



The English Speaking Catholic Council  

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Le conseil catholique d'expression anglaise

**BRIEF**

**SUBMITTED TO THE FEDERAL PARLIAMENTARY COMMITTEE**

**ON PALLIATIVE AND COMPASSIONATE CARE**

**BY THE ENGLISH SPEAKING CATHOLIC COUNCIL**

In 1980, a group of individuals who represented various sectors of the English-speaking Catholic community and its organizations met with the idea of consolidating our human and material resources for the development of our community. This led to the formation in 1981 of the English Speaking Catholic Council (ESCC) with a mandate to act as a focal point in coordinating the English-speaking Catholic community of Greater Montreal. Over the years, the ESCC has assumed a higher profile which now extends throughout the Province of Quebec and beyond.

Inspired by the contemporary Catholic understanding of the role of the laity in the modern world, the English Speaking Catholic Council assists in the promotion of its community's values and advocates those values in the resolution of issues affecting this community. The Board of Directors is made up of women and men from both the private and public sectors, all volunteers, who come together with a commitment to support their community in education, health and social services, community animation, culture and social justice.

The English Speaking Catholic Council acknowledges with deep gratitude the invaluable contribution of the principal authors of this brief: Dr. Ramona Coelho, a family physician who works at CLSC Metro in Montreal. Her training included a focus in palliative care. She spends half of her practice caring for disabled and frail elderly persons who are homebound. And Daniel Cere, Ph.D., Professor, Faculty of Religious Studies, McGill University, and member of the Board of the ESCC.

The English Speaking Catholic Council is pleased to present this Brief to the Federal Parliamentary Committee on Palliative and Compassionate Care.

Mary McDaid, President

The English Speaking Catholic Council

Montreal, December 17, 2010

## **Introduction**

The Catholic tradition has a long history of commitment to health care. Currently it is the largest non-government health-care provider in the world with over 5000 hospitals, 18,000 health care clinics, and 15,000 homes for the elderly, chronically ill and handicapped. Globally Catholic healthcare institutions provide 25% of all AIDs care, including hospices for those dying of AIDS. The Montreal Catholic community has continued this deep tradition of Catholic commitment to health care. Perhaps its most stellar example is Marguerite d'Youville, an impoverished young widow working in Montreal during the 18<sup>th</sup> century, who founded the Grey Nuns, a religious order that has worked tirelessly to establish an array of hospitals and health care institutions in Canada, Latin America, Africa, and Asia. Catholic social teaching stresses the dignity of the human person and the need for solidarity with those who are suffering and vulnerable.

## **Palliative Care**

Palliative care is medical service whose focus is to reduce the severity of symptoms for patients suffering from a fatal disease or condition. It is a tradition of medical practice that deeply resonates with a longstanding Catholic commitment to support the fundamental right of every person to a "good death."

Palliative care is holistic care that includes a variety of core services such as optimal pain and symptom relief, psychological counselling, physiotherapy, massage therapy, art therapy, pastoral services, family counselling, among others.

Currently in Canada, we have approximately 240,000 deaths per year. This number will rise to 330, 000 by 2026, and to over 425, 000 by 2036.<sup>(16)</sup> Sadly as few as 16-30% of dying Canadians currently have access to palliative care or end-of-life services.<sup>(2)</sup> Until now, palliative care

medicine is primarily applied to patients dying with cancer. Symptom relief is important for all and not just those who are dying from cancer. <sup>(7)</sup> Palliative care education and training need to be disseminated more widely in the medical community in order to make good palliative care readily available for patients in need.

There is a misconception among Canadians that too much of our healthcare spending is being focused on end-of-life care. In fact, our sources suggest that health care funding dedicated to end-of-life care has not increased since the 1960's. <sup>(1, 18)</sup> Furthermore, innovative reforms to our existing palliative care practices and systems may lead to significant savings in the long run. Training in high-quality palliative care needs to be a central focus of medical education for health care workers.

### **Chronic Care**

The medical community knows how to treat chronic diseases reasonably well, but often is not as good at treating **the patient**. We need to avoid aggressive interventions when the chance of recovery is very poor (e.g. multiple intubations for someone with end stage chronic obstructive pulmonary disease). But at the same time, good symptom control is essential when the outcomes of treatment are favourable.

As well, we need to focus on the basics – mental health, nutrition, monitoring for decline in function, checking the living quarters for safety, avoiding overmedication, limiting falls, and bed sore prevention, all with the goal of keeping patients as independent as possible. <sup>(5)</sup>

Lastly, discussing end-of-life issues early alleviates anxiety by encouraging families and patients to plan wills, make financial provisions, and resolve family conflicts. Lack of foresight and planning often means that patients are forced to deal with these difficult issues when they are acutely sick in the hospital.

## **Home Care**

As it stands, prolonged hospitalization often has devastating effects. Elderly persons rarely return home at the level of functioning when they were first admitted. With bedrails up, and intravenous lines in, patients become bedridden and de-conditioned. On admission basic accessories such as glasses, canes or hearing aids are often forgotten, or worse, these articles are lost in the numerous transfers around the hospital that a patient endures. The nutritional status of patients often deteriorates over the course of their hospital stay due to declines in psychological well-being, difficulties in accessing food in sealed containers, or aversion to the taste and presentation of hospital food. A lack of coordination among the staff (e.g. untimely checking for vital signs or transferring patients in the middle of the night) can disturb sleep patterns and make it harder for the patient to function normally. Often the patient is so weakened that they cannot go home even after the medical crisis is resolved.<sup>(6)</sup> Although attention to these details will help prevent deterioration, the benefits of keeping patients at home or shortening their hospital stay should not be underestimated.<sup>(10,12)</sup> We need a well-planned expansion of home care and education of health care workers especially in years to come.

Creative collaborative systems of home and institutional care may actually relieve pressure on our public health care system. According to a SIPA research program conducted in Montreal, increasing home care services decreases or shortens hospitalizations and improves the patients', as well as their families', quality of life. The cost of increased home-care and community services was balanced by the decreased use of long-term care facilities and hospitals.<sup>(19)</sup> Also, a clearer picture is formed of family functioning making it easier to detect elder abuse, mental health problems, chronic care issues, or substance abuse. Also, homecare would allow for patients to die in their homes if that is their wish.<sup>(17)</sup>

## **Elder Abuse**

In Canada, elder abuse is not uncommon.<sup>(8)</sup> Financial abuse is the most reported. Often the perpetrators are family members.<sup>(4)</sup> We need to support families in order to decrease elder abuse. Family caregivers shoulder a tremendous burden of physical work and emotional strain. Their income and employment is often lost and they are not properly compensated for the load they take off our long term care facilities. Caregivers are more likely to experience depression and anxiety than the general population (the rate is six times higher when caring for a partner, and twice as high when caring for a parent).<sup>(3)</sup>

Caregivers need to be adequately supported and compensated. Physicians and healthcare workers checking on patients (again homecare is ideal), need to assess the functioning of the care-giver as well.<sup>(14)</sup> Family members often provide care at great cost to their own health.

### **The Dignity of the Vulnerable and Disabled**

The most serious impediment to improving care may well be our own societal attitudes. In recent years, a number of prominent social and legal theorists argue that public policy tends to systematically marginalize vulnerable sectors of society such as children, the elderly, the disabled, and the dying. In *Frontiers of Justice*, Martha Nussbaum points out that modern conceptions of citizenship tend to centre on a narrow ideal of the independent self-sufficient adult. However, many stages of human life do not fit into this highly restrictive model of the able rights-bearing citizen.

This narrow conception of citizenship focused on the self-sufficient adult blinds us to the universal fragility of human life and ends up closeting our dying and disabled at the margins of our health care systems. The Catholic tradition, in unison with other religious and cultural traditions, argues that fundamental human rights must include respect and care for the most

fragile and vulnerable stages of human life. Every person has a fundamental right to high quality care, respect and social support throughout their life.

The English Speaking Catholic Council

Montreal, Quebec

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