



Position Statement



END-OF-LIFE ISSUES

CNA POSITION

At the end of life many issues having ethical, legal and practical implications may need to be addressed. These include palliative care,¹ the withholding or withdrawing of treatment in situations of futility² and wishes for organ and tissue donation. It is imperative that clients are informed about and have the opportunity to prepare advance directives³ for their end-of-life care.

CNA believes in an individual's right to self-determination and accurate information to make an informed decision before consenting to treatment. When making decisions about treatment at the end of life, nurses offer clients respect, promote autonomy, provide up-to-date information, and help them to express their health needs and values. CNA encourages nurses and other health care professionals to communicate with clients regarding their health care and treatment to identify how clients wish end-of-life issues to be addressed.

CNA advocates the client's right to decide on treatment options and for their decisions to be respected by nurses and other health care professionals. CNA encourages all Canadians to formulate advance directives before medical crisis occurs through health and legal education programs, community health centres, and discussions with their health care professional.⁴ The preferences, values and needs of the client must be the primary consideration of health care professionals in the provision of quality care.⁵

CNA advocates the client's right to refuse treatment. A competent person has the right to refuse, or withdraw consent to any clinically indicated treatment, including life-saving or life-sustaining treatment.⁶ When treatment is declined, care is always available. Appropriate and effective palliative care provides relief from pain and symptoms and should be accessible to all Canadians. Nurses must advocate adequate resources, including nursing services and palliative care, for care at the end of life.

BACKGROUND

The CNA *Code of Ethics for Registered Nurses* (1997) provides an ethical framework to address end-of-life issues – “Nurses value health and well-being and assist persons to achieve their optimum level of health in situations of normal health, illness, injury, or in the process of dying.”⁷ Nurses provide care directed toward the health and well-being of their patients and support a broad continuum of health services, including palliative care services.

Technological advances have raised a number of troubling ethical dilemmas. These dilemmas are confounded by interdisciplinary team conflicts, unresolved family issues, and shortages of nursing and other resources. CNA's *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* (1999) provides guidance for ethical issues that “involve value preferences where individuals of good will are uncertain or disagree about the right thing to do when someone's life, health or well-being is threatened by disease or illness.”

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Advance directives serve as a framework to communicate the person's wishes, even though they may or may not be supported by legislation. Many Canadians receiving care are fearful that they will be subjected to treatments to which they would not consent in the event that they are unable to speak for themselves.

In considering the range of issues related to end-of-life treatment, CNA has developed statements with other key national health-related organizations: the Joint Statement on Resuscitative Interventions and the Joint Statement on Advance Directives (1994). The principles identified in these documents form the basis of decision-making about bioethical issues and will be helpful as facilities review their cardiopulmonary resuscitation (CPR)⁸ orders, particularly do-not-resuscitate orders.⁹ The joint statements include guiding principles for health care facilities when developing CPR policy; CPR as a treatment option; competence; the treatment decision, its communication, implementation and review; and palliative care and other treatment. Decisions about CPR as an appropriate treatment option should be clearly identified on a client's health record to make all health care professionals aware of these decisions.¹⁰

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Replaces:

CNA Policy Statement on The Role of the Nurse in Organ Donation & Tissue Transplantation (June 1994)

Also see:

CNA Fact Sheet: Organ Donation and Tissue Transplantation (2000)

CNA Fact Sheet: Palliative Care (2000)

Joint Statement on Advance Directives (CNA, Canadian Healthcare Association, Canadian Homecare Association, Canadian Public Health Association, Home Support Canada, Canadian Long-Term Care Association and developed in collaboration with the Canadian Bar Association, 1994)

Joint Statement on Resuscitative Interventions (CNA, Canadian Medical Association, Canadian Healthcare Association, Catholic Health Association of Canada, and developed in collaboration with the Canadian Bar Association, 1995)

Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care (CNA, Canadian Medical Association, Canadian Healthcare Association, Catholic Health Association of Canada, 1999)

References:

- ¹ *Palliative care* is the active, compassionate care of dying persons and their families when neither the prolongation of life nor curative treatment is any longer an appropriate goal. Methods of palliation and the compassionate atmosphere of hospice care, mean that, some pain and symptoms can be relieved and other physical, emotional, and spiritual needs experienced in advanced disease can be met.

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- ² *Futility* is a term often used in discussions of withholding or withdrawing treatment, thus “futile” and “non-beneficial” treatments are defined to include situations in which a physician can determine that a treatment is “medically” futile or non-beneficial because it offers no reasonable hope of recovery or improvement, or because the person is permanently unable to experience any benefit. In other cases the utility and benefit of a treatment can only be determined with reference to the person’s subjective judgment about his or her overall well-being.
- ³ An *advance directive* is a document prepared by a competent person intended to direct the kind of treatment that person will receive if he or she later becomes incompetent. The two basic forms of advance directives include instructional directives about particular treatments and directives that name a substitute decision-maker. A person can include both forms within a single advance directive document.
- ⁴ Canadian Nurses Association. (May 1998). *Advance Directives: The Nurses’ Role, Ethics in Practice*. *CNA Today*. Ottawa: Author.
- ⁵ Canadian Nurses Association et al. (1999). *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care*. Ottawa: CNA.
- ⁶ Treatment decisions about potential resuscitative interventions should be made within the context of discussions concerning the plan of treatment, and on the basis of the person’s medical condition and his or her expressed wishes. These decisions should be considered before the need for intervention arises or a crisis occurs. They should be made in the context of the person’s autonomy and with full disclosure of options in a supportive environment.
- ⁷ CNA’s *Code of Ethics for Registered Nurses* (1997) provides guidance for decision-making concerning ethical issues and a basis for self-evaluation and peer review regarding nursing practice.
- ⁸ *Cardiopulmonary resuscitation* (CPR) was developed as a treatment intervention for cases of sudden unexpected cardiac or respiratory arrest. CPR is understood to include mouth-to-mouth resuscitation, chest compression, bag-and-mask positive-pressure ventilation, intubation and defibrillation.
- ⁹ A *do-not-resuscitate order* is a type of instructional advance directive specifically related to resuscitation. CPR has become such an expected response to cardiac or respiratory arrest that it is sometimes used inappropriately and even in situations when death is anticipated and awaited. Resuscitation is treatment and like other treatments it must be consented to or refused.
- ¹⁰ Canadian Healthcare Association et al. (1998). *Making Decisions About CPR: Cardiopulmonary Resuscitation*. Ottawa: CMA.