

May 4, 2020

www.TheEFC.ca/Palliative

The Evangelical Fellowship of Canada, together with interfaith partners, has called for all levels of government to address the urgent need for high quality palliative care across Canada, as articulated in our 2016 [Interfaith Statement on Palliative Care](#).

We have developed a faith-based [Palliative Care Toolkit](#) to raise awareness of what palliative care is and how individuals and church communities can help offer support and practical assistance. We are making this resource widely available, free of charge, in order to inform and equip Canadians to become involved in palliative care.

The EFC supported Bill C-277, legislation to establish a *Framework on Palliative Care*, in 2017. We also participated in Health Canada's consultation on the Framework in 2018.

The EFC is the national association of evangelical Christians in Canada. Established in 1964, the EFC provides a forum for Canada's four million Evangelicals and a constructive voice for biblical principles in life and society.

Our faith calls us to care for those who are vulnerable and to uphold the sanctity of life. We respond to suffering, and particularly to those who are living with illness or nearing the end of life, with care and compassion, journeying with those who are walking in the shadow of death.

[A holistic and compassionate response to suffering](#)

Physical pain is primarily a physical question, one that modern medicine is generally well equipped to address. The experience of suffering, though, is a broader human question – one that involves not just physical, but emotional, psychological, spiritual and social dimensions. Responding well to suffering, then, requires a more holistic approach.

Isolation and stigma often come with incurable illness. People are vulnerable to feelings of despair and to feeling like a burden to family or caregivers and to the medical system. The strongest independent predictor of desire for hastened death in terminally ill patients is depression and hopelessness.¹

Individuals who have a progressive, life-limiting disease or who are nearing death commonly experience multi-faceted suffering that is beyond the scope of medical treatment alone. This

¹ <https://www.bcmj.org/articles/addressing-existential-suffering>

suffering is best and properly addressed by high quality palliative care that considers not just illness and its symptoms, but the whole person, and includes a range of supports for the patient and their loved ones.

One of the unique aspects of palliative care is how it recognizes the patient's spiritual needs and makes room for those needs to be met. Spiritual care helps to meet the needs of patients who are isolated or afraid and who may be grappling with issues of meaning, purpose and connection.

Palliative care and MAiD

Palliative care is distinct from medical assistance in dying in approach, definition and philosophy.

The Canadian Hospice Palliative Care Association and the Canadian Society of Palliative Care Physicians published a *Joint Call to Action*² earlier this year to clarify the relationship of hospice palliative care and MAiD, stating:

Hospice palliative care focuses on improving quality of life and symptom management through holistic person-centered care for those living with life threatening conditions. Hospice palliative care sees dying as a normal part of life and helps people to live and die well. Hospice palliative care does not seek to hasten death or intentionally end life. In MAiD, however, the intention is to address suffering by ending life through the administration of a lethal dose of drugs at an eligible person's request.

The EFC agrees with the many voices in the palliative care community who contend that hastened death has no part in palliative care. We urge you to respect those voices and maintain that distinction in the definition of palliative care.

We supported the adoption of the World Health Organization's definition of palliative care in the *Framework on Palliative Care in Canada*, particularly its statement that palliative care affirms life and regards dying as a normal process, intending neither to hasten or postpone death.

- **We urge you to uphold the distinctiveness and life-affirming definition of palliative care.** Government policy should recognize the philosophical and practical separation between palliative care and MAiD.

² <https://www.cspep.ca/wp-content/uploads/2019/11/CHPCA-and-CSPCP-Statement-on-HPC-and-MAiD-Final.pdf>

Support for providers and facilities

There is a growing awareness of how practice environments influence both patient outcomes and the retention of health professionals. There is evidence that moral distress in physicians and nurses has an impact on professional quality of life and staff turnover.³

Compelling physician and facility participation in MAID creates a poisoned environment which reduces the quality of care available to patients. Physicians, including palliative care physicians, are feeling pressured to participate in euthanasia against their conscience or deeply held beliefs. As the Physicians Alliance Against Euthanasia says, physicians increasingly feel pressured and bullied to participate in MAID:

The pressure has been intense for many physicians, especially amongst palliative specialists, some leaving even before this latest development. Descriptions were made of toxic practice environments and fear of discipline by medical regulators.⁴

Over 1,100 physicians, including Dr. Balfour Mount, the Canadian doctor who coined the phrase “palliative care,” have signed a declaration stating that they do not want to end the lives of the patients under their care.⁵ Many health care professionals enter the field of palliative care out of a desire to help patients live fully to the end of their natural life.

There are health care providers within many fields, such as doctors, nurses, PSWs, pharmacists and administrators, who have deeply held beliefs that prevent them from participating in ending the lives of others through MAID. Objections to MAID may be rooted in religious belief or philosophy of care or the objections may be due to the circumstances of a particular patient.

Facilities, including hospices, are also under pressure to fundamentally change their philosophy of care by providing or allowing MAID within their institutions. One high-profile example is the Irene Thomas Hospice, which is operated by the Delta Hospice Society. This is not a faith-based enterprise. The hospice is located next door to an institution which provides MAID, but the Fraser Health Authority in B.C. has said it will close down the hospice if it does not begin to offer MAID on its premises.⁶

Allowing patient access to MAID does not require compelling practitioners or institutions to participate in MAID against their deeply held beliefs or to make MAID available in every hospice or palliative care bed.

³ <https://psycnet.apa.org/record/2016-52569-001>

⁴ <https://collectifmedecins.org/en/press-release-2/>

⁵ <https://collectifmedecins.org/en/declaration/signatories/>

⁶ <https://www.ctvnews.ca/health/standoff-between-b-c-and-hospice-refusing-to-offer-assisted-dying-1.4773755>

- **We recommend care for health care providers who provide end-of-life care, including strong, specific conscience protection for health care providers and institutions.** It is essential to ensure no one is compelled to participate in the MAID process against their conscience or deeply held beliefs and to ensure health care training programs and medical schools do not screen out applicants who conscientiously object to performing MAID. Palliative care or hospice settings must not be required to offer MAID.

Increased training for healthcare providers

A study by the Canadian Institute for Health Information finds that three out of five Canadian primary care doctors say they don't feel well prepared to help people in need of palliative care.⁷ In an international survey, Canadian primary care doctors felt less prepared to manage care for palliative patients, on average, than doctors in ten peer countries. Less than half (41%) of Canadian primary care doctors felt well prepared to manage patients in need of palliative care, compared to 81% of primary care doctors in the U.K. and 92% in the Netherlands.⁸

We encourage the committee to recommend planning for end-of-life care across all care settings, including training for staff in long-term care facilities.

- **Palliative care should be included as part of the core curriculum for all medical and nursing students**
- **Support continuing education on palliative care for physicians, nurses and other health care workers who already accredited and practising**

Improved public awareness

The majority of Canadians indicate strong support for palliative care, but a 2016 Ipsos poll found a lack of overall awareness around palliative care. Only 58% of Canadians were aware of what palliative care involves on an unaided basis, and 55% were aware of end-of-life care. Less than half were aware of residential hospice care (49%), advance care planning (36%) and federal Compassionate Care Benefits (15%).⁹

As the population ages, more Canadians will be looking for resources on end-of-life and palliative care services. This is an opportunity for cooperation and connection with civil society partners, including faith communities.

- **We encourage the Committee to consider initiatives to improve public awareness of palliative care**

⁷ <https://www.cihi.ca/en/access-data-and-reports/access-to-palliative-care-in-canada/palliative-care-in-canada-inconsistent-patients-say>

⁸ <https://www.cihi.ca/sites/default/files/document/access-palliative-care-2018-en-web.pdf>, p. 35

⁹ <http://www.palliativecarematters.ca/news-collection/ipsos-survey-report>

Aligning data collection with benchmarks

Benchmarks, or standards of performance that services are measured against, allow for better monitoring of patient outcomes and demonstrating improvement in patient outcomes.

There are international systems of data collection. In England, the Cicely Saunders Institute leads an initiative to collect data on palliative care in terms of patient outcomes. It uses standardized measures to provide a comprehensive picture of the patient's condition, circumstances and needs.¹⁰ Australia has a national program funded by their federal Department of Health to track patient outcomes, the Australian Palliative Care Outcomes Collaboration. It tracks the national service level performance.¹¹ These measures improve communication between patients and health providers. They also indicate whether patient and caregiver outcomes are improving and goals are being met.

It is important to plan for future increased need for palliative care, taking into consideration the demographic shift of an aging population and the rate of chronic and complex medical illnesses that are more likely to need palliative care. As one report states, "Evidence suggests that bespoke approaches to policy-making which take into account the specific needs and wants of certain populations are better than a 'one-size-fits-all' approach."¹²

- **We recommend the Committee support aligning data collection with benchmarks**

Summary of recommendations

What will improve palliative care in Canada?

We recommend:

- a continued focus on compassionate, life-affirming care that maintains the distinction between palliative care and MAID
- support for palliative care providers and hospices, include strong, clear conscience protection for individuals and institutions
- increased training for health care providers in palliative care across all settings
- initiatives to raise public awareness about the availability of palliative and end-of-life care
- aligning data collection on palliative care with benchmarks on patient outcomes.

¹⁰ <https://www.kcl.ac.uk/cicelysaunders/attachments/Studies-OACC-Brief-Introduction-Booklet.pdf>

¹¹ <https://link.springer.com/article/10.1007/s00520-014-2351-8>

¹² <https://www.mariecurie.org.uk/globalassets/media/documents/policy/marie-curie-reports/state-of-the-nations-mariecurie-report-england.pdf>,