Volume 6, Number 1

June 2006

CANADIAN CATHOLIC BIOETHICS INSTITUTE

Bioethics Update

Some Notes on Palliative Care

Written for the Canadian Organization for Life and Family (COLF), Annual Conference, Ottawa, March 23-24, 2006

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Caring for the dying has such a long and significant history that it would be difficult to imagine that anyone would be opposed to providing good palliative care to those at the end of life. Instinctively, most people tend to their sick and dying relatives, giving of their love, time and resources so that the person concerned will "die well". Roman Catholics have always made sure that the person's spiritual needs and religious duties are a priority, and that the person is visited by a priest and receives the sacraments, the "last rites". We know that advances in medical technology have changed this picture in many ways, for example, the person or the family now have more decisions to make about beginning or withdrawing some treatments. Nonetheless, once it becomes clear that these treatments are not working, or are judged overly burdensome, then the decision to withdraw or not attempt other treatments means that the person and the family now have to face the reality of death, imminent or otherwise. The need for palliative care arises when the person has clearly entered the dying phase, and it is then that the availability of palliative care becomes an issue.

Palliative Care in Canada

In her report to the Canadian government, *Still Not There,* issued in 2005, Senator Sharon Carstairs indicated that by the year 2026, eight million Canadians will be over 65: about 20% of the population.[1] At present, not surprisingly, seniors account for 75% of deaths every year. It is estimated that this will increase every year until 2020. This will mean increasing demands on end of life care throughout the country.

How is Canada responding to this challenge? Although according to the report there are over 430 programmes which provide palliative care, it is estimated that no more than 15% of the relevant population has access to palliative care.[2] For children, this number falls to an incredibly low 3.3%.[3] Lack of federal leadership is cited as the main reason for this dismal showing, together with, naturally, lack of federal funding. The report makes ten major recommendations, including basic federal/provincial/territorial collaboration, not easy to negotiate in our current system where it is the responsibility of the provinces to deliver health care.

This is the major recommendation, followed by the demand that the different tiers of government make the provision of palliative and end of life care a top priority in the restructuring of the health care system by implementing consistent norms of practice, integrating services, and enhancing home care, pharmacare, and improving respite services for caregivers.

The federal Government has allocated money for research endeavours in palliative and end of life care through the Canadian Institutes of Health Research (CIHR), and these will be important for any longterm strategy. This fulfills Recommendation 10, which demanded research into socio-economic factors, and research into "the physical, mental and economic impact on informal caregivers". It is important to notice that the spiritual dimension is never explicitly mentioned, and that is something that we should emphasize in any recommendation that we make. If "emotional" impact can be assessed, there is no reason why spiritual impact should be omitted, especially given the transcendent nature of end of life matters, even for those who are not of a specific, religious persuasion. It should be noted that many people *want* the spiritual dimension to be explicitly recognized, and government should not omit that.

Nationally, palliative care concerns are represented by the Canadian Palliative Care Association, and each province has its own palliative care association. The Catholic Health Association of Canada (CHAC) is part of an overarching group called *Quality End of Life Care Coalition of Canada,* which collaborates with other major interest groups in lobbying for good end of life care.

The Provision of Palliative Care in other Countries

Balfour Mount notes that the provision of good palliative was lacking in Holland when that country moved to allow euthanasia and Physician Assisted Suicide (PAS), although palliative care is now improving there.[4] In Oregon it has been noted that, as palliative care improved, the demand for PAS declined.[5]

The United Kingdom is thought to be more advanced in the provision of palliative and hospice care than in any other country, although there are currently attempts to legalize euthanasia and PAS. A look at the current status of end of life care, however, shows facilities in the UK are still underfunded and are unable to meet the needs of all who would benefit.[6] There are 237 palliative care consultants, with 100 posts not filled. (Perhaps this is because it is true in many countries that geriatric and palliative care physicians are less well paid than most other specialists). There are 3,950 palliative care beds, and 2,522 of these are in the voluntary sector. The average stay in hospice is 13 days. Home Care services are also needed for those who die at home.[6]

The palliative care section of the World Health Organization (WHO) reports that in low income countries, there is little or no access to palliative care. It is estimated that there is unrelieved moderate to severe pain in about four and a half million out of six and a half million terminal cases of cancer and HIV/AIDS in the developing countries.[7] There are problems with the use and control of opioids, and palliative care training is neglected. WHO is trying to improve knowledge of opioids, and is issuing training books to inform people about home care, especially in the rural areas.[8] This sounds haphazard, but when Senator Carstairs talks about the availability of palliative care for only 15% of our dying population, it is questionable how much better off we are in Canada compared with any of the countries mentioned.

The Spiritual Dimension of Suffering

The question about suffering, or rather, its avoidance, is central to the apparently growing openness to euthanasia and PAS. Catholics have a distinctive way of viewing suffering according to the *Declaration on Euthanasia*, which states:

> Nevertheless the fact remains that death, often preceded or accompanied by severe and prolonged suffering, is something which naturally causes people anguish. Physical suffering is certainly an unavoidable element of the human condition; on the biological level, it constitutes a warning of which no one denies the usefulness; but, since it affects the human psychological makeup, it often exceeds its own biological usefulness and so can become so severe as to cause the desire to remove it at any cost. According to Christian teaching, however, suffering, especially suffering during the last moments of life, has a special place in God's saving plan; it is in fact a sharing in Christ's passion and a union with the redeeming sacrifice which He offered in obedience to the Father's will.[9]

In *Salvifici Doloris,* 1984, John Paul II adds emphasis to the explanation of suffering when he wrote:

> The Redeemer suffered in place of man and for man. Every man has *his own share in the Redemption.* Each one is also *called to share in that suffering* through which the Redemption was accomplished. He is called to share in that suffering through which all human suffering has also been redeemed. In bringing about the Redemption through suffering, Christ *has* also *raised human suffering to the level of the Redemption.* Thus each man, in his suffering, can also become a sharer in the redemptive suffering of Christ.[10]

John Paul then warns us in *Evangelium Vitae*: "When the prevailing tendency is to value life only to the extent that it brings pleasure and well being, suffering seems like an unbearable setback, something from which one must be free at all costs." He continues: "Furthermore, when he denies or neglects his fundamental relationship to God, man thinks he is his own rule and measure, with the right to demand that society should guarantee him the ways and means of deciding what to do with his life in full and complete autonomy".[11]

He saw this as one of the more alarming features of the Culture of Death, "marked by an attitude of excessive preoccupation with efficiency and which sees the growing number of elderly and disabled people as intolerable and too burdensome".[12]

Concern about Painkillers at the End of Life

Many people are concerned about the use of strong painkillers at end of life, and this question is dealt with by the *Declaration on Euthanasia*, which states:

> At this point it is fitting to recall a declaration by Pius XII, which retains its full force; in answer to a group of doctors who had put the question: "Is the suppression of pain and consciousness by the use of narcotics... permitted by religion and morality to the doctor and the patient (even at the approach of death and if one foresees that the use of narcotics will shorten life)?" the Pope said: "If no other means exist, and if, in the given circumstances, this does not prevent the carrying out of other religious and moral duties: Yes". In this case, of course, death is in no way intended or sought, even if the risk of it is reasonably taken; the intention is simply to relieve pain effectively, using for this purpose painkillers available to medicine. However, painkillers that cause unconsciousness need special consideration. For a person not only has to be able to satisfy his or her moral duties and family obligations; he or she also has to prepare himself or herself with full consciousness for meeting Christ. Thus Pius XII warns: "It is not right to deprive the dying person of consciousness without a serious reason".[13]

The use of strong painkillers focuses attention on the point made by many in the palliative medicine field that not enough time is allocated to training in this area in medical schools, and that there is uneasiness on the part of many family doctors in using any form of terminal sedation. More education is needed to allay those fears. There is also the current ethical and legal concern that terminal sedation could be used intentionally to end someone's life as a 'backdoor" form of euthanasia, and this needs to be addressed nationally.

Concern for Caregivers

Any adequate palliative care programme must be concerned for the caregivers, especially those at home. St. Elizabeth Healthcare, for example, uses part of its budget towards providing respite care for caregivers, and some local authorities provide this, recognizing that more is needed. Senator Carstairs emphasizes this in her report in Recommendation Two,[14] and, since the Catholic Church calls for good palliative care, it must also take this dimension into account.

Work to be done by the Catholic Community

The CCBI, COLF, The Euthanasia Prevention Coalition, and other interested parties have met under the leadership of Bishop Fabbro to discuss possible strategies to counter moves towards the legalization of euthanasia and PAS in Canada. It is clear that one of our strongest platforms is in advocating for the provision of good palliative care, to reassure people that their physical, emotional and spiritual needs at the end of life are important and will be met. It is imperative that the Catholic community itself be educated about palliative care, for our individual benefit and for that of the common good.

1. The Honourable Sharon Carstairs, P.C. S*till Not There: Quality End of Life Care – A Progress Report*, June 2005.
2. *Ibid.,* P.1.
3. *Ibid.*
4. Dr. Balfour Mount, live Simulcast with Jean Vanier, CPAC, January 31, 2006.
5. Ilora Finlay, "Euthanasia, What it is and what it is not". *Dolentium hominum*, 2005, No.58, P. 49.
6. The National Council for Palliative Care (UK), *Submission on the Assisted Dying for the Terminally Ill Bill,* 2004, Sections 44-47.
7. WHO Regional Office for Europe, *Palliative Care: The Solid Facts,* 2004.
8. WHO, *Caregiver Booklet: A Guide for Patients, Family Members and Community Caregivers,* 2003.
9. Congregation for the Doctrine of the Faith, *Declaration on Euthanasia,* 1980, Section III.
10. Pope John Paul II, *Salvifici Doloris,* 1984, Section 19.
11. Pope John Paul II, E*vangelium Vitae,* 1995, Section 64.
12. Ibid.
13. CDF, *Declaration on Euthanasia,* 1980, Section III.
14. The Honourable Sharon Carstairs, *Still Not There,* 2005, P. 29.

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