care or safety (CNA, 2017). Conscientious objection is permissible within the law; however, this has created several grey areas.

There are many health care institutions within Canada that are faith based (Amies, 2017). This has led to entire facilities conscientiously objecting medical assisted deaths, even to the extent that they do not allow eligibility assessments within the premises (Amies, 2017; Otte et al., 2017). As a result, patients have undergone transfers that would not be considered within

their best interest and has even placed some patients at harm (Amies, 2017). On a larger scale, entire communities have restricted access to MAiD due to having the only proximate health care facilities identifying as faith based (Amies, 2017). Legal case precedent states that institutions have the right to freedom of religion, but only if that institution is set up primarily for religious purposes (Amies, 2017). Hospitals are quite obviously set up and funded by tax-payer dollars in order to provide health care, not religious services (Amies, 2017). Despite these facts, many Canadians have restricted access to their legal right to request MAiD.

Nurse Practitioner Role

Within British Columbia, NPs are defined as advanced practice nurses that “provide comprehensive clinical care including the diagnosis and management of disease/illness, prescribing medications, ordering/interpreting laboratory/diagnostic tests, and initiating referrals to specialists” (BCNPA, 2017, para 1). The role was created in response to a lack of primary care physicians in a time of increasing health care costs (Worster, Sarco, Thrasher, Fernandes, & Chemeris, 2005). A systematic review found that NPs can provide care equal to physicians, with equivalent health care outcomes (Horrocks, Anderson, & Salisbary, 2002). Likewise, patients have reported increased satisfaction and quality of care when that care was provided by a NP (Horrocks, Anderson, & Salisbary, 2002). NPs are also reported to spend more time with their patients than their physician colleagues, despite similar averages in patient visits per day (Worster et al., 2005). Despite these positive attributes, the role of NPs remains relatively underutilized (Worster et al., 2005). However, the role and scope of practice continues to expand and develop (Alchin, 2017). Many roles within the model of care for NPs within British Columbia include caring for our most vulnerable and marginalized populations and increasing

care in rural communities (Bradley, 2015). Therefore, we can expect more demands on NPs to provide palliative care and MAiD services (Stokes, 2017)

Canada is the first country that incorporated NPs into medical assisted dying, allowing for a full scope of practice within the legal parameters outlined (CNA, 2017; Stokes, 2017). Providing comprehensive, holistic, and quality care during a complex and emotionally charged procedure such as MAiD requires not only skill and experience, but also tact and caring (Bradley, 2017; Stokes, 2017). This is an immense responsibility for any practitioner, but upon closer examination of the unique role of NPs, we can find evidence that the role is suited for providing MAiD (Amies, 2017; Bradley, 2017). The role of NPs has been described as a blending of nursing, medical, and social sciences, allowing skilled practitioners to practice beyond the medical model (Stewart & Denisco, 2015). This “flexible paradigm” (p. 31) develops a practitioner that has a foundation in nursing theory, an advanced education with assessment and pathophysiology components, alongside work experience as a nurse (Stewart & Denisco, 2015). Importantly, this is not to state that physicians do not practice holistically or in a caring manner. A quote from a medical sociologist in an article discussing holistic care summarizes this theme well by stating:

“Traditionally medical school curricula have focused on the pathophysiology of disease while neglecting the very real impact of disease on the patient's social and psychological experience, that is, their illness experience. It is in this intersection that humanism plays a profound role” (Indiana University, para 7).

As stated previously, NPs have a base within nursing theory, many of which have the building blocks of caring and humanism (Stewart & Denisco, 2015). NPs also are typically able to spend more time with their patients, and their patients report higher satisfaction and quality of care

(Horrocks, Anderson, & Salisbary, 2002). End of life care requires unique and sensitive care, even more so when medically assisted dying is requested. With these outlined role characteristics, it is not far reaching to assume that NPs are capable of providing quality care during MAiD procedures. Patients and their families undergoing the process of MAiD require attentive care that is not limited by time and funding constraints.

Barriers/Solutions

Rural

Numerous debates have arisen in regard to rural communities and MAiD access. Geography is a barrier for rural Canadians to access health care, a problem that is further magnified when speciality care such as palliation is required (Collins & Leier, 2017). There are concerns that those in rural communities may lack access to the service due to lack of provider availability, especially in the context of providers and assessors legally requiring to be independent from each other (Collins & Leier, 2017). Rural providers often have a closer relationship with their peers than urban providers (Schiller, 2017). However, there is also the legitimate question of will those in rural communities choose MAiD due to the inability to access palliative care due to scarcity of access, chronic low funding, and limited providers (Collins & Leier, 2017). It reported that only 16-30% of Canadians have access to palliative care (Canadian Hospice and Palliative Care Association, 2010). It is therefore a legitimate concern that rural Canadians may opt for MAiD due to their inability to access palliative care. Another concern for rural citizens is that the potential for their sole care provider to be a conscientious objector is a possible reality, thereby forcing distant travel or opting out (Schiller, 2017). The *Carter v. Canada* (2015) ruling stated that “ultimately Canadians should be able to make a truly informed

choice between physician assisted dying, no medical intervention, and palliative care” (Canada. Parliament, 2016, Section 1.4, para 3).

However, Bill C-14 has passed with limited improvement to access and education for palliative care. Solutions are thereby limited. The current solution is the MAiD Care Coordination role, which acts as a liaison between patients, assessors, prescribers, and other resources (Schiller, 2017). Telemedicine has also acted to reduce the barrier for locating assessors in rural areas (Schiller). Although concerns have been raised about this practice, telemedicine is currently utilized as an effective resource in other complex health care service situations (Schiller). Interestingly in the Netherlands, they supply their rural communities with specialized mobile MAiD assessment units (Snijdewind, Willems, Deliens, Onwuteaka-Philipsen, & Chambaere, 2015). Mobile MAiD units consist of a multi-disciplinary team dedicated to providing medically assisted deaths (Snijdewind et al., 2015). They have full scope of practice, and independently provide patients with all assessments, paperwork, and procedures required for a medically assisted death (Snijdewind et al., 2015). This solution has potential to increase access to MAiD assessments but is limited in its ability to increase access to palliative care. Although not an immediate solution, ensuring that both medical and nurse practitioner programs include detailed and comprehensive palliative care education could reduce this disparity. Likewise, providing incentives for specialization in palliative care in rural communities, especially for NPs who do not have a professional association that rejects the ability for MAiD and palliative care to exist symbiotically. Overall, there are valid concerns on behalf of rural communities and their lack of access to palliative care and MAiD.

Compensation

Another barrier to providing equal access to MAiD for all Canadians is the lack of available providers due to compensation issues. A recent report by Dying with Dignity Canada (DWDC) states that practitioners are ceasing to provide MAiD services due to unsustainable funding options (2017). This reduction in providers creates added pressure to those still providing. Resultantly, wait times are increased especially for those requesting home services or residing in rural areas (DWDC). DWDC stated that the current funding model is “woefully inadequate given the amount of time, legal responsibility, emotional burden, and complexity of care required within this area of practice” (para. 5). In summary providers can bill \$40/hour (up to 90 minutes) for the initial assessment and can charge a flat fee of \$200 for the procedure (alongside with a \$113.15 same day visitor fee) (DWDC). Allowing for billing of only 90 minutes for the initial assessment may send a message to the patients that their provider is rushed (DWDC). Many provider physicians are reported that assessments are taking typically 3.5 hours or more, and the day of procedure took an entire work day (DWDC). When compared to financial compensation for comparable hours within a primary care clinic, this report stated physicians earn half as much (DWDC). Given that MAiD within Canada is expected to save health care dollars, it would be a reasonable solution to have NPs within the current salary-based funding model providing MAiD services.

Cost Analysis

Although it is a controversial angle on the topic of MAiD, a report by two physicians from Calgary published within the Canadian Medical Association Journal analyzed the cost analysis of MAiD in Canada (Trachtenberg & Manns, 2017). They utilized estimates from the Netherlands and Belgium for epidemiological data of patients who have undergone physician

assisted suicide (Trachtenberg & Manns, 2017). They then compared the estimated cost of these patients undergoing MAiD versus surviving to their expected prognosis (Trachtenberg & Manns, 2017). It has been readily proven that health care costs rise dramatically near the end of life, and the results of this study reflected such facts (Trachtenberg & Manns, 2017). They estimated that MAiD will reduce Canadian health care spending by 34.7 million to 138.8 million dollars annually, which far exceeds the cost of implementing MAiD (Trachtenberg & Manns, 2017). Although this is one unique study, its results highlighted the unlikeliness that MAiD would not create a financial burden on health care spending (Trachtenberg & Manns, 2017)

Available Resources

Flexibility within a law that has such momentous ramifications is a great responsibility. Fortunately, there are many resources available to both practitioners and patients. The Canadian Association of Medical Aid in Dying Assessors and Providers (CAMAP) is a comprehensive resource that provides education, leadership, guidelines, peer support, and conferences (2017). Likewise, Dying with Dignity Canada is a similar resource, but provides more accessible information for patients and persons requiring practical support, such as finding independent witnesses (2015). All health authorities have a Needs Care Coordination Centre where patients who wish to request MAiD may be referred to and this service helps to coordinate care within their respective health authority (Amies, 2017). Lastly, in regard to MAiD resources, each province has outlined detailed guidelines and provided standardized protocols that ensure both patient safety and legal protection for providers/assessors (Amies, 2017).

In order to provide fully informed consent for MAiD, assessors should have at minimum a basic knowledge of primary palliative care (Otte, Jung, Elger, & Bally, 2017). Unfortunately, palliative care education is given minimal attention for both medical and NP education (Wheeler,

2017). However, there are some helpful available resources for self-learning basic palliative care such as Fast Facts, ePrognosis, and the Cochrane library database. Fast Facts is a Wisconsin based non-profit organization run by palliative care specialist that provides Continuing Medical Education (CME) credits and one page primers on numerous palliative care topics (Palliative Care Network of Wisconsin, 2017). As MAiD assessors, it is expected that the patient's prognosis be accurately documented within their chart. Although most often this will be determined by specialists, assessors can anticipate being called upon to discuss patient status in terms of prognosis (Wheeler, 2017). ePrognosis is a website that has created algorithms based on systematic reviews to guide providers with evidence based tools to determine prognosis (ePrognosis, 2017). Lastly, the Cochrane database provides a plethora of high quality systematic reviews on clinically based palliative care topics, and can be readily accessed from their website (Cochrane, 2017).

Future Ideas

Implications for future practice and research are important to indicate, especially with a new and developing practice change such as MAiD. Firstly, the record keeping and statistical data has not been completed in a systematic manner that is essential for researchers to find problems and target solutions (Li et al, 2017). For example, we do not know how many NPs are providing MAiD in Canada, how many patients are requesting MAiD but denied, and how many patients withdraw their requests (Li et al., 2017). More robust methods are required for both data collection and research methods. This will provide an accurate platform on which to base future research upon. Secondly, as MAiD develops into a more routine practice, we need further research in order to develop theories and frameworks to ensure practice changes are effective and successful (National Institutes of Health, 2005). Canada is one of the pioneers in medical

assisted dying laws, therefore it is even more imperative we provide services in a quality manner. Theory provides a systematic way to understand complex situations, such as MAiD (National Institutes of Health, 2005). Although there are numerous theories that could be adapted to assist MAiD providers in providing quality care, such as the Alberta framework discussed earlier in this paper, theory that specifically explores MAiD is non-existent at this time. In contrast, we have numerous guides and checklists to ensure all safeguards and procedural targets have been obtained, but this seems to medicalize a procedure that is inheritably emotional and subjective. Therefore, the methodology of grounded theory, which is a qualitative research method used to develop theories, is needed to generate theories to guide practitioners (National Institutes of Health, 2005). Having theories that are specifically related to MAiD will help providers to provide quality care during such a complex and emotionally involved procedure. Future practice depends on such theories being generated, tested, and disseminated to front line providers (National Institutes of Health, 2005). In order to improve practice, we need to improve data collection and increase the amount of research generated on MAiD, more specifically grounded theory based research.

Implications for future practice in regard to policy include ensuring from a legal standpoint we remain informed and that we practice within the policy's outlined by our respective health authority. In terms of legalities, we can also expect the law to change after the mandatory three-year review of the clauses around mature minors, psychiatric illness, and advanced directives (Amies, 2017). It will be important for NPs to ensure they remain up to date on changes to the law in order to provide relevant care to their patients. As practicing NPs, our continuous learning on MAiD policy will mainly be accomplished by self-directed learning and health authority-based education. More and more health authorities will begin to recognize that

NPs have been given full authority to provide MAiD services and adapt their policy to reflect this full scope. This reality will become especially prominent in an economic climate where current fee for service funding models for medical practitioners appears to be unsustainable.

Lastly, we need to ensure that our education as NPs requires standardized and mandatory training on both palliative care and MAiD. Future considerations for NP master's education could include a mandatory education unit on providing evidence based holistic palliative care. This could come in the form of clinical experience or lectures. Palliative care is typically a speciality field with additional education (Wheeler, 2017). However, the reality of an aging population and more persons surviving chronic diseases, we can expect to encounter numerous patients that are classified as end of life within our primary care practices (Wheeler, 2017). A multi-year survey reported that 90% of NPs within the study had limited exposure and lacked comfort providing end of life care (Kriebel-Gasparro & Doll-Shaw, 2017). Therefore, having a well-rounded education on palliation, including MAiD, before entering the work force, will allow NPs to incorporate MAiD into their palliative care practice (Wheeler). Further education for graduated NPs could include completing Doctor of Nurse Practitioner (DNP) program, which could specialize in palliative care (Kriebel-Gasparro & Doll-Shaw, 2017). Similarly, graduated NPs could have opportunities to complete fellowships with palliative care specialists. Likewise, programs that train PhD level NPs could assist with addressing the lack of research on MAiD, palliative care, and overall NP practice. The need for palliative care providers is continuously growing, whereas the pool of available qualified providers remains low, ensuring NPs are educated on palliative care and MAiD can help ensure our patients have access to quality care (Wheeler, 2017).

At this current time, it is unknown how many NPs are currently providing MAiD services within Canada. It is known however, that there is a lack of providers, which is affecting access to such services. Previously within this paper, evidence was provided that NPs are suited to provide MAiD procedures. Nevertheless, the reality of healthcare is restricted to the confines of budgets and politics. In an optimal reality, I would recommend that Canada begins to change the model of care surrounding MAiD to reflect what is currently utilized in the Netherlands: mobile MAiD units composed of multi-disciplinary providers that travel to patients and complete full services (Snijdewind, Willems, Deliens, Onwuteaka-Philipsen, & Chambaere, 2015). These services could be funded both federally and provincially, and could act to reduce the financial burden and workload of current providers. In reality, too much is unknown about MAiD in Canada to fully support such an idea. More research and proper data collection will need to be completed.

Conclusions

This project provided an overview of the history of euthanasia in ancient and early modern times following up to the development of MAiD legislation. An in-depth analysis of court cases, events, and precedents, allows practitioners to better understand the current structure of Bill-C-14. Fear of the unknown can restrict practitioners from providing accurate information to their patients, or from becoming MAiD assessors themselves. To target this knowledge gap, this paper detailed procedural and substantive safeguards alongside with clarification on legal terminology utilized within Bill C -14. A detailed discussion outlining the procedure which included medications, a theoretical framework, and expectations was presented. An objective ethical discussion on general arguments for and against MAiD acted to provide an overview of such a contentious and ethical procedure. Lastly, this paper delineated how NPs are suited to provide MAiD and how we can overcome barriers such as geographical

disparities and compensation. Resources for both medically assisted death and palliative care were provided.

Historically the debate around euthanasia has been ongoing for many years, however the lead up to and creation of Bill C-14 occurred relatively quickly. No matter our personal opinions, MAiD is now legalized, and as NPs we have an ethical obligation to ensure our patients have informed access to such procedures. It is imperative we are aware of the details of Bill C-14, while also being knowledgeable on the ethical consideration around MAiD. Practically, we also need to be aware of resources that are available on how to protect ourselves legally, while ensuring patient safety. Within such a controversial and highly emotional procedure, we also need to ensure as practitioners we are emotionally, mentally, and spiritually able to provide MAiD if we choose to do so. Although the topic of death and dying is often uncomfortable for both patient and provider, it is an important topic that can have lasting impacts on the health and quality of life of all of our patients (Otte et al., 2016).

Appendix A

Relevant Terminology

Active Voluntary Euthanasia: Intentionally administering medications to cause a patient's death at the patient's request with their full, informed consent (Porter, Johnson & Warren, 2005).

Death: Irreversible cessation of the vital function of respiration, circulation, and pulsation. No traces of brain activity for over a period of 48 hours (Porter, Johnson & Warren, 2005).

Euthanasia: The "good death". Withholding or withdrawing life sustaining treatments from a patient with the intent to cause death. Can be active, passive, voluntary or involuntary (Porter, Johnson & Warren, 2005).

Involuntary Active Euthanasia: Intentionally administering medications to cause a patient's death without the patient's request and full informed consent (Porter, Johnson & Warren, 2005).

Medical Assistance in Dying: The administration of a prescribed substance that intends to cause the death of that person of whom meets specific eligibility criteria (CNA, 2017).

Passive Euthanasia: Withdrawing of life sustaining treatments to allow someone to die (Porter, Johnson & Warren, 2005).

Physician Assisted Suicide: Physician provides medication to a patient with the understanding that the patient intends to use them to commit suicide (Porter, Johnson & Warren, 2005).

Principle of Double Effect: Acceptable effect is the purpose and intent of the treatment (such as pain relief), whereas the secondary effect (such as respiratory depression) is not intended.

Allows for evaluation of moral permissibility (Porter, Johnson & Warren, 2005).

Withdrawing of Life Sustaining Treatment: Stopping of treatments that are intended to sustain life, such as food, IV fluids, artificial ventilation, and medications (Porter, Johnson & Warren, 2005).

Appendix B

BRITISH
COLUMBIAMinistry of
Health**Medical Assistance in Dying
PATIENT REQUEST RECORD**

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Patient Label

For cases involving a health authority (HA), when this Patient Request is first documented fax or mail a copy to applicable HA (pg 3). Retain original in patient's health record. If MAiD is administered, Prescriber to fax all forms to the BC Coroners Service at 250-356-0445.

PATIENT INFORMATION

Last Name		First Name		Second Name(s)	
Personal Health Number (PHN)		Birthdate (YYYY / MM / DD)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other - specify:	
Patient's Home / Residence Address					
Medical Diagnosis Relevant to Request for Assisted Death					
Location at Time of Request <input type="checkbox"/> Home <input type="checkbox"/> Facility - Site: Unit: <input type="checkbox"/> Other - specify:					

PATIENT REQUEST**By initialing and signing below, I confirm that:**

Initials	I am at least 18 years of age and I request medical assistance in dying. I make this request voluntarily and without pressure from others.
Initials	I believe that my medical condition is grievous and irremediable, my suffering is intolerable, there are no treatments that I consider acceptable, I am in an advanced state of irreversible decline, and my death is reasonably foreseeable.
Initials	I have been fully informed of my diagnosis and prognosis and of options for treatments towards cure or control of my condition/disease, that may be applicable to my circumstances.
Initials	Treatments for symptom control, including the potential benefits of palliative care or other treatment, have been described to me in a manner that I understand.
Initials	I consent to be assessed for eligibility and capability by one or more colleagues of my medical or nurse practitioner (practitioner) and, if I am eligible, that a pharmacist and other staff will be contacted to aid in addressing my request.
Initials	I understand that my practitioner will confirm with me whether my request is to take prescribed medication(s) that I may self-administer orally or that a practitioner will administer medications to me by intravenous injection.
Initials	I understand that if I choose self-administration and the regimen is not effective within a reasonable period of time, as determined by me and my practitioner, my practitioner will administer intravenous medication to fulfil my request.
Initials	I have had an opportunity to ask questions and to request additional information, and have received answers to any questions and responses to any requests.
Initials	I understand that I have the right to change my mind at any time.
Initials	I expect to die when the medication to be prescribed is administered.

PATIENT SIGNATURE FOR INITIAL REQUEST (must be signed in front of the two independent witnesses listed on page 2)

Signature of Patient		Print Name		Date Signed	
PROXY SIGNATURE (IF APPLICABLE) (must be signed in front of the patient and the two independent witnesses listed on page 2)					
If patient is physically unable to sign, a proxy (another person) may sign on the patient's behalf and under the patient's express direction. The proxy cannot be either of the witnesses listed on page 2 of this request form. The proxy must be at least 18 years old, understand the nature of the request, not know or believe they are a beneficiary in the will or recipient of financial or other material benefit resulting from the death of the patient, and must sign in the presence of the patient and witnesses.					
Signature of Proxy		Print Name		Relationship	
		Date Signed		Phone Number	
Address		City		Province	Postal Code

Appendix B

Medical Assistance in Dying PATIENT REQUEST RECORD Page 2 OF 3

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Last Name of Patient		First Name of Patient		Second Name(s) of Patient	
CONFIRMATION OF INDEPENDENT WITNESSES					
By initialing and signing below, I confirm that:					
Witness 1	Witness 2				
Initials	Initials	I am at least 18 years of age and understand the nature of the request for medical assistance in dying.			
Initials	Initials	The patient is personally known to me or has provided proof of identity.			
Initials	Initials	The patient (or the proxy in the presence and at the express direction of the patient) signed this request in my presence and in the presence of the other witness.			
Initials	Initials	I do not know or believe that I am a beneficiary under the will of the patient, or a recipient, in any other way, of a financial or material benefit resulting from the patient's death.			
Initials	Initials	I am not an owner or operator of a health care facility where the patient is receiving treatment or of a facility in which the patient resides.			
Initials	Initials	I am not directly involved in providing health care services to the patient.			
Initials	Initials	I do not directly provide personal care to the patient.			
SIGNATURE OF INDEPENDENT WITNESSES (must be signed in the presence of the patient and the other witness)					
WITNESS 1					
Signature of Witness 1		Print Name	Date Signed	Phone Number	
		Street Address and City		Province	Postal Code
WITNESS 2					
Signature of Witness 2		Print Name	Date Signed	Phone Number	
		Street Address and City		Province	Postal Code
NEAREST RELATIVE (OPTIONAL)					
Name of Nearest Relative		Relation		Contact Number	

Appendix B

Medical Assistance in Dying PATIENT REQUEST RECORD Page 3 OF 3

HLTH 1632 PAGE 3 OF 3

Last Name of Patient	First Name of Patient	Second Name(s) of Patient
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 **DO NOT COMPLETE** the section below until immediately prior to medical assistance in dying.

PATIENT CONFIRMATION OF REQUEST AND CONSENT IMMEDIATELY PRIOR TO MEDICAL ASSISTANCE IN DYING				
By signing below, I confirm that I was given the opportunity to withdraw my request, and I give express consent to receive medical assistance in dying at this time.				
Signature of Patient	Print Name	Date Signed		
PROXY SIGNATURE (IF APPLICABLE) (must be signed in front of patient) If patient is physically unable to sign, a proxy (another person) may sign on the patient's behalf and under the patient's express direction. The proxy cannot be either of the witnesses listed on page 2 of this request form. The proxy must be at least 18 years old, understand the nature of the request, not know or believe they are a beneficiary in the will or recipient of financial or other material benefit resulting from the death of the patient, and must sign in the presence of the patient.				
Signature of Proxy	Print Name	Relationship		
	Date Signed	Phone Number		
Address		City	Province	Postal Code

Health Authority fax numbers for submission of forms:

FHA: Fax: 604-523-8855**NHA:** Fax: 250-565-2640**VIHA:** Fax: 250-727-4335**IHA:** Fax: 250-469-7066**VCHA:** Fax: 1-888-865-2941**PHSA:** Fax: 604-829-2631

For mailing addresses of Health Authorities, see Document Submission Checklist, HLTH 1632.
<http://www2.gov.bc.ca/assets/gov/health/forms/1632.pdf>

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Appendix C

BRITISH
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**Medical Assistance in Dying
ASSESSMENT RECORD (PRESCRIBER)**

HLTH 1634 2016/12/15 PAGE 1 OF 3

Patient Label

For cases involving a health authority (HA), fax or mail a copy of this Assessment to applicable HA (pg 2). Retain original in patient's health record. If MAiD is administered, Prescriber to fax all forms to the BC Coroners Service at 250-356-0445.

PATIENT INFORMATION

Last Name		First Name		Second Name(s)	
Personal Health Number (PHN)	Birthdate (YYYY / MM / DD)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other - specify:		
Medical Diagnosis Relevant to Request for Assisted Death					

PRACTITIONER CONDUCTING ASSESSMENT

Last Name		First Name		Second Name	
CPSID #	OR	CRNBC Prescriber #	Phone Number		
Mailing Address			City	Postal Code	
Location of Assessment <input type="checkbox"/> Home <input type="checkbox"/> Facility - Site: Unit: <input type="checkbox"/> Other - specify:					

Initials

I have been contacted by the patient or another colleague and agree to be an assessor. **I am prepared to be the prescriber** concerning this patient's request for medical assistance in dying.

CONFIRMATION OF ELIGIBILITY AND INFORMED CONSENT

Each assessing medical or nurse practitioner (practitioner) is to make these determinations independently, document in the health record, and summarize their findings by initialing the boxes below. *Comments for any matter in any section are clarified in the medical record.*

If it is determined that the patient does not meet the criteria, the practitioner assessor is to advise the attending practitioner and the patient of the determination and of their option to seek another opinion.

Patient Diagnosis

Patient Prognosis

Assessment Was Conducted

<input type="checkbox"/> In Person	Date of Assessment			
<input type="checkbox"/> By Telemedicine	Date of Assessment	Name of Witness - Regulated Health Professional	Profession	College ID

By initialing and signing, I confirm that:

Initials	The patient is personally known to me or has provided proof of identity, and has consented to this assessment.
Initials	I do not know or believe that I am a beneficiary under the will of the patient requesting medical assistance in dying or a recipient, in any other way, of a financial or other material benefit resulting from the patient's death, other than the standard compensation for their services relating to the request.
Initials	The patient's request for medical assistance in dying was made in writing and signed and dated by the patient or by another person on their behalf and under their express direction.
Initials	I am satisfied that the request was signed and dated by the patient, or by another person on their behalf and under their express direction, before two independent witnesses who then also signed and dated the request.
Initials	The patient's request for medical assistance in dying was signed and dated after the patient was informed by a practitioner that they have a grievous and irremediable medical condition.
Initials	The other assessor and I are not each other's mentor or supervisor, and I do not know or believe that I am connected to the other assessor or to the patient in any other way that would affect my objectivity.

Appendix C

Medical Assistance in Dying PRESCRIBER ASSESSMENT RECORD Page 2 OF 3

HLTH 1634 PAGE 2 OF 3

Last Name of Patient		First Name of Patient		Second Name(s) of Patient	
I have determined that the patient has been fully informed of:					
<ul style="list-style-type: none"> • Their medical diagnosis and prognosis. • The feasible alternatives including, but not limited to, comfort care, hospice care, and pain control. • Their right to withdraw their request at any time and in any manner. • The potential risks associated with taking the medication to be prescribed. • The probable outcome/result of taking the medication to be prescribed. • The recommendation to seek advice on life insurance implications. 					
I have determined that the patient meets all of the criteria to be eligible for medical assistance in dying:					
Initials	The patient is eligible for health services funded by a government in Canada.				
Initials	The patient is at least 18 years of age.				
Initials	The patient is capable of making this health care decision.				
Initials	The patient has a grievous and irremediable medical condition (serious and incurable illness, disease, or disability) that causes the patient enduring physical or psychological suffering that is intolerable to them and that cannot be relieved in a manner that the patient considers acceptable. The patient is in an advanced state of irreversible decline and natural death is reasonably foreseeable.				
Initials	The patient has made a voluntary request for medical assistance in dying that was not made as a result of external pressure.				
Initials	After having been informed of the means that are available to relieve their suffering, including palliative care, the patient has given informed consent to receive medical assistance in dying.				
Consideration of capability to provide informed consent. Initial one of the following: <i>(Capable means that person is able to understand the relevant information and the consequences of their choices)</i>					
Initials	I have no reason to believe the patient is incapable of providing informed consent to medical assistance in dying.				
OR					
Initials	I have reason to be concerned about capability and I have referred the patient to another practitioner for an assessment of capability to provide informed consent to medical assistance in dying.				
	Name of Practitioner Performing Determination of Capability				
	On receipt of the requested assessment, I determine that the patient: <input type="checkbox"/> is capable of providing informed consent <input type="checkbox"/> is not capable of providing informed consent				
CONCLUSION REGARDING ELIGIBILITY and PRACTITIONER SIGNATURE					
I determine that the patient: <input type="checkbox"/> Does meet the criteria for medical assistance in dying <input type="checkbox"/> Does not meet the criteria for medical assistance in dying <i>If it is determined that the patient does not meet the criteria, the practitioner assessor is to advise the attending practitioner and the patient of the determination and of the patient's option to seek another opinion.</i>					
Practitioner Signature		CPSID #		CRNBC Prescriber #	
		Date		Time	
THIS FORM DOES NOT CONSTITUTE LEGAL ADVICE; it is an administrative tool that must be completed for medical assistance in dying.					
Health Authority fax numbers for submission of forms: FHA: Fax: 604-523-8855 NHA: Fax: 250-565-2640 VIHA: Fax: 250-727-4335 For mailing addresses of Health Authorities, see Document Submission Checklist, HLTH 1632. IHA: Fax: 250-469-7066 VCHA: Fax: 1-888-865-2941 PHSA: Fax: 604-829-2631 http://www2.gov.bc.ca/assets/gov/health/forms/1632.pdf					

Appendix C

Medical Assistance in Dying PRESCRIBER ASSESSMENT RECORD Page 3 OF 3

HLTH 1634 PAGE 3 OF 3

Last Name of Patient		First Name of Patient		Second Name(s) of Patient	
PLANNING FOR MEDICAL ASSISTANCE IN DYING					
Initials	I have received and reviewed the assessment by at least one other colleague indicating the patient is eligible for medical assistance in dying.				
Initials	I have discussed with the patient the following options for administration and the patient has requested: <input type="checkbox"/> Practitioner-administered Intravenous (IV) Regimen, or <input type="checkbox"/> Patient self-administered Oral Regimen (supervised by practitioner)				
Initials	I have planned for potential issues (failure of oral route to achieve effect, issues with initiation of intravenous access, etc.)				
Initials	A location and timeline for provision.				
	Planned Location <input type="checkbox"/> Home <input type="checkbox"/> Facility - Site: Unit: <input type="checkbox"/> Other - specify:				
	Planned Date		Days From Initial Request		
	If intended date is less than 10 days from initial request, the assessor, the patient and I are in agreement that: <input type="checkbox"/> Death is imminent, or <input type="checkbox"/> The patient's loss of capacity to provide informed consent is imminent.				
Initials	I have reviewed with the pharmacist the request, assessments, and a plan to provide and administer medical assistance in dying, as well as to return any unused medications to the pharmacist within 48 hours after confirmation of death.				
Initials	I have indicated on the prescription or order that the medication is for medical assistance in dying.				
If planning was discontinued prior to administration, indicate reason and submit this form to the appropriate Health Authority.					
<input type="checkbox"/> Patient withdrew request <input type="checkbox"/> Patient's capability deteriorated (no longer capable of providing informed consent) <input type="checkbox"/> Death occurred prior to administration					
ADMINISTRATION OF MEDICAL ASSISTANCE IN DYING					
Date (YYYY / MM / DD)		Location <input type="checkbox"/> Home <input type="checkbox"/> Facility - Site: Unit: <input type="checkbox"/> Other - specify:			
Location Address					
Initials	Immediately prior to administering the prescription, the patient was given an opportunity to withdraw their request and gave express informed and voluntary consent to receive medical assistance in dying (pg 3, Patient Request Record).				
Initials	The medication was administered via the method chosen by patient: <input type="checkbox"/> Practitioner-administered Intravenous (IV) Regimen <input type="checkbox"/> Patient self-administered Oral Regimen (supervised by practitioner) <input type="checkbox"/> Practitioner administered IV backup kit _____ hours after ineffective self-administration				
	Medication Administered		Interval Between Administration and Confirmation of Death		
PRACTITIONER SIGNATURE					
Practitioner Signature		CPSID #	OR	CRNBC Prescriber #	
		Date		Time	

VSA 406A Medical Certification of Death

A medical or nurse practitioner must complete the Medical Certification of Death within 48 hours of death in compliance with Section 18 of the *Vital Statistics Act* and provide the completed form to the Funeral Director so that a Disposition Permit may be issued.

To order additional VSA 406A forms, fax or email the Vital Statistics Agency. Stockroom Fax: 250 952-9094. Email: HLTH.VSStock@gov.bc.ca

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Appendix D

BRITISH
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**Medical Assistance in Dying
ASSESSMENT RECORD (ASSESSOR)**

HLTH 1633 2016/12/15 PAGE 1 OF 2

Patient Label

For cases involving a health authority (HA), fax or mail a copy of this Assessment to applicable HA (pg 2). Retain original in patient's health record. If MAiD is administered, Prescriber to fax all forms to the BC Coroners Service at 250-356-0445.

PATIENT INFORMATION

Last Name		First Name		Second Name(s)	
Personal Health Number (PHN)	Birthdate (YYYY / MM / DD)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other - specify:		
Medical Diagnosis Relevant to Request for Assisted Death					

PRACTITIONER CONDUCTING ASSESSMENT

Last Name		First Name		Second Name	
CPSID #	OR	CRNBC Prescriber #	Phone Number		
Mailing Address			City	Postal Code	
Location of Assessment <input type="checkbox"/> Home <input type="checkbox"/> Facility - Site: Unit: <input type="checkbox"/> Other - specify:					

Initials	I have been contacted by the patient or another colleague and I agree to be an assessor concerning this patient's request for medical assistance in dying. If the patient is eligible, the practitioner listed here will be the prescriber.	Prescribing Practitioner
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CONFIRMATION OF ELIGIBILITY AND INFORMED CONSENT

Each assessing medical or nurse practitioner (practitioner) is to make these determinations independently, document in the health record, and summarize their findings by initialing the boxes below. *Comments for any matter in any section are clarified in the medical record.*

If the patient is determined to not meet the criteria, the practitioner assessor is to advise attending practitioner and patient of determination and of his or her option to seek another opinion.

Patient Diagnosis
Patient Prognosis

Assessment Was Conducted

<input type="checkbox"/> In Person	Date of Assessment			
<input type="checkbox"/> By Telemedicine	Date of Assessment	Name of Witness - Regulated Health Professional	Profession	College ID

By initialing and signing, I confirm that:

Initials	The patient is personally known to me or has provided proof of identity, and has consented to this assessment.
Initials	I do not know or believe that I am a beneficiary under the will of the patient requesting medical assistance in dying or a recipient, in any other way, of a financial or other material benefit resulting from the patient's death, other than the standard compensation for their services relating to the request.
Initials	The patient's request for medical assistance in dying was made in writing and signed and dated by the patient or by another person on their behalf and under their express direction.
Initials	I am satisfied that the request was signed and dated by the patient, or by another person on their behalf and under their express direction, before two independent witnesses who then also signed and dated the request.
Initials	The patient's request for medical assistance in dying was signed and dated after the patient was informed by a practitioner that they have a grievous and irremediable medical condition.
Initials	The other assessor and I are not each other's mentor or supervisor, and I do not know or believe that I am connected to the other assessor or to the patient in any other way that would affect my objectivity.

Appendix D

Medical Assistance in Dying ASSESSOR ASSESSMENT RECORD Page 2 OF 2

HLTH 1633 PAGE 2 OF 2

Last Name of Patient		First Name of Patient		Second Name(s) of Patient	
I have determined that the patient has been fully informed of:					
<ul style="list-style-type: none"> • His or her medical diagnosis and prognosis. • The feasible alternatives including, but not limited to, comfort care, hospice care, and pain control. • His or her right to withdraw their request at any time and in any manner. • The potential risks associated with taking the medication to be prescribed. • The probable outcome/result of taking the medication to be prescribed. • The recommendation to seek advice on life insurance implications. 					
I have determined that the patient meets all of the criteria to be eligible for medical assistance in dying:					
Initials	The patient is eligible for health services funded by a government in Canada.				
Initials	The patient is at least 18 years of age.				
Initials	The patient is capable of making this health care decision.				
Initials	The patient has a grievous and irremediable medical condition (serious and incurable illness, disease, or disability) that causes the patient enduring physical or psychological suffering that is intolerable to them and that cannot be relieved in a manner that the patient considers acceptable. The patient is in an advanced state of irreversible decline and natural death is reasonably foreseeable.				
Initials	The patient has made a voluntary request for medical assistance in dying that was not made as a result of external pressure.				
Initials	After having been informed of the means that are available to relieve their suffering, including palliative care, the patient has given informed consent to receive medical assistance in dying.				
Consideration of capability to provide informed consent. Initial one of the following: <i>(Capable means that person is able to understand the relevant information and the consequences of their choices)</i>					
Initials	I have no reason to believe the patient is incapable of providing informed consent to medical assistance in dying.				
OR					
Initials	I have reason to be concerned about capability and I have referred the patient to another practitioner for a determination of capability to provide informed consent to medical assistance in dying.				
	Name of Practitioner Performing Determination of Capability				
	On receipt of the requested opinion, I determine that the patient: <input type="checkbox"/> is capable of providing informed consent <input type="checkbox"/> is not capable of providing informed consent				
CONCLUSION REGARDING ELIGIBILITY and PRACTITIONER SIGNATURE					
I determine that the patient: <input type="checkbox"/> Does meet the criteria for medical assistance in dying <input type="checkbox"/> Does not meet the criteria for medical assistance in dying <i>If it is determined that the patient does not meet the criteria, the practitioner assessor is to advise the attending practitioner and the patient of the determination and of the patient's option to seek another opinion.</i>					
Practitioner Signature		CPSID #	OR	CRNBC Prescriber #	
		Date		Time	
If planning was discontinued prior to administration, indicate reason and submit this form to the appropriate Health Authority.					
<input type="checkbox"/> Patient withdrew request <input type="checkbox"/> Patient's capability deteriorated (no longer capable of providing informed consent) <input type="checkbox"/> Death occurred prior to administration					
THIS FORM DOES NOT CONSTITUTE LEGAL ADVICE; it is an administrative tool that must be completed for medical assistance in dying.					
Health Authority fax numbers for submission of forms:					
FHA: Fax: 604-523-8855		NHA: Fax: 250-565-2640		VIHA: Fax: 250-727-4335	
IHA: Fax: 250-469-7066		VCHA: Fax: 1-888-865-2941		PHSA: Fax: 604-829-2631	
For mailing addresses of Health Authorities, see Document Submission Checklist, HLTH 1632. http://www2.gov.bc.ca/assets/gov/health/forms/1632.pdf					

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Appendix E

BRITISH
COLUMBIA**BC Coroners Service Report of Medical Assistance in Dying Death****Please ensure death is reported immediately as per Coroners Act (s. 2)****Please FAX this form, and all accompanying Provincial Health MAiD forms, to the BC Coroners Service @ 250-356-0445**

General Information					
Name of Reporting Physician/Nurse Practitioner::		Physician/Nurse Practitioner ID#:		Physician/Nurse Practitioner Contact (Phone/email):	
Date Reported:	Time Reported:		Location reported from:		
Decedent Information					
Decedent Surname		Decedent Given Name (1st)		Decedent Given Name (2nd)	Decedent Given Name (3rd)
Birth Date (dd/mm/yyyy)	Age	Sex <input type="checkbox"/> F <input type="checkbox"/> M		Date of Death (dd/mm/yyyy)	
Home/Residence Address		City		Postal Code	Province
					Place of death same as home address? <input type="checkbox"/> YES <input type="checkbox"/> NO
Place of Death (if different from home address)			Type of Premise (i.e. hospital, care home, office)		
Was the precipitating/originating illness, injury, condition the result of an accident, violence or self-inflicted injury? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown			If Yes, what was the accident, violent event or self-inflicted injury?		
Date of Accident/Violent event/self-inflicted injury (dd/mm/yyyy)			Place of Accident/Violent event/self-inflicted injury:		
Personal Health Number (PHN)		Family Physician/Nurse Practitioner Name:		Family Physician/Nurse Practitioner Contact #:	
Identified by		Relation	Contact #	ID Method	
Nearest Relative		Relation	Contact #		
Physician/Nurse Practitioner - Remarks/Additional Comments:					
For internal Use Only					
Date Received: _____		Received by: _____		Approved: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> PENDING	
Comments:					

This form, and the information contained therein, must not be shared, forwarded or disseminated to anyone without the written authorization of the BC Coroners Service

This form has been prepared pursuant to the authority of the Chief Coroner, Coroners Act Regulation, B.C. Reg. 298/2007

Appendix F

BRITISH
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**Medical Assistance in Dying
DOCUMENT SUBMISSION CHECKLIST**

HLTH 1636 2016/12/15

Patient Label

Upon provision of MAiD, Prescriber to fax a copy of this form, and copies of all the forms listed below, to the BC Coroners Service at 250-356-0445. Retain original forms in patient's health record.

DOCUMENTS SUBMITTED TO BC CORONERS SERVICE

- ☐ **1. Patient Request Record - Medical Assistance in Dying, HLTH 1633**
http://www2.gov.bc.ca/assets/gov/health/forms/1633fil.pdf
- ☐ **2. Assessment Record (Assessor) - Medical Assistance in Dying, HLTH 1634**
http://www2.gov.bc.ca/assets/gov/health/forms/1634fil.pdf
- ☐ **3. Assessment Record (Prescriber) - Medical Assistance in Dying, HLTH 1635**
http://www2.gov.bc.ca/assets/gov/health/forms/1635fil.pdf
- ☐ **4. Consultant's Assessment of Patient's Informed Consent Decision Capability - Medical Assistance in Dying, HLTH 1636**
(if an assessment was requested)
http://www2.gov.bc.ca/assets/gov/health/forms/1636fil.pdf
- ☐ **5. Prescription and Medication Administration Record - Medical Assistance in Dying**
Available from a Health Authority Pharmacy or the CPSBC
- ☐ **6. Medical Certification of Death, VSA 406A**
A medical or nurse practitioner must complete the Medical Certification of Death within 48 hours of death in compliance with Section 18 of the *Vital Statistics Act* and provide the completed form to the Funeral Director so that a Disposition Permit may be issued.
To order additional VSA 406A forms, fax or email the Vital Statistics Agency.
Stockroom Fax: 250 952-9094. Email: HLTH.VSstock@gov.bc.ca
- ☐ **7. BC Coroners Service Report of MAiD Death (send to the BC Coroners Service ONLY, do not send to health authority)**
www.gov.bc.ca/maid-form

DOCUMENTS SUBMITTED TO HEALTH AUTHORITY (IF APPLICABLE)

If the request was initiated and/or provision of medical assistance in dying was performed on-site or involved a program of a health authority (HA), fax or mail a copy of all the above forms, **except the BC Coroners Service Report of MAiD Death form**, to the relevant HA below:

- ☐ **FHA:** Fax: 604-523-8855 Medical Assistance in Dying Care Coordination Centre, Fraser Health
Central City Tower - 4th Floor, 13450 - 102nd Avenue, Surrey BC V3T 0H1
- ☐ **IHA:** Fax: 250-469-7066 Medical Assistance in Dying Care Coordination Service, Interior Health
1815 Kirschner Road, Kelowna BC V1Y 4N7
- ☐ **NHA:** Fax: 250-565-2640 Care Coordinator, Medical Assistance in Dying, Northern Health
600 - 299 Victoria Street, Prince George BC V2L 5B8
- ☐ **VCHA:** Fax: 1-888-865-2941 Care Coordination Service, Medical Assistance in Dying, Vancouver Coastal Health
855 12th Avenue West, #CP-380, Vancouver BC V5Z 1M9
- ☐ **VIHA:** Fax: 250-727-4335 Care Coordination Service, Medical Assistance in Dying, c/o Victoria General Hospital
#1 Hospital Way, Victoria BC V8Z 6R5
- ☐ **PHSA:** Fax: 604-829-2631 PHSA Medical Assistance in Dying Office
Suite 202 - 601 West Broadway, Vancouver BC V5Z 4C2

SUBMITTED BY

Name	Date	Phone Number

Appendix G

This culminating project is part of the degree requirements for the Master of Nursing – Nurse Practitioner Program at the University of British Columbia. For completion of this project, a manuscript has been developed for submission for publication. The manuscript is based on this scoping review and its recommendations. The intention of submitting a manuscript for publication is to update and inform Nurse Practitioners around the world on Canada’s medically assisted dying laws, and to likewise make the argument that Nurse Practitioners are well-suited for providing such services.

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[alerts/chpca-policy-alert-bill-c-14-medical-assistance-in-dying-\(maid\)-update.aspx](http://www.chpca.net/projects-and-advocacy/chpca-policy-alerts/chpca-policy-alert-bill-c-14-medical-assistance-in-dying-(maid)-update.aspx)

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[2-1573-4edb-969e-e465673d35cb%40sessionmgr4007&bdata=JnNpdGU9ZWhvc](http://web.a.ebscohost.com.ezproxy.library.ubc.ca/ehost/detail/detail?vid=0&sid=c5e8f7a2-1573-4edb-969e-e465673d35cb%40sessionmgr4007&bdata=JnNpdGU9ZWhvc3QtOGl2ZSZzY29wZT1zaXRl#AN=28292790&db=mnh)

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