Commentary on CANO/ACIO 2015 conference presentations

Medically Assisted Death in Canada: Careful and Thoughtful Practice Directions for Oncology Nurses (CANO/ACIO Session III-02)

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Presentation abstract (condensed)

In 1993, the Supreme Court of Canada ruled in a split decision against Sue Rodriguez, a woman with advanced ALS wanting medical assistance to end her life. Twenty-two years later, however, the Court ruled unanimously in favour of Lee Carter, a woman with progressive spinal stenosis, wanting medical assistance to die. The Court’s ruling impacts federal and provincial/territorial legislation, as well as professional regulations. Recognizing that governments and professional bodies may wish to write practice-guiding policies, the Supreme Court instituted a 12-month waiting period before its ruling takes effect. This session [examines] the ruling’s impact on oncology nurses’ work in hospital- or community-based interprofessional settings.

Commentary on the presentation by Jennifer Stephens

The subject of medically assisted death is a topic passionately debated in Canada, even after the February 6, 2015, ruling of the Supreme Court of Canada in the Carter v. Canada case in which the higher court ordered that Criminal Code prohibitions on assisted suicide and voluntary euthanasia violate the Charter of Rights. Wisely, the Court prohibited the invalidation for 12 months in order to allow federal and provincial Parliaments to write Charter-compliant legislation. Professional organizations, most notably the Canadian Medical Association (CMA), have scrambled in the past few months to discuss end-of-life care and assisted dying. At its 148th annual meeting held in Halifax this August, the CMA agreed not to support assisted death while at the same time confirming that physicians have a duty to provide information on all options for patients, including access to medications that can facilitate death (Sullivan, 2015). The Canadian Nurses Association (CNA) likewise welcomes the opportunity to participate in legislative discussions around medically assisted dying and how it relates to the Code of Ethics for Registered Nurses (although professional nursing organizations such as CANO/ACIO or CNA have not formally been invited to the table at the federal level). An early 2015 survey of 700 CNA members revealed that more than half of nurses support legislation to allow medically assisted dying (Headley, 2015).

This workshop at the CANO/ACIO conference was very popular, and attendees poured into the room for several minutes after the presentations had started necessitating the addition of 20-plus chairs to the back of the room to accommodate participants. Using a case study as the basis for discussion, the three session presenters offered an example of a terminally-ill patient with colon cancer who was discussing options for end-of-life care with his nurse. An expressed desire to end his life (and suffering) was one of them. Not surprisingly, the presentation pivoted precariously around ethics, swiveling continuously between patient needs and nursing clinical practice standards. Concerns echoed around the room from nurses who felt they would be challenged, by legislation or other entities, to support medically assisted dying. The presenters utilized the CLEOs framework (Consideration of the Legal, Ethical, and Organizational aspects of medicine) to promote conversations around concepts pertaining to medically assisted death such as informed consent, as well as personal versus professional rights and responsibilities. The overall sense in the room was that medically assisted dying, even in the oncology context, was something requiring continued discussion from both a nursing and interprofessional perspective.

Legislation for medically assisted death (or physician assisted suicide) currently exist both nationally and internationally. Within Canada, Quebec Bill 52 becomes effective December 2015. This legislation frames medically assisted death within the context of end-of-life care offering provisions for both terminal palliative sedation and medical aid in dying (Hivon, 2013). This Bill is carefully crafted to reflect similar legislation in the United States (Washington, Oregon, Vermont), Belgium, and Luxembourg. Within this legislation, as within international laws around medically assisted death, the physician is the touchpoint for decision-making and access to terminal care. The discussion seems to be intimately linked to a wavering ethical line between the rights of persons (patients) and the rights of physicians. Whose rights prevail in the case of terminal illness? Those of the patient who desires release from mental and physical suffering or those of a physician who may be morally opposed to offering assistance for whatever reason?

Citizens of Oregon tackled these hard questions in the early 1990s when a dedicated grassroots movement successfully lobbied for the first death with dignity legislation in the United States (passed November 4, 1994, but enacted on October 27, 1997). Simply stated, a physician has no professional duty to participate in the provision of lethal medications to patients for self-administration meant to end their life at the time of their choosing. Health care staff, including nurses, pharmacists, physiotherapists, dentists, and the like, have no obligation to discuss physician assisted suicide with patients or to provide education or referrals. The annual report by the Oregon government on the Bill states that in 2014, 155 people were prescribed lethal medications, and 105 utilized their...
In brief
What this presentation highlighted:
• Carter v. Canada changes the Canadian Charter of Rights in February 2016 to legalize physician assisted death.
• Utilization of the CLEOs framework (Consideration of the Legal, Ethical, and Organizational aspects of medicine) to facilitate conversation around vocabulary and other concepts that relate to medically assisted death such as informed consent, as well as professional versus personal rights and responsibilities.
• Professional organizations including the Canadian Medical Association and the Canadian Nurses Association are surveying members and holding meetings to determine how this legislation will impact practice and standards of care.

Next steps:
• While nursing’s voice is not at the federal discussion tables around Canadian Bill S-225, nurses have important roles to play in terms of patient education and collaboration with physicians and interprofessional teams around end-of-life care.
• Oncology nurses will be affected by professional regulatory changes as well as changes to palliative and hospice care.

Supportive Care for Cancer Survivors in the Community: The Roles of Parish Nurses and Nurse Practitioners (CANO session: II-04-A)
Krista Wilkins

Abstract
The expanding cancer survivor population creates complexity for the health care system. Cancer survivors experience a number of physical and psychosocial issues, as well as chronic health problems that greatly affect quality of life, health and productivity. Community-based care providers, including parish nurses and nurse practitioners, are assuming greater responsibility for the ongoing supportive care sought by cancer survivors. They offer a health promotion perspective that may be useful in helping cancer survivors normalize their lives and give them increased control of their health. Their perspectives on their ability to provide supportive care to cancer survivors are poorly understood. An interpretive, descriptive qualitative design was adopted to better understand the care that is provided to cancer survivors by parish nurses and nurse practitioners. This presentation will describe these experiences of these community-based care providers in taking care of cancer survivors in New Brunswick, including their professional responsibilities and their informational needs and preferences in caring for cancer survivors. Data were captured through semi-structured interviews. Interviews were transcribed and reviewed for common themes. While recognizing the uniqueness of these experiences, the results of this research may serve as a starting point for conversations about how to implement best practices in delivering ongoing supportive care to cancer survivors in community settings.

Commentary on the presentation by Jacqueline Galina
As the number of cancer survivors increases (Canadian Cancer Society’s Advisory Committee on Cancer Statistics, 2014), there is a greater need to care for the unique and complex needs in cancer survivorship (Hewitt, Greenfield, & Stovall, 2006; Howell et al., 2011). Some models of cancer care have shifted cancer survivorship care (CSC) from specialized cancer clinics to community care settings (Howell et al., 2011) where clinicians care for a spectrum of care needs (Aggarwal & Hutchison, 2012; Martin-Misener & Bryant-Lukosius, 2014). Parish nurses and nurse practitioners are two groups of community health care professionals that have received little attention from oncology researchers. More specifically, the perspectives of parish nurses’ and nurse practitioners’ roles in survivorship care have been previously unexplored. This presentation described two qualitative studies that used interpretive description (Thorne, 2013) to fill these empirical gaps.

Interviews summary
Interviews with six parish nurses and eight community nurse practitioners sought descriptions of 1) their role and responsibilities in caring for
cancer survivors; and 2) their informational needs to best provide this care. Interpretive descriptive analyses found that parish nurses perceived their role as one that allowed them to speak with parishioners about their spirituality in the context of their health. These nurses regard each parishioner as a unique component within their family, as well as the larger congregation to which they also provided care. Parish nurses identified that they were limited in their knowledge about cancer while wanting to provide accurate and best care. The nurse practitioners regarded themselves as a provider of holistic health care and that their provision of supportive care to their patients was lifelong. They identified that communication with cancer survivors was challenging and that they wanted foundational oncology education in order to feel more prepared and comfortable in their primary care setting.

Significance and relevance to nursing practice

This presentation adds to our knowledge about how parish nurses and community nurse practitioners regard their roles and responsibilities in the care of cancer survivors and what additional information they need to best provide this care. Stemming from and founded in a nursing worldview, these studies appropriately used interpretive description (Thorne, 2013) as the method to analyze interviews with these nurses. The intention of an interpretive descriptive analysis is to use the clinical wisdom within the nurse researcher to clarify the nature of a given health context to build knowledge and develop future strategies for improvement (Thorne, 2013). In this context, the findings from this study offer important insight into the care that cancer survivors may receive when discharged into the community. Such insights, as well as the guidelines and recommendations for Canadian cancer survivorship care (Howell et al., 2011), provide complementary information useful for stakeholders and/or policymakers to instill positive change in community-based cancer survivorship care. The current Pan-Canadian Guidance on Survivorship Services (Howell et al., 2011) identifies the importance of an organized delivery of survivorship services, specifically citing the relevance of partnerships with community groups. Considering the increased transfer of cancer survivorship care into the portfolio of community care providers (Howell et al., 2011; Martin-Misener & Bryant-Lukosius, 2014), these partnerships are more urgently needed than ever before. Additional literature outlining the perspectives of cancer survivors receiving care from these community care providers would offer an important supplement to suggested community practice changes.

The findings from this study are useful for hospital-based oncology nurses, and/or specialized oncology nurses, to understand the informational needs of non-specialized oncology nurses who care for cancer patients beyond the hospital-based oncology clinic. Drawing from the recommendations in the Pan-Canadian Guidance on Survivorship Services (Howell et al., 2011), any clinician caring for cancer survivors should receive education to increase their awareness of the needs of cancer survivors. Follow-up care providers, such as parish nurses and nurse practitioners working in the community, are categorically identified to receive specific survivorship education (Howell et al., 2011). The findings highlighted in this presentation, as well as the cited survivorship care recommendations, call attention to the value of specialized oncology nursing knowledge. Specialized oncology nurses can be empowered to share their expertise with non-specialized clinicians, such as those providing follow-up cancer care in the community. This may include education about common issues for persons post-cancer-treatment, survivorship care planning, or the distribution of relevant survivorship resources. Each of these nursing roles is vital in the course of cancer care. As such, avenues for knowledge exchange to highlight challenges and informational needs would improve the overall quality of cancer care across the cancer care trajectory.

In-Brief

What we already know:

• Cancer survivors continue to have a number of complex needs beyond the active treatment phase of cancer.
• Cancer survivorship care is increasingly being provided outside of oncology clinics, such as primary and community health settings, by non-specialized oncology nurses.

What this presentation showed:

• Parish nurses and nurse practitioners believe they have an important role in post-treatment cancer survivorship care.
• These nurses consider themselves as outsiders to the cancer system and perceive this as a barrier to the care that they provide.

Next steps:

• Strategies for knowledge exchange between nurses that provide care at various phases of the survivorship trajectory are needed.
• Insight into the perspectives of cancer survivors receiving survivorship care from these providers is needed.

REFERENCES