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Chair

Mr. Bill Casey

Standing Committee on Health

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● (1110)

[*English*]

The Chair (Mr. Bill Casey (Cumberland—Colchester, Lib.)): I call the meeting to order.

Thanks very much, everybody, for being here. We're going to continue our study on Bill C-277, an act providing for the development of a framework on palliative care in Canada. I think we're all very interested in this and all very supportive. We welcome the testimony of our witnesses today. We look forward to your presentations.

On the first panel, from the Canadian Hospice Palliative Care Association, we have Sharon Baxter, executive director, accompanied by the Josette Roussel, senior nurse adviser to the Canadian Nurses Association.

If you could keep it tighter, it will give us more time for questions. Thanks very much.

Ms. Baxter.

Ms. Sharon Baxter (Executive Director, Canadian Hospice Palliative Care Association): First, let me thank you for allowing us to present this morning. I want to extend especial thanks MP Marilyn Gladu for putting the motion forward. We're thrilled to be able to present today.

The Canadian Hospice Palliative Care Association is the national association that provides leadership in hospice palliative care in the pursuit of excellence regarding the care of persons approaching death so that the burdens of suffering, loneliness, and grief are lessened. Hospice palliative care is aimed at the relief of suffering and improving the quality of life of persons who are living with, or dying from, an advanced illness or who are bereaved.

I noticed in the motion that there was a question about definitions. There are a number of definitions. If you refer to the brief we've submitted, on the last page we provide definitions for “hospice palliative care”, “palliative approach to care”, and “advance care planning”. These terms tend to get intertwined in people's thinking. Hopefully, that will be helpful for you.

We are pleased that there is a desire to develop and implement a framework designed to guarantee that all Canadians have access to high-quality palliative care. The provision of specialist hospice palliative care in acute care hospitals and residential hospices and the palliative approach to care provided in the community—including home care, long-term care, and other settings—have not received the attention, funding, and support that's needed in light of our aging population. It's going to become a critical issue.

Now, if I may, I'd like to take a little time to highlight some of the existing resources and documentation that could help you in developing and implementing a palliative care framework. To be clear, we are not starting from scratch. We have a lot of information and there have been a lot of reports.

CHPCA, my association, serves as the secretariat for the Quality End-of-Life Care Coalition of Canada. It was formed in 2000, so we've been around for 17 years. I'd like to give a quick shout out to a few of the coalition members who are in the room today. The Canadian Nurses Association, Pallium Canada, the Canadian Cancer Society, and the Canadian Society of Palliative Care Physicians are all in the room today. There are 39 national associations, including all the professional associations and disease-specific groups, and they've been working together for 17 years to try to highlight the issue of hospice palliative care.

At the end of our brief, we've also listed the coalition members just for your information, because, obviously, we don't want to take up the time today.

The Quality End-of-Life Care Coalition produced a guiding document called, “Blueprint for Action 2010 to 2020”, and it identified four priority areas of focus. They have stood the test of time through the last decade. The first one is ensuring all Canadians have access to high-quality hospice, palliative, and end-of-life care. The second is providing more support for family caregivers, including bereavement support through the federal compassionate care benefit and other opportunities. We actually have about six or seven different ideas. The third is improving the quality and consistency of hospice palliative care in Canada, including research, training, and education. The fourth is encouraging Canadians to discuss their wishes for their care in the future, including at end-of-life. We've often referred to this as advance care planning. It's called different things, depending on where you are in Canada. It's so Canadian that in different jurisdictions they call it different things.

Between 2012 and 2015, the Government of Canada provided CHPCA and the Quality End-of-Life Care Coalition funding for a three-year initiative called, “The Way Forward: An Integrated Palliative Approach to Care”. This culminated in the development of a national framework and the dissemination of practical resources and tools to help governments, policy-makers, regional planners, health service organizations, and health care providers on the ground to adopt a palliative approach to care. Indeed, five provinces are using it as a foundational piece of work in trying to push out an integrated model.

“The Way Forward” was intended to be a catalyst for action by raising the awareness and understanding of a palliative approach to care. The initiative also defined “hospice palliative care”, a “palliative approach to care”, and “advance care planning”. I refer you to the lexicon of terms. At the end of our brief, we've put some links to some of these documents and in “The Way Forward” we have a lexicon of terms. Hopefully, that will help you with your deliberations.

Traditionally, the last days or weeks of life are the most common time for referrals to hospice palliative care programs and services, if at all, and these are often reserved for individuals designated as “dying”. Those tend to be the patient who is dying with an end-of-life experience that needs specialist care—cancer patients, or those with HIV or AIDS or some of those diseases—but not necessarily those patients who are not designated as dying, like the dementia patient. Indeed, about 65% of Canadians die of diseases that do not necessarily need specialist palliative care, but do need a palliative approach to care. There is this nuance between the two.

The overarching goal of the initiative was to ensure more Canadians can live well until dying by enhancing their quality of life through the course of illness and through the process of aging, and not just in the last days or weeks of life.

In December 2016, just two months ago, CHPCA undertook an environmental scan of all the provinces and territories, as well as the QELCCC members, to determine where they stood in the implementation of a palliative approach to care. Given that health is a provincial and territorial responsibility, it is absolutely imperative to understand where their priorities lie to best determine how we proceed federally. The surveys provided important information that will drive the adoption of a palliative approach to care. Remember that the initial project was only $3 million and was a catalyst project, so it was just the start of the conversation.

The two surveys offered the following highlights. I'll name a few of them.

While public awareness is one driver of adoption of a palliative approach to care, we need to do more to enhance the understanding of a palliative approach to care and advance care planning with the public and health care providers. I think the issue of public awareness is an interesting piece of work that we really need to do. Most Canadians are confused about what hospice palliative care is, what a palliative approach is, what “do not resuscitate” means, what sedation is, and what your rights are among hydration, nutrition, and treatment. It's all blurry in the minds of Canadians, and we really need to do a much better job of giving them that information.

Next, a national education curriculum and ongoing continuing professional development through enhanced skills and training are needed for all health care providers across all settings of care. As well, conversations about the palliative approach need to be better integrated into usual medical care. This would help to make a palliative approach part of ongoing treatment and not necessarily a separate specialized or referral-based program, so that it becomes part of the care that anybody will receive when they're coming to the end of their life.

Also, ongoing advocacy efforts for a palliative approach to care must continue, particularly in light of the introduction of medical assistance in dying, which has created a need to clarify what hospice palliative care is all about, where it is available, and what more needs to be done to ensure that it is accessible to all Canadians. We've often said that it would be a shame if a Canadian chose MAID when they could have benefited from hospice palliative care, so we need to be able to make sure that they're given that opportunity. In addition, current care pathways need to include a palliative approach, and tools and materials for health care systems and professionals must enable adoption.

Last, we must ensure resources are available and dedicated to hospice palliative care and flexible to meet population health needs, including those Canadians who are members of the indigenous culture or vulnerable groups.

This final report was given to Health Canada just on Tuesday. There are several other great reports, studies, environmental scans, and evidence, such as the recent consensus statement and lay panel recommendations coming out of a November 2016 three-day Palliative Care Matters consensus conference that was held here in Ottawa. You can see that a lot of this is very recent. All the findings are consistent with the “Blueprint for Action” and many of the other reports. They include calls for a national care strategy; a national secretariat, including a national centre for research; a national public awareness campaign regarding the palliative approach to care and advance care planning, for the public and for health care providers; education and training for health care professionals; and caregiver support. As you can see, there is a great consensus among all these studies.

I notice that Bill C-277 references all Canadians. It is imperative that policy-makers remember that not all Canadians have equal access to health care—especially hospice palliative care—in this country. Vulnerable populations, including those who are indigenous, disabled, homeless or vulnerably housed, impoverished, or incarcerated are often forgotten. Innovative models for delivering hospice palliative care are required to meet these populations' unique needs and to address the barriers they face when accessing services.

● (1115)

Barriers to accessing high-quality palliative care include non-malignant diagnoses, geography—we do a much worse job providing services to rural Canada—poverty, lack of supports, comorbidities, mental health, and substance abuse all play into how these people do not receive the care they need at the end of their lives. When you say "all Canadians", we really need to think about all Canadians.

Another group who are often not considered are children. A recent study from SickKids in Toronto that was finished in 2012 cited that overall only 18.6% of deceased children who might have benefited from palliative care received the care based on their diagnosis, and 25.2% had their care only eight days before they died. We can do much better. Pediatric palliative care has developed as an integrated model of care and can successfully be adapted in the adult population. We can learn from their experience.

In summary, we really don't need to study the situation any further. The studies and reports have all been done. The ample evidence clearly points to one course of action, which is to support and fund the agreed-upon priorities to make hospice palliative care accessible to all Canadians. Governments, health care associations, and organizations have all been partners in this, but corporate Canada has a role to play. The Canadian Hospice Palliative Care Association, my association, has a champion's council that is made up of leaders of industry and commerce. They've just launched a program called Canadian compassionate companies that highlights companies and organizations that accommodate—

● (1120)

The Chair: I'm sorry, Ms. Baxter, we have to move along, but thank you.

Ms. Sharon Baxter: I'll just finish then. It highlights companies and organizations that support the "caregiving at end of life" roles of their employees.

That was it.

The Chair: Thank you very much. I'm sorry to end it but we have to move on.

Ms. Roussel.

Ms. Josette Roussel (Senior Nurse Advisor, Canadian Nurses Association): Thank you, Mr. Chair.

My name is Josette Roussel. I'm a registered nurse and senior nurse adviser for the Canadian Nurses Association, the national professional voice representing nearly 139,000 RNs and nurse practitioners, including almost 1,400 nurses with specialty certification in hospice palliative care.

Nurses are leaders with a fundamental role in developing and implementing a palliative approach to care, and therefore, I am pleased to inform the committee that CNA is supportive of this important bill. I will now turn to the CNA's four suggestions, including several amendments for the committee's consideration. These are outlined in detail in the brief that we will submit to the committee.

First is the need for greater emphasis on a palliative approach to care throughout the bill. CNA advocates for a palliative approach to care enabled by advance care planning. This approach is guided by core tenets of palliative care, such as dignity, hope, comfort, quality of life, and relief of suffering. This care is provided earlier in the course of the illness, in all health settings, by a range of health care professionals. It involves physical, psychological, social, and spiritual care. CNA believes that the proposed bill must speak to the palliative approach to care as opposed to limiting the discussion to a specific service provided in the patient's final days.

We therefore recommend that paragraph 2(1)(a) be as follows:

> defines what palliative care and a palliative approach to care is.

Second, we suggest expanding palliative care training and education beyond specialized palliative care providers. Research reveals that our country does not have adequate palliative care training for health care providers. One way to address this gap would be to include education and training in the core curricula for students in all health care disciplines. We, therefore, recommend that paragraph 2(1)(b) be amended as follows:

> identifies the palliative care training and education needs of palliative health care providers as well as other health care providers.

Third, CNA encourages the committee to support the development and implementation of national evidence-based standards for integrated palliative care. Currently, there are no nationwide policies and evidence-based standards of care to ensure integration of the palliative approach to care across the continuum. In addition to not having a framework for palliative care, there are no standardized and widely adopted methods to guide health care providers, including nurses, on when and how to implement the palliative approach to care.

The lack of national evidence-based standards for integrated palliative care renders it impossible to collect relevant data and to track and report on key indicators. Therefore, provinces and territories have limited capability to understand whether, where, and how to improve palliative care. Therefore, CNA recommends that paragraph 2(1)(d) be amended as follows:

> collects standards from research and data on palliative care.

Finally, I would like to address the provision of funding to develop a framework for palliative care in Canada. CNA supports the recommendations outlined in the 2015 Quality End-of-Life Care Coalition of Canada report titled "The Way Forward".

The coalition calls for federal funding for the establishment of a national secretariat that would oversee development, implementation, and maintenance of a national palliative care framework. This would set strategic directions and lead to a coordinated, comprehensive, pan-Canadian approach to palliative care. Reinstatement of Health Canada's secretariat on palliative and end-of-life care is a move that CNA would support.

In closing, I emphasize that CNA is a strong advocate for high-quality palliative care that is accessible to all Canadians in settings that best suit their care needs.

I would like to thank the committee for providing CNA with the opportunity to speak on behalf of RNs and NPs in Canada on this important matter, and I look forward to your questions.

● (1125)

The Chair: We'd like to thank you both for coming.

We're going to start our first round of seven-minute questions with Mr. Oliver.

Mr. Len Webber (Calgary Confederation, CPC): Mr. Chair, I have a question with respect to the questioning. I had a brief conversation with the clerk here. Will there be only one round of seven minutes or are we going with what we usually do—two rounds of seven minutes?

The Chair: We'll have two rounds, seven minutes for the first round and five minutes for the second round.

Mr. Len Webber: So it's just normal. Okay.

The Chair: Mr. Oliver, go ahead.

Mr. John Oliver (Oakville, Lib.): Great. Thank you very much.

Thank you very much for coming and providing your testimony today. It's very much appreciated. Speaking for myself, and I'm sure most around this table, there's a real appreciation of the need for a palliative care framework in Canada. In fact, as we've introduced medical assistance in dying, if you want to call that a choice, if there is no other choice, if there isn't a good, robust palliative care system to support people, then are we really providing a choice for them? It's important that Canadians and their families have access to this. I think we all have our own personal stories as well of very difficult end-of-life circumstances that we've had to work through, so thank you for coming.

I'm highly supportive of the bill. I want to thank MP Gladu for her work on this and for bringing it forward to our attention. My comments are only meant to be helpful. We have one shot at this, so let's get it right. Most of my questions will be dealing with paragraphs 2(1)(a) to (f) under the framework on palliative care. The first one is about defining what palliative care is.

Sharon, you had introduced a hospice palliative care definition, and generally I think people turn to the WHO definition of palliative care.

I guess to both of you, will there be any controversy in deciding the definition of palliative care? I'm wondering if you have a different view, because your hospice definition is different from WHO's.

Ms. Sharon Baxter: The World Health Organization put out a definition based on a worldwide model. In Canada, unlike in the U.S., we've taken a different perspective on specialist palliative care. We don't differentiate between hospice care and palliative care in Canada the way they do in the U.S. Some of that was driven by the U.S. having a hospice benefit. We don't have that in Canada.

When we talk about hospice palliative care—or just palliative care, you can drop the hospice—it's what we refer to as specialist care, the stuff that happens in acute-care hospitals, usually with intense pain and symptom management, that type of thing. This palliative approach to care came out of a movement in Australia, to actually try to.... It's not the specialist palliative care.

You know, my grandmother at 93 had dementia and had been sick for seven years. She never took a pill. She was healthy physically but not mentally, so she needed a palliative approach to care. Even within Canada there's different jargon used. There's advance care planning and so on. I don't think there will be conflict. It will be interesting. The three definitions that we gave you are the ones we used in “The Way Forward” project, which seemed to get a lot of support, so it should be fine.

● (1130)

Ms. Josette Roussel: I think with the coalition we did agree on the definitions around palliative care and the palliative approach to care. It's important to emphasize the palliative approach to care, as it does mean reaching out to a larger number of individuals earlier in the system so that you have a clearer plan in place for later on. Both are needed. It's just a new concept and a concept that's not well understood, but it's very important in reality because of our contextual piece in the health care system.

Mr. John Oliver: To me, palliative care can occur in a hospital, it can occur in a hospice, or it can occur at home.

Ms. Josette Roussel: Of course.

Mr. John Oliver: It's really attempting to be responsive to the needs of the patient and the family around them, as long as you can manage things like other complications and pain management with it.

My second question is sort of around that. It's making sure that we have the words right on health care providers, palliative health care providers, and supporting palliative caregivers. There is no term “palliative health care provider”. We have health care providers who are providing palliation. We have caregivers who are providing palliation.

I'm assuming that we would want to make sure that we've identified the training and the educational needs of both health care providers and caregivers. Even for volunteers there would be palliative care training, right?

Ms. Sharon Baxter: Right now there are about 35,000 Canadians who are volunteers at hospice palliative care programs in this country. It's a loose number, because there's no one database on that, but it's considerable. They take the training through the hospice palliative care programs.

As we push out this palliative approach to care, we really need to start to talk to all Canadians. It's really important, what you've brought up. We haven't got our heads around what that really means.

Mr. John Oliver: Just speaking with the words then and being a bit more focused here, it says, identify “the palliative care training and education needs of”, and I think, Josette, the wording of your proposed amendment was “of palliative health care providers” and “other health care providers”—

Ms. Josette Roussel: Correct. I wanted—

Mr. John Oliver: —which confused me, because there is no palliative health care provider, so we're either training and educating health care providers....

Ms. Josette Roussel: We were suggesting a broader term to reach other health care providers—

Mr. John Oliver: Yes, of all health care....

Ms. Josette Roussel: —all health care providers who will benefit from training in light of the previous discussion around the palliative approach to care.

Mr. John Oliver: For you, is “health care provider” broad enough, or do you think we should be adding “and caregivers” in there?

Ms. Josette Roussel: It's important to highlight the caregivers as well.

Mr. John Oliver: In the proposed legislation, it says identify “measures to support palliative caregivers”. That's paragraph 2(1)(c). Is that sufficient for non-registered health care providers?

Ms. Josette Roussel: We saw that one as sufficient.

Mr. John Oliver: Sharon, are you comfortable with that?

Ms. Sharon Baxter: Yes. I just need to mention that the training for health care providers and caregivers is totally different. It's not the same type of training, but they're both really important.

Mr. John Oliver: Sorry, say that again.

Ms. Sharon Baxter: The training we would provide for health care providers who provide hospice care and the palliative approach to care is a totally different training model from what you would provide for caregivers who are helping care for those who are dying. It's different and we actually have some models in this country, so somehow we have to get the language so that it's clearly.... They're both very important, but they're different.

Mr. John Oliver: There is a report that says that out of 77,000 physicians, there are only 51 palliative care specialists and only 123 family doctors who have training in palliative care. Also, out of 360,000 RNs, 1,348 have certification in palliative care. My sense is that we need to do broad training of health care providers, and I'm sure, other categories as well.

The last question I have is in the concept and definition. When does palliation end? I've heard from some families, particularly who have come through hospices, that they've had tremendous support through death, but as soon as death occurs, they're done. In terms of the bereavement and closure for families with the caregivers who were side by side with them through the death of a loved one, it's an abrupt loss. Are you aware of any models that extend palliation to some kind of closure and bereavement process for families?

● (1135)

Ms. Sharon Baxter: The existing hospice palliative care programs spend a lot of time on bereavement and actually try to carry the bereavement past the point of death, but they're not funded within the health care system, so it's done by those programs and it is not done by the programs that aren't doing it.

Really quickly, one of the things you can do.... The compassionate care benefit—the federal benefit that we have all endorsed—ends the day your family member dies, and we've asked for them to extend it for a period of two weeks. It makes sense. They're looking into it. We heard that they took our repeated letters seriously, and they're going to look into it.

We have to pay attention to bereavement. When you don't do the service well and you don't provide support to family members who are bereaved, they end up in the health care system themselves, so it's very important.

Thank you for asking the question about bereavement.

Mr. John Oliver: Thank you.

The Chair: Mr. Webber, I understand you're splitting your time with Dr. Carrie.

Mr. Len Webber: Again, Mr. Chair....

The Chair: We're going to have one round.

Mr. Len Webber: It's one round now.

Can I just have a little bit of a rant here for a minute?

We have probably two of the top experts on palliative care in Canada here presenting to us, and we've had to cut Sharon off of her presentation. Now we're only going to give them seven minutes each to present to us. I find that disappointing.

We've tried to shorten down our study here on palliative care by limiting the witnesses and cutting down presentations. To me, I just think we're not doing a thorough study by doing that, so I'm just disappointed. I wanted to express that and now I feel better expressing that.

The Chair: Okay. We'll start your time now.

Mr. Len Webber: No. I'm still raving here, Mr. Chair.

I just need clarification. We have seven minutes for the Conservatives to ask questions, and that's all.

The Chair: We have two panels. We can't get through everything if we do four rounds of questions.

Mr. Len Webber: Why are we doing so many panels on one day, then? We should have two hours with Ms. Baxter and Ms. Roussel. I don't know why we have to be in such a hurry. They've made a great effort to come here today, and we are just cutting it short. I'm very frustrated by that. This is an important study. It's an important bill.

Thank you for listening to my raving. You can start the time now. Actually, it's not funny.

Anyway, thank you Mr. Chair. Thank you, Josette and Sharon, for being here today.

Thank you, Mr. Oliver, for bringing up the bereavement portion of care and palliative care. I think it is incredibly important that there be bereavement support out there and that it be funded. It's of key importance to the families who are survivors of their lost one.

I want to bring up another important issue, and that is spiritual care for patients who are in palliative or end-of-life care. I think it is incredibly important to have it. Cancer advocates, patients, and caregivers are raising concern in Alberta right now about a decision that Premier Notley and her NDP government have decided to implement, and that is to remove spiritual care from the funding of palliative care. I find that to be an extreme shame as well.

My question to both of you is this. How important do you think spiritual care is in the spectrum of palliative and end-of-life care?

Ms. Sharon Baxter: We have national norms and standards for hospice and palliative care that were developed in 2002 and revised in 2012. They came up with nine domains of care that are important to deal with when the patient is getting near the end of life. Only one is medical care; only one refers to pain and symptom management. The other domains refer to spiritual care, psychological care, grief and bereavement, and.... I won't get into them all because I likely won't remember them all, but there's a lovely little chart.

They're all equally important. When somebody's in the last stages of life, it's not necessarily just pain and symptom management—the medical side of things—it is the spiritual care, and it's very important. I hadn't heard that about Alberta, but the model of specialist care includes physician, social worker, spiritual care adviser, maybe an occupational therapist. It needs to be whatever is needed, and it needs to be comprehensive.

● (1140)

Ms. Josette Roussel: The quality of palliative care is best when it's offered through a team-based approach, and spiritual care is a part of that approach and very important. Nurses know that first-hand, when we are listening to our patient's conversation at three o'clock in the morning, when they're in distress.

Distress has different meanings, especially when you are living those circumstances of end of life. You are either having physical symptoms of distress, or it could be spiritual. It could be symptoms that you need to discuss. It's part of a quality palliative approach to care.

Mr. Len Webber: I completely agree with you. It's just shocking that Notley is cutting funding in that area.

I don't know how much time I have left—

The Chair: It's three minutes and 31 seconds.

Mr. Len Webber: —but I have to share now. I will pass on to Dr. Carrie.

Mr. Colin Carrie (Oshawa, CPC): Thank you very much, Len.

Thank you very much, Mr. Chair, and thank you very much to our witnesses today. This is so important.

I want to get right to my questions. My first one is to the CNA.

You mentioned expanding the training for health care providers. What leadership role have you taken, in the nursing profession, to get that extra certification or specialization? I know some other professions are working on things, but could you give us some examples of what you think are important when you're looking at how to integrate it and looking at the state of training?

Ms. Josette Roussel: Currently we see gaps, and we're actually working with the Canadian Partnership Against Cancer on nationally examining educational gaps for all professionals: nurses, physicians, and other professional groups. We haven't completed our survey, but we're finding that there are gaps. We certainly see that this is an issue that we should address earlier on in the curriculum and integrate this aspect of care early, before the professionals are practising.

Of course, what we've done as an association is to provide nurses with experience in hospice palliative care the opportunity to gain a national certification. It provides them with a specialist title and certification that's nationally recognized. We have 1,400 nurses. They're specialized. It's not enough; we need more. Of course, we're promoting the certification program and attracting employers to really enhance the uptake of this certification. It has a lot of benefits.

Continuing education is very important. Right now, before I came to do the presentation, I was just reviewing the current programs available, and there are very few. There are some in Ontario, certificate and post-certificate programs for nurses, and there is one in Quebec, but I saw it was closed for this year. Very few programs are available, and nurses have to manage continuing education by their employers. Pallium is a program that's really been successful in reaching out to teams and nurses. Virtual Hospice is another great resource for nurses, but we can do more, of course.

Ms. Sharon Baxter: CHPCA was the co-lead on the EFPPEC project that is educating future physicians in end-of-life care and trying to get palliative care education into the curriculum of family physicians. It ran for five years. It was a federally funded program. We had about 40 hours of training in the schools of medicine, and that has been decreased over time. It has not increased; it has actually decreased.

We also ran the SCOPE project, which was creating the social work curriculum. I'm actually a social worker by training. We created national social work training, but there was no funding to carry it on. To this day, none of the schools of social work actually offer it as a full package. We've done some of the preliminary work of creating these core competencies and curriculum, but we haven't been able to push it out. It's a growing need.

The Chair: Thanks very much.

Mr. Davies.

Mr. Don Davies (Vancouver Kingsway, NDP): Thank you, Mr. Chair.

I have a number of questions, but before I do, I have to correct the record because Mr. Webber has misled the committee here.

There's been no cut by the Notley government of any spiritual specialists. I've just quickly Googled it. There was a decision to cut a specialist position at the Tom Baker Cancer Centre, which was made by the director of that centre. It was not a decision of the Notley government whatsoever.

As a matter of fact, I'll quote, "Alberta's Health Minister said [the centre] reassured her office that patients seeking spiritual guidance or comfort in the TBCC will receive it."

In her quote, Minister Sarah Hoffman said, "Access to spiritual support can not only be crucial on a personal level to a patient, it can also have a meaningful effect on the patient's recovery and well being." She added that Alberta Health "will be following up with AHS to monitor the transition" to ensure that spiritual services are provided.

I just wanted to clarify in case anybody was misled by Mr. Webber's comment.

What is true, though, is that the Conservative Party, which Mr. Webber is a member of.... One of the first acts of the Harper government was to eliminate the federally funded national secretariat on palliative and end-of-life care when they first took office in 2006. That cut the budget $1 million to $1.5 million from that secretariat. Over the last 11 years we've been without that funding.

I think it was you, Ms. Roussel, who referenced that it would be your advice that the government should re-establish a national secretariat to coordinate a national palliative care strategy.

● (1145)

Ms. Josette Roussel: CNA would support the reinstatement of the secretariat, given all the progress and needs that we currently have in developing a national framework.

Mr. Don Davies: Thank you.

Ms. Baxter, pardon me if you've answered this, but I want to be clear. You pointed out that there are fewer than 85 residential hospices in the whole country, with an average capacity of only nine beds. You stated that we're talking about hundreds of beds, not thousands of beds. In your view, approximately how many new hospice beds would we need to make available in Canada in order to adequately address this shortage?

Ms. Sharon Baxter: It's all about providing the right level of care and the right setting of care for the right patient at the right time. Residential hospices are terrific to provide care for those who are dying with a cancer diagnosis or something that's complex, and we need more than what we have.

However, in a rural community, having one residential hospice in a jurisdiction that has 200 miles of travel doesn't make sense. We need to look at all the models of care. Residential hospices are important, and we could do much better. We need more. I won't put a number on how many—

Mr. Don Davies: Has there been any work done on a number? That's the purpose of my question, to get an idea of a number.

Ms. Sharon Baxter: There is not a firm number.

Here's the thing with residential hospices. In Ontario, the Ontario government has invested money to build more residential hospices, but because their funding model is not 100% funded, they really need the support of the community to be successful. They need them to be driven by the community.

Mr. Don Davies: Thank you.

Ms. Roussel, I want to come back to you about nurse practitioners.

The CNA's 2010 submission to the parliamentary committee on palliative and compassionate care argued that the federal government should remove federal barriers that prevent nurse practitioners and other health professionals from practising to their full scope of practice in relation to end-of-life care.

Do those federal restrictions still exist, and if so, what advice would you give this committee to improve that situation?

Ms. Josette Roussel: Since 2010, we've had progress on a federal barrier that was affecting palliative care. It was related to the prescription of controlled drugs and substances. The regulations were in place in 2013.

The remaining federal barriers to a full scope of practice for nurse practitioners are in relation to federal policies and forms of different departments. We've been meeting with several officials, members of Parliament, and ministers on this issue in the past eight months. We are progressing well. Everyone understands the issue and is in agreement that these barriers should be removed in order have an optimal workforce and use of that team approach.

Mr. Don Davies: Thanks, Ms. Baxter. I probably have time for one question.

Ms. Roussel, if you want to answer this after Ms. Baxter....

Ms. Baxter, in a letter published in the *Toronto Star* last year, you wrote:

> We are at a crossroads: Awareness of hospice palliative care in Canada has never been higher with the recent media spotlight on assisted dying. We can either focus on making HPC a guaranteed right in the next Health Accord being negotiated right now, or we can engage in a re-branding exercise.
>
> We are largely a death-denying society and no matter its name, hospice palliative care will continue to be the pariah in the room until it is made a healthcare priority.

I think those were wise words.

In your view, should the federal government propose stand-alone funding for palliative care in the current health accord negotiations, rather than grouping it in the much broader home care envelope?

● (1150)

Ms. Sharon Baxter: The charge from the Prime Minister in the letter to the health minister was $3 billion for home care, including palliative care. They've stopped the "including palliative care" in some of their notifications, which is a concern for some of us.

We just need to make it a priority. It can't just be home care that we make a priority because Canadians die in many settings. Home care is a big issue. If you ask Canadians where they want to die or where they want to live for as long as they can, it's going to be at home. We can do a much better job. If we fail at keeping them at home, they end up in an acute-care hospital bed, which is the most expensive part of our health care system. We can do a much better job. The level of patient-centred care in a hospital when somebody is lying there dying is not great. In some cases, they have to be there because they need more nursing care than what can be provided at home. We need to find the balance. It needs to look at all those settings of care. It's really important that we do that. I'm not bent on that having to be under the home care dollars, but it needs to be funded in a comprehensive manner.

Mr. Don Davies: Ms. Roussel, do you have any opinion?

Ms. Josette Roussel: We think it's a matter of discussions between the provinces and territories and the federal government. We were vocal around the better home care aspect. We have an action plan around advance care planning, which I brought.

As Sharon said, it's a matter of having sufficient access to it in home care and in hospitals when it's needed. It's a matter of having options for Canadians. Right now, they don't have sufficient options.

Mr. Don Davies: Okay, good. Thank you.

Mr. Chair...?

The Chair: No, you're done. Thank you very much.

Dr. Eyolfson, you're up.

Mr. Doug Eyolfson (Charleswood—St. James—Assiniboia—Headingley, Lib.): All right. Thank you, Mr. Chair.

Thank you both for coming. I practised medicine for almost 20 years in emergency departments, so much of what you say is resonating quite loudly with me. In the emergency department, we see holes in the system from just about every angle coming into our department, and one of them is our palliative care system, or more often, the lack thereof. People come into the emergency department and what they obviously need, from the state of their illness, is palliative care.

One our of frustrations is that very often when the specialist, very often an oncologist, has said there's nothing more that can be done, the patient is put back into the hands of the primary care provider. Primary care providers don't always understand what's involved and how to access that system. You may have alluded to this, but should a national education program of all health care providers be provided, particularly addressing when to bring this subject up?

Ms. Sharon Baxter: That's what “The Way Forward” is about. It's about the palliative approach to care, so it's less about the specialists' care and more about the family physicians, the emergency wards, and whatnot being able to have the right conversation with the patient, know where they can refer to if they need to refer, and find the right level of care.

We really haven't really done that much.... This is new for Canada, and we really haven't done that. We did an Ipsos Reid poll of physicians and nurses in this country as part of “The Way Forward” project two or three years ago, and we found great receptivity—these were people not working in hospice palliative care—about knowing more about palliative care, being willing, and citing this as a gap in their care. The sky is the limit on being able to roll this out, but we haven't rolled it out yet.

Mr. Doug Eyolfson: Further to education, one of the frustrations we also have is that there are patients who obviously need palliative care, their care providers know this, but for many patients and their families, there's a misunderstanding of what palliative care means. All they understand about palliative care is that they're giving up. As Mr. Davies so eloquently said, we are a death-denying society. We are.

I have had patients come in and they're not plugged into palliative care when they obviously should be, and it's at an hour when I can get hold of their primary care provider, who tells me, “I've been talking until I'm blue in the face; they won't accept palliative care because they think it's giving up.”

This is even more of an issue in patients who are a different cultural group, a different diaspora, or recent immigrants who are having trouble understanding so much of our society. They think that everyone is just giving up on them, but they don't want to give up.

Should there also be a push to educate the general public about this, so that people generally have this on their radar before any diagnosis even comes up, before they even think that they need it, so that they have some idea of what this is and what it can provide?

● (1155)

Ms. Josette Roussel: It's very, very true. We see this first-hand as registered nurses, and it's a whole culture shift about having a conversation and explaining what it means in words that are not so definite. It's a shift that we've done recently. I worked in Ottawa as a registered nurse at Bruyère, and we've had these conversations with the patients and family and explained that, as their wish is that treatments will continue, we're here to support them and ensure that their quality of life will remain. That's true that there's a lack of knowledge and understanding on what it means, and as providers, we're not giving up.

Ms. Sharon Baxter: There's a national program called “Speak Up: Start the Conversation about End-of-Life Care”, which is run by my association. It's part of the advance care planning in Canada project. One of the things we found is that nurses and physicians and others who work in the field, but don't work specifically in palliative care, have a hard time having those conversations. There are a lot of tools that have been available that are now available to some of the health care providers to start having those conversations. Canadians are being encouraged to have those conversations, as well, within their families around what they want, what they think they want, and all these sorts of things. It's becoming more and more important to do this as we get to be an aging population so that we know what our loved ones want. We encourage that to be picked up too.

Again, it's been meagrely funded. How do you roll some of this stuff out? It becomes important that we have these conversations with Canadians.

Mr. Doug Eyolfson: Yes. This is more a comment than a question. From my own experience the shift in earlier medical terminology—and, of course, in medicine we love our terminology—we sometimes will mean something in a benign way, but it doesn't come across benignly to the patients.

Everyone remembers the days when it was common to say DNR for "do not resuscitate". That term strikes terror into patients and families. If you say DNR they think someone's being put in a back room and forgotten about. Since we've changed the terminology of levels of care, we're doing the same thing, but explaining. We're doing everything that can be done up to this point, and that one type of care isn't appropriate. We can get people to accept that, which is exactly the same as a DNR, but again it's just not in those brutal terms.

I think the medical profession needs to do a better job in getting terminology out there that people understand and are more accepting of, and making sure that people understand what these terms mean. I think that could be part of the training and part of the conversation that would help to facilitate a lot of patients into accepting and embracing palliative care.

Ms. Sharon Baxter: Agreed.

Ms. Josette Roussel: The Speak Up campaign has a lot of tools. We've had great success in providing general education and giving access to these great tools.

Ms. Sharon Baxter: All the provinces have instituted some sort of legislative framework around advance care planning, advance directives, whatever they are calling them in each province, so it's starting. But how do you get to Canadians? It's a big issue.

Mr. Doug Eyolfson: Exactly.

Thank you.

The Chair: Okay. That's perfect timing. The time is up.

That completes our round with our present guests.

Mr. Webber has raised the issue about not enough time. We just have a two-hour meeting. We have two panels, and we have given one hour to each panel. It's important we hear from as many witnesses as we can. You're not being shortchanged. We just have only so much time. We do the best we can. We appreciate your contribution very much. Every presenter today is important to us. Every presenter has something to help us make our decisions.

I want to thank you very much for coming. We're going to take a little break because some PowerPoint presentations have to be set up. Then we'll be right back.

● (1200)

(Pause)

● (1205)

The Chair: We're going to start our next session. Are we under way with the names in the right places? Yes? Very good.

For our second round, we have with us the Canadian Society of Palliative Care Physicians, with Dr. David Henderson. Dr. Henderson has given me a primary course in palliative care over the last year and a half or so. We also have with us Dr. Martin Chasen, medical director of palliative care for the Brampton Civic Hospital.

We're going to start with Dr. Henderson, I understand. You have 10 minutes. We're going to have one round of seven minutes for questions, but you have 10 minutes.

Dr. J. David Henderson (President, Canadian Society of Palliative Care Physicians): Thank you very much.

It's a pleasure to be here. This is such an important issue that we are thrilled to be here to help support this.

To quickly come to the point of the matter, our society certainly recommends the acceptance of Bill C-277. We've been supporting this concept for quite some time. We're thrilled to see this coming forward and to see the uniformity across all parties in understanding this need and the importance of this issue. We're happy that this is moving forward. We're here to help make sure it moves forward, and we'll do what we can to support it.

I know that you have already had several presentations and are getting the big gist of things, but I want to bring us back to a big picture and down to earth a little. Despite Dr. Oz and all the wonderful health care you get through Dr. Google, the world mortality rate unfortunately is still at 100%. We'll all die eventually, so this is really the only issue that is non-partisan. It's non-faith-based. It's women, it's men, and it's children. This is something that affects everyone.

We're all going to be dealing with this at some point, but dealing with this today is different than it was even 50 years ago. With the advent of some of the advances in health care, dying has changed. It has become more complicated and we need to be able to address that.

I think the aging demographics that we're facing have been discussed before. The graph I have here is a nice one to give a good visual of where we are and the urgency with which we need to move these things forward. If you look at where we are on the graph, you'll see a very large jump from 2011 to 2021 in the number of people who are going to be 65 and older. We know we're human beings. We know we have parts that wear out and break down, and we can't get replacement parts very readily, so things are going to happen. This is going to be the largest part of the population that ends up driving the demand for palliative care services. Again, as that baby boomer generation is hitting this age group, we can see very dramatic increases in the numbers, very significantly so.

I've actually put myself on the graph. I'm coming into this, too, so one could say that this is a very self-serving thing for me, because not only do I want to make sure that I can get the care I'm going to need down the road, but I've put in my son, who's now 15, at where he will be at 65, so that coming down the road for my children and my children's children we will have a strong foundation for the type of care they're going to need as well.

As I look around the room, I see a couple of grey hairs here and there, so you know what? If there's no other good reason, folks, this is for all of us sitting in the room, and also, some day, for some of the younger people sitting off to the side.

Where are some of our current gaps? I've broken it down very basically into professional and human resources. We've talked about that a bit, about just the sheer numbers of people with a bit more of that advanced training in palliative medicine, or the specialty training, and that builds into the skilled providers. Along with that aging demographic, it includes those of us working in palliative care. We have an aging demographic of skilled labour as well, and that too needs to be replaced as time goes on.

In the current gaps in terms of public issues, access now has been well documented as a big issue. There are pockets of places where access is pretty good but likely could be better. I know that in our neck of the woods—because on the east coast we do have some of that aging population—we're probably a little bit skewed on the curve. We have wait-lists now to access palliative care services, which is just atrocious, but that's the reality of the world right now.

As I said earlier, people are living longer with multiple comorbidities because we've been able to manage their renal failure and manage their heart failure. As well, they may have a couple of new arteries in their heart, so they're pumping longer. We've advanced some things, but at the end of the day we still have people with more chronic comorbidities that complicate things as they are getting older, and as these organs and parts still continue to wear out.

There's a higher complexity from the physical nature of it, but it's also a higher complexity because of our generation too. We have a lot of people who have been moving back and forth across the country for work opportunities the way our children do, so often there are not as many caregivers around family-wise to help provide the care in the home that we used to have years ago.

● (1210)

Again, with the aging demographic, we have higher numbers requiring care, and because people are living longer, often there are lower numbers of care providers. If someone is 91 and their spouse is 92 and a fair bit of physical care needs to happen, there are limitations, because of that age range, in what they can and cannot provide physically.

As far as informational gaps that we're facing go, again we still don't have national indicators for palliative care across the country. We don't have our national standards. There's no national reporting and there's no national oversight. That's one of the key things I think this bill can actually bring to the table and really needs to bring to the table. We need that large-scale look at how things are going in a unified way so we can start to look at how things are being done across the country and optimize best practices and make sure they get translated across the country so that we can all do better.

Some great work and some great projects have been done. Now is the time to be taking those and implementing those across the country. As I've said in the past, the time of pilot projects should be done. We need to be moving forward.

I'll just very briefly make one statement, and I think maybe Mr. Oliver made a comment on this earlier. Medically assisted dying is not a choice when there is no other choice. Unfortunately, that's the way it is in Canada right now because of the lack of access to palliative care services.

Bill C-277 would fulfill some of the recommendations that were brought forward in the Special Joint Committee on Physician-Assisted Dying. Specifically number 19 was to:

> re-establish a Secretariat on Palliative and End-of-Life Care; and that Health Canada work with the provinces and territories and civil society to develop a flexible, integrated model of palliative care by implementing a pan-Canadian palliative and end-of-life strategy.

Number 18 was to:

> ensure that culturally and spiritually appropriate end-of-life care services, including palliative care, are available to Indigenous [people].

This bill would also ensure that palliative care is provided to the people the federal government is responsible for providing health care to. The groups under federal jurisdiction include first nations people living on reserves, the Inuit, serving members of the Canadian forces, eligible veterans, inmates in federal penitentiaries, and some groups of refugee claimants. We need to ensure that we have national standards in this for that population as well.

The bill talks a little bit about the Canada Health Act. When we really start to look at the Canada Health Act, we see that it says that all Canadians should have universal complete access to care. Approval of Bill C-277 would ensure that Canada set the standards for access to quality palliative care for all ages including children, all geographies, and all diagnoses.

To ensure that Canadians have access to high-quality palliative care, we have developed a couple of documents recently that we sent to all the members previously and can certainly make available again. The web connection is present there for you. Basically we're stating clearly that we need to look at implementing the palliative approach to care as outlined in the national framework document “The Way Forward”, which you've heard about today and, I think, previously as well. That document is a good foundation for how things should be moving forward. We, along with many other palliative care organizations and other organizations throughout the country, have endorsed that.

Again, we don't need to start from scratch. One of our key messages is that we need to start to work on implementation as opposed to doing further development.

The second document, which we released just a couple of weeks ago, was looking at the cost-effectiveness of palliative care. Very briefly, some of the different studies looked at lowering costs of delivery by up to 30%. Even more importantly when you look at the delivery of this care, it will also help to free up scarce resources in acute care such as beds in intensive care units for patients who truly need them.

When palliative care can be involved early on, you start to have some of those discussions about goals of care and what the patients' wishes are and their understanding of their illness. They can realize that going into the ICU may not be what's really in their best interests. It's not going to fix things. If we can keep people out of the ICU, for whom there really isn't going to be true benefit, that will open up those beds for somebody else who truly can benefit from using up those very limited resources.

Again, we come back to that aging population. There's going to be a bigger demand on everything throughout health care. There are going to be more people who will need those intensive care beds, so we need to be really making sure we utilize our resources as efficiently as possible. At the same time, while we're offering the same type of care, we're improving quality of life and quality of care for patients with serious illnesses and for their families.

● (1215)

Health care costs have been escalating as a consequence of our failure to adapt to the changing demographics of Canadians and advances in chronic disease management, including cancer. Change is now long overdue. Continued failure to invest in palliative care will be a lost opportunity to achieve better efficiencies, improve outcomes, and reallocate budgets to other priorities. The status quo really neither meets Canadians' needs nor is financially sustainable.

What we're recommending certainly is the forward movement and acceptance of Bill C-277. We'd really like to see an established well-funded secretariat, and the formation of a small, nimble, high-level working group made up of key national organizations to start working with the secretariat on implementation.

Focus needs to be on administrative cost containment so that funds can see their way to the delivery of services. We've seen other projects go on and lots of money put into major infrastructure, which unfortunately hasn't translated into a lot of key things hitting...your rubber hitting the road. This is something where there's lots of good work happening across the country. We have shown in the palliative care world that we work well together. We've been doing things on a shoestring for years. This can be done efficiently. We want to see the monies get to providers out in the areas with increased resources so that we can actually make those differences that need to happen.

We need to bring in additional stakeholders, when and where required, to develop the efficiencies, gain the insights, and mobilize strategies. Having another 100-body committee to work on things is going to be very slow and tedious. Again, you see by that demographic curve, we're into it now. We don't have 10 or 15 years to be doing this. Our hospitals are already starting to be overloaded. I know in Nova Scotia they have overcrowding. They're having to develop new terms to label the levels of overcrowding we're having in some of our hospitals because of this aging demographic and the demands.

What is needed? Again, we need to start with what we know. We really need to be collecting standardized national data. That can happen as well through a national secretariat to help move that forward and make sure we're doing this: setting, monitoring, and enforcing national standards and indicators for palliative care in Canada; and making accreditation of health care services both in hospitals, long-term care homes, home care services, etc., all mandatory and contingent on palliative care services being provisioned to nationally accepted standards. We also need to—and my colleague here will be speaking to this, I think, a bit more—standardize and insist on integration of core competencies in the schools of health care professionals.

We had the opportunity to hear from the Canadian Nurses Association today. I know for medicine, for nursing, for social work, and for pharmacy in particular the core competencies are developed. The big challenge has been getting those integrated within the health care professional schools. That is something for which we may need some federal pressure to help make that happen. We've been advocating. We've been trying to get that to happen, but there's so much competition for that time within our professional schools that you have to look to take something out to add some more time in. But, at the end of the day, what we're doing is so fundamental it needs to be there.

● (1220)

The Chair: Thank you very much.

Our next presenter is Dr. Martin Chasen.

Dr. Martin Chasen (Medical Director of Palliative Care, Brampton Civic Hospital, William Osler Health System): Good afternoon to all of you.

I am a clinician in the trenches, and I think that what I'm going to say to you will answer a lot of those questions, because I'm going to show you that it's all practically possible and it delivers good results.

I'll present myself. I am from South Africa. I came here in 2004, to McGill, initially. Then I went to Ottawa, and I'm now in Brampton. I am a qualified internal medicine specialist, as well as a medical oncologist, and I also have a degree in palliative medicine.

In South Africa, which has the reputation of having the most hospices in Africa, we indeed have a recognized university degree. I was in the first class that got it, in 2004. We do see that having it formally recognized changed a lot of government policy.

I'm going to reference two documents. The first is Bill C-277, which clearly says that in order for a patient to have a proper...and to really have a voluntary decision to participate in medically assisted dying, he must be given the choice of palliative care. I think that has motivated me a lot to develop what we've done.

I'm not sure if any of you know about the 2015 quality of death index. It's a report by *The Economist*'s intelligence unit, and I think it is enough motivation to say that Canada is at number 11 on the list. This is not good enough. Before I got to Canada, I did read that the Honourable Irwin Cotler, in 2002, when he was justice minister, said that palliative care is a basic human right, and I think we should move forward on that one.

You may have heard many definitions of palliative care as an approach that looks at patients who have life-limiting disease and their families, and that is impeccable symptom management. It definitely involves the psychosocial, spiritual, physical, and every other domain of a human being. It's holistic care.

In the World Health Organization definition, there are little attachments that people don't know about, and I'm going to speak specifically about three of these attachments.

First, palliative care “affirms life and regards dying as a normal process”. It doesn't “hasten”, nor does it “postpone” death. It “offers a [full] support system to help patients live [as long as possible and] as actively as possible”, keeping people as comfortable as possible for as long as possible. It has a goal of enhancing quality of life, and once again, it is “applicable early in the course of illness”.

This is not just about end-of-life care. We now know from many clinical trials in patients.... The most topical one is in patients with metastatic lung cancer. The patients who were randomly assigned to receive palliative care and normal chemotherapy had less chemotherapy and lived longer.

This is the model that we put together, initially in Ottawa and now in Brampton. What it looks at is the four pillars. This is a model where we start with an in-patient palliative care service for those patients requiring specialist palliative care: terrible pain that's not controlled, extreme anxiety, or existential issues, so the patient needs to come into hospital to be treated in a palliative care unit.

We also have a consultative service in our hospital, where patients are referred to us from the different wards—orthopaedic, medical, geriatric, internal medicine—and I'll show you that. Patients are seen and treated in conjunction with the most responsible physician. We cannot see all the patients. There are more than enough patients, so our aim is to build capacity. I'm surprised that nobody is speaking about building capacity at such a great level, but we have an enormous obligation to build capacity.

Then, what we recently started is the ambulatory outpatient clinic; we have patients who are able to come to the clinic and are seen. We also—I'm going to show you some results of this—have a robust community service. We have patients being seen in their home by a physician, as well as a nurse. We work as a dyad.

Around the centre of these four pillars, we are embedded within education, because without education we will never be able to build capacity. In our specific area in the LHIN, we have made it a goal to have as many of the LEAP courses as we can to build capacity. I'm sure you've heard of that, learning essential approaches to palliative care, with the Pallium project.

● (1225)

Then, of course, we all need to know that research is important. Why is it important? Because research allows you to have that margin of error. It tells you you're not doing as well as what you want to do, that you need to research this to get better. It's a self-audit. Let's use our model, and it works.

Since I started this program in Brampton, these are the patients who have been referred to us as new patients, and you will notice that the majority, more than 765 patients have been referred to us from general internal medicine. Palliative care is not only about patients with cancer, and I will once again ask you to please not call them palliative care patients. They're patients with cancer, cardiac failure, renal failure, chronic obstructive airways disease. They're patients with a terminal disease.

We're getting patients from all spheres, and this brings in the question: how do we bring it in earlier? How do we start the earlier goals of care discussion? From the ER, we've had 104 patients referred directly to us. How do we start the discussion of advance care directives, not necessarily saying that a DNR doesn't mean any treatment? I like the term ANC, allowing natural causes, but, of course, explaining to a patient that it means that everything possible that can be done will be done to keep them as comfortable as possible for as long as possible.

Here are some little graphs that we can show you since we started the palliative care outpatient clinic at the Brampton Civic Hospital, as well as the Etobicoke General Hospital. We only got it going in April of last year, but you can see that we're having more and more patients referred to us on an outpatient basis. We have already admitted 60 patients into the ward directly from the community through the outpatient clinic. They have not gone to wait for a day or two in the ER, where you have 400 to 600 visits a day, where you have people coming from the long-term care facilities who can wait 30 hours there, where you have 300 patients from the long-term care facilities dying in the ER while waiting to see a doctor.

Seeing them in the community, putting them into the outpatient and then, if necessary, admitting the patients.... You will notice, of course, that the last month or two we've had a decrease in palliative care clinic visits, the reason being that we've had more home visits. We're taking the palliative care to the patients where they want it and wherever we can do it as is best, but it's a dyad. This is teamwork. This is about communication. This is not about the patient belonging to me, and that is where I appeal to you to try a funding model that is not fee for service.

If you have a funding model that's not fee for service, everybody can be obliged to do education, to do research, but when you have a fee-for-service model, it's about how many patients I can collect. That is the one recommendation I would say. We move the patients into the community, but of course, we change the funding structure of how people are paid.

The other program I'd like to speak to you about is the palliative rehabilitation program. This program was designed and implemented very successfully here in Ottawa at the Élisabeth Bruyère and the Ottawa Hospital. The goal of palliative rehabilitation is to enhance the physical, psychological, social, and professional well-being of the patient.

Answering the questions that were asked by Mr. Webber about whether we look at the spiritual aspect, each one of our patients gets a spiritual history. You can have a physical history: how is your pain, your nausea, your vomiting, your anxiety, your depression? But for your spiritual history, it's do you have faith? How important is it to you? Do you have a community that you work in? Do you have community support and how would you like me as your physician or your health care provider to provide a spiritual backup for you?

The palliative rehabilitation patients we're seeing here. I'm just going to show you. This was an eight-week program where we had the patient see the OT, the physio, the dietitian, the social worker, the nurse, and the doctor with the patient and the family at the centre of the team. These are values that are taken before the program and eight weeks later, and you can clearly see the statistical significance of the general activity of the patient that's improved, their mood, their working, their relationships with others, their walking, as well as an enjoyment of life. These are validated tests shown statistically significant.

● (1230)

I have to bring you one of these because this is the patient testimony, if we're talking about patient-reported outcomes and what it means to the patient and their family. They said, “I feel I have been remiss in not writing to you sooner. I cannot say enough about how positive I felt being involved with your team. The thing that impressed me most was your profound respect for me. I think that this was only surpassed by the admiration and respect you had for each other. This allowed me to open up and be more trusting. I knew that anything I shared of value and significance was relayed to other team members. My wife and I were no longer on our own.”

None of our patients want to feel helpless, hopeless, and abandoned. It's our job to take that away from a patient. “Simple things seem to take on a profound meaning 'you need to eat more', 'don't feel guilty about resting', 'you don't have to endure the pain, that's why we give you medication” are a few things that come to mind. As I write I realize that the most important thing is that we felt we were part of a team and that made all the difference.”

So how do I see the future? I see the future with public health, billboards at the side of the road saying, “This is palliative care. It is not physician-assisted suicide”. I also say to you palliative medicine specialty training needs to be brought to the fore. It's happening. It needs a push. The funding of hospital and community palliative care rehabilitation teams, which is not an expensive funding model, have been off course to push the leap as well as the Pallium educational sessions and research.

I thank you for your attention.

The Chair: Thank you very much.

Now we'll start one round of seven minutes with Ms. Sidhu.

Ms. Sonia Sidhu (Brampton South, Lib.): Thank you, Mr. Chair.

Thank you, Dr. Henderson and Dr. Chasen, for coming from Brampton. Your valuable presentation is very impressive and eye-opening.

The first question is for Dr. Henderson.

Does your organization have a recommendation about how to reduce the regional disparities and gaps for palliative care in urban, rural, and on-reserve regions?

Dr. J. David Henderson: We're actually working right now on some staffing models. As my colleague here says, part of the problem with trying to develop what human resources are required for palliative care is that there aren't any good evidence-based models of the numbers of people they have. What is out there starts to talk about how many physicians you need, and that's all it looks at. This can't be looked at as a physician resource issue without looking at a whole-team approach. That's the model we're looking at.

You also can't look at it from a purely demographic numbers approach, either, which is often how it's done. You need *x* number of doctors per 100,000 people. Well, 100,000 people in an older part of the country is different from, say, Calgary, where you generally have a younger population. You have to look at the curves of that same 100,000 people. How many people are over the age of 65? Where are the demands at this time?

We're developing a model that really will be looking at the team approach of how many nurses, social workers, pharmacists with extra training in palliative medicine, and palliative care physicians as a specialty team need to be in an area based on, really, even going back and looking at our death rate, because that tells you how many people, as a better number than just pure population, are needing these kinds of services.

We're in the process of working on that right now, but that is something that's very much needed. There are great models across the country showing how this can be done. Again, I go right back to Dame Cicely Saunders, who was the founder of the modern hospice movement. She said this is best delivered by an interdisciplinary team having access to that good quality palliative care nurse.

Honestly, I see the palliative care nurse as the key ingredient to this whole mixture, especially for community, rural, urban, everywhere, because you can have more nurses out there working with the primary care teams, physicians, nurse practitioners, and so on, helping to guide them a little bit but also helping to ensure that the right assessments are being done, the right information is getting to the primary care team, and when it's more complex, being able to pull in the palliative care consultant to be able to help with more of that expertise.

I think that's the way we need to be looking at moving forward, so we are working on that. Hopefully, over the next few months, we'll have some better, clearer.... I know what we need, but I can't tell you it yet.

● (1235)

Ms. Sonia Sidhu: Thank you.

Dr. Chasen, I had an opportunity to go to the Brampton Civic Hospital where you work. I also toured the geriatric ward. Can you share some of the challenges faced by a palliative care unit on the front line at Brampton Civic, which would provide a useful tool for making Bill C-277 and the future national palliative care plan?

Dr. Martin Chasen: I know the question was asked, how many hospice beds do you need per population? The Gomes formulas dictate between eight and 10 hospice beds per 100,000 of population. If we have a million people in Brampton, we are looking at a lot more than 10 beds, which is what we have at the moment. There are initiatives at a provincial level to build hospices, but we have the issue that 54% of patients are dying in acute care hospitals, when we don't really want 54% to be dying in acute care hospitals.

We have shown that the better the community support, the more likely the patient is to go home and not bounce back into the emergency room. I think that's where our issue is. We don't necessarily need only hospices. We probably need some form of step-down facility in which you don't have a physician going in every day, but maybe every second or third day; in which you don't need one nurse per three patients, but maybe one nurse per five patients; in which you concentrate more on patient care, not necessarily just giving the medication; in which you bring in psychosocial support, which is so poorly lacking.

There is very little funding for spiritual or psychosocial support. Much of the funding is being brought in privately, or from people who are donating money, and from raising money from a charitable organization.

I think palliative care needs to be brought into the health care act. Hospices really need to be brought in as well, so that they're not a separate entity. That could increase the continuum. We don't need fragmented money coming from different areas. We need one pool and everyone should be going along that line.

Ms. Sonia Sidhu: As you know, the William Osler Health System recently opened the Peel Memorial urgent care centre in the Peel Memorial Centre for Integrated Health and Wellness. As we look at the best way to provide palliative care, can you speak about these facilities as alternative methods for health care delivery?

Can you also elaborate on how the home care visit model works?

● (1240)

Dr. Martin Chasen: I'll start off with the home care visit. We work with nurses and the CCACs, which are now part of the lens because it's all at a provincial level. We are making a concerted effort to train as many nurses in that model as possible, going through the LEAP courses and the Pallium courses. This, of course, raises the standard that we should be measuring. We should have outcome measures of how many nurses qualified through LEAP this past year, how many volunteers, or how many physicians have managed to do the LEAP courses.

The nurse-doctor model is the ideal model. I think there is a role for nurse practitioners, specifically in areas in which there is no physician. I do not think that nurse practitioners need to do this on their own, taking the responsibility to actually behave like physicians. The job of a nurse and the job of a physician are not the same. Definitely, the dyad is the best. In areas in which you don't have a physician, then perhaps the nurse practitioner can take on the most responsible person role for the patient.

The Peel Memorial site is of course to enable more patients to get more care. This is one of the areas in which we as palliative care physicians will be involved. It's a nurse-led clinic looking at patients with chronic medical problems.

One of our goals over there is.... The “surprise” question is a gold standard framework question that is not ours. It's developed in the U. K., which, by the way, is the highest country on the quality of death index. The surprise question is asked when a patient comes into the emergency room: “Would you be surprised if this patient were alive in one year?” If you would be surprised if the patient were still alive, he needs to have a “goals of care” discussion. If you're not able to do that, find somebody who can do it because perhaps what you think is good for the patient, the patient or the family don't always think is good for the patient.

That's what I would say.

The Chair: The time's up.

Mr. Webber.

Mr. Len Webber: Thank you, Drs. Chasen and Henderson, for being here today.

My question is to Dr. Henderson. I'm going to come back to spiritual care again. How important do you think it is in the spectrum of palliative and end-of-life care? How important is spiritual care to you?

Dr. J. David Henderson: It's imperative that it's part of it. Throughout my whole career, I've said that the pain and symptom management part of it is the easy stuff. It's the existential suffering that is always the hardest. There are so many things we can do for all the other symptoms, but at the end of the day, this is a monumental time in that person's life and for their family.

We pull apart religion and spirituality. More and more in our country people have moved away from organized religion, but inevitably everybody has some sense of spirituality. It's imperative that's brought into the picture. Otherwise, you've missed the boat completely. Even when we teach about managing pain, we talk about something called “total pain” and that's part of it. If you're not addressing that component, you sometimes can't get their physical pain under control because we're missing that piece of the puzzle.

When you said Alberta's cutting it—and I understand that wasn't quite accurate—my first comment to Kathryn Downer from Pallium, who was sitting beside me, was, “There's someplace in this country that gets funding for spiritual care?” It's not in most places. We rely on the generosity of spiritual care providers, who we identify to work with our teams, and they see this as a real need.

Honestly, they're a challenge to find. Across the spectrum, we talk about education and needing to have our nurses well-educated, as well as physicians, and so on. From the spiritual care community, they need to have education in palliative care. I've been in some situations where a spiritual care provider has come in and completely traumatized the situation. They decided that everybody needed to pray for a miracle when the rest of the family were at peace with, you know, Dad is dying. There are small children in the home, and somebody comes in and says, “We need to pray for a miracle that this doesn't happen now.” That wasn't helpful at all and we had the wife come out crying saying, “Please pull him out of here.”

It's important that you find the right provider who can do this kind of work. No matter in what area we go through, including spiritual care, it's imperative that it's there.

● (1245)

Mr. Len Webber: Dr. Chasen, you nodded your head a few times during his comments. I would think you would agree as well.

Dr. Martin Chasen: Absolutely. As I said, all our physicians now do a spiritual history. It's not developed by us. There is a lot of scientific literature being written by Christina Puchalski specifically. It's a quick part of the history, but it's a definite part of the history. You cannot look at the total person without understanding what the frame of reference is. What is the moral standard? Where do they come from? What do they expect? What do they want? It's a mind-body game we're in.

Mr. Len Webber: Thank you.

Dr. Henderson, you alluded to Mr. Davies' research on Google that indicated that I was misleading this panel here. I did some Googling as well since being accused of misleading this panel. I can quote a Google article from Red Deer, Alberta, indicating that, "Alberta Health Services is changing the way it delivers spiritual care at hospitals in the central zone" of Alberta. It says, "The contracts of about 11 part-time hospital chaplains are not being renewed." These are decisions made by Alberta Health Services, which is being funded by the Government of Alberta. Premier Notley and the NDP government could end that tomorrow. They could provide funding or bring it back, but they chose not to. To be accused of misleading this committee is false and I would suggest that perhaps Mr. Davies do some more Googling, read some more articles, and perhaps maybe come to the hospitals. I've talked to patients who are devastated over the fact that these cuts are being made in spiritual care. It is disturbing. I suggest some more research there, Mr. Davies.

I would like to ask a question to Dr. Chasen, from South Africa. You've indicated that we rank number 11 in the world with regard to palliative care quality.

Dr. Martin Chasen: The quality of death index looks at various aspects. It looks at the palliative health care environment, the human resources, affordability of care, quality of care, and community engagement. Those are the five indices. I think there are 80 different, specific topics, but this is an international document and one that we can be judged against.

Mr. Len Webber: Absolutely.

You're from South Africa. Where does it rank based on your experience there? Is it something we can learn from other countries and what they do? Obviously it is because we rank number 11.

Dr. Martin Chasen: South Africa falls down a lot, maybe, based on the amount of money that's spent specifically for palliative care, but it's bringing it into the governmental policy. There's a clear vision. There's accountability for that vision. There's continued auditing of that vision and there's a setting of standards. That's what we need to do here.

Dr. J. David Henderson: And they struggle because we take their best doctors.

Mr. Len Webber: Yes. Exactly.

Now, you indicated, Dr. Henderson, that some great work is being done here in Canada. Are there any specific places that we can learn from in terms of their best practices? Are there places that stand out from others?

Dr. J. David Henderson: Yes. Almost across the country you can find a pocket of something where you go, "Wow, that's great". I'm from the east coast, so I'll bring this one up. It's quite new. We did a project in partnership with Prince Edward Island where we did training with our paramedics. You may have heard of it. It started off with paramedics actually extending and doing a little bit more work in long-term care facilities. They have their advanced paramedics able to go to a long-term care facility and do a little bit more of an assessment, call back to a physician, and ideally keep that person in the long-term care facility.

Discussions started on whether or not we could do this for other special patient populations. We talked about palliative care. We thought that sounded like a great idea. As you start to look at that 24-hour coverage, how do you get access in the middle of the night, weekends, and so on? They said it was a great project, and we received some funding through the Canadian foundation for innovative health.

They started saying that we needed to do education, so I introduced that project to Pallium, who within a couple of months had developed LEAP Paramedic, which formed the standard training. Over about a month, we provided training to every EHS professional in Nova Scotia and Prince Edward Island and got the project up and running. Now there's a special patient population that we as a palliative care team or even a primary care physician can register the patient for. It provides more information to EHS so that they will know what potentially they will be responding to.

Within that, there are more goals of care for the person so that they will know, yes, they will respond here, but the person does not want to go to the hospital. They will know when they respond that they may need to help address some acute shortness of breath, or acute nausea and vomiting, or something like that, as opposed to needing to pick up the person and take them to hospital.

It has gone over tremendously. I still have on my to-do list a note that I have to write. Yesterday I had a case where one of our patients had developed nausea and vomiting through the night. She was quite dehydrated, quite elderly, and was probably heading toward going to the emergency department. Our EHS colleagues arrived, and the comment I heard from the daughter was that she so much appreciated that they stopped and said, "Okay, let's look at what's going on here" as opposed to saying, "She has this symptom and that symptom. Let's get her to emergency."

They asked what her goals were, and found out that ideally she didn't want to go to hospital. They were calm. They discussed it. They gave me a call. We did some interventions. They gave her some fluid at home and gave her some anti-nausea medication. I was able to drop in a little bit later on, and she was doing much better. So there was a patient who avoided an emergency room visit. She was happier. Her husband was happier. Her daughter was happier. They complimented the EHS team. It's on my to-do list that I need to send an email back through our folks to give a pat on the back to those EHS providers. It's always nice to hear that your work is appreciated.

That's one project, but there are many right across the country. Alberta is doing the same project, and now LEAP Paramedic has incorporated some of the Alberta things. It's been adapted a little bit. There are now really three provinces that this has had uptake in, and it's starting to spread across the country. There are lots of great examples of that. Ten years ago we wouldn't have thought of using EHS as a partner in this, but again, at two o'clock in the morning they can go and they have had some extra education. In Nova Scotia they have some different tools and medications on their buses that they didn't have previously, so now they are able to help make more things happen.

● (1250)

The Chair: Mr. Davies.

Mr. Don Davies: Thank you.

Dr. Henderson, I take it the prime lesson we have to take from this is that none of us are getting out of this alive. Is that right?

Dr. J. David Henderson: Absolutely correct.

Mr. Don Davies: Okay.

First of all, I want to thank both of you for taking the time to be here. I've learned a lot from both of you. I have a number of questions.

You made reference to the wait-list, Dr. Henderson. Can you give us an idea of generally how long the wait-list to access palliative care is in Canada?

Dr. J. David Henderson: In Canada? No, I can't tell you that. A lot of places choose not to have a wait-list. They'll keep trying to see people just as quickly as they can, which means the caseload for their staff ends up becoming kind of monumental. Even within Nova Scotia, there are caseloads where, based on the nurses' caseload, they could have 80 to 90 to 100 patients on their caseload. You can't see most of those people, so how many of them need to be on the caseload? They are just not getting the attention they need to be able to be kept from needing those extra emergency room visits and so on.

In our district, we have chosen to keep a reasonable caseload per nurse of about 25 so that they are able to make the contacts. The 25 is constantly changing.

Mr. Don Davies: You made a reference to wait-lists. I'm trying to find out. It's your term—

Dr. J. David Henderson: We've been up close to a two-month wait-list—

Mr. Don Davies: Two months.

Dr. J. David Henderson: —when the average life expectancy is about six months.

Mr. Don Davies: I've seen some references to the number of people who would like to access palliative care but end up not getting it. Do we have a general idea of how many people are actually getting quality palliative care and how many are not?

Dr. Martin Chasen: The often-quoted figure in the Auditor General's report is about 35%.

Mr. Don Davies: The 35% are receiving palliative care.

Dr. Martin Chasen: They have access to it, yes.

Cancer Care Ontario has a provincial standard in cancer centres of having a palliative care patient seen within two weeks, but that's in a cancer centre in a specialized centre, which I do believe is not where the majority of patients are going to be seen.

In order for us to do what we've done and see those patients in the community, we've had to employ doctors. I will say that palliative care is actually very cost-effective, because those doctors don't cost the hospital any money at all, other than maybe a computer, and hopefully they can get a place to hang their coat up. Those doctors are not ordering blood tests. They're not ordering X-rays. They are admitting patients and trying to get the patients back into the community. We can't really see where that saving comes, but we do know, for instance, that 60 patients didn't go to the ER and wait there. They went straight into hospital.

It's very difficult to understand how to measure the savings, when all of it goes into the black hole of the exchequer.

● (1255)

Mr. Don Davies: Dr. Chasen, in the last meeting, we had some testimony around the need to maybe increase palliative care education for physicians in medical school. I'm getting the sense from you that it's a whole specialized field, a specialty in and of itself, but what can you tell us about what you'd like to see in Canadian medical schools in terms of the amount of time and training they give to each graduate of medical school on palliative care?

Dr. Henderson, you might prefer to answer.

Dr. J. David Henderson: Actually, we just got the green light to go ahead and do a refresh of the EFPPEC, educating future physicians. I think Sharon Baxter mentioned it today.

The core competencies were developed, I think in 2004 or 2005, and the problem was getting those core competencies integrated within the medical schools. What we've seen through some recent research is that the number of hours of this baseline undergraduate education has actually diminished in most schools to a point where it's really quite low.

The core competencies are developed. We need to get them implemented within the schools. We are going to look at refreshing them, but there won't need to be that many changes in them. That's there for physicians. Core competencies are developed for nursing, and again they're having a harder time getting this education into their core curriculum, because there are that many more nursing schools. Again, it's a challenge. They only have so much time, so if you're trying to get something else in, it means you have to take something else out.

Everybody has their own baby that they want to hug and keep in there. It's a huge challenge. The reality is that this education crosses so much. You don't even have to call it palliative care education, because it's applicable to everything you do in health care. So much of it is about communication, effective communication, listening to the patients, understanding the goals of care. Even if they're coming in for gall bladder surgery, if you can do pain management better and nausea management better, you're going to do well.

Mr. Don Davies: I want to end with two questions and let you tell us your opinions. Dr. Henderson, in an editorial you co-authored in *The Globe and Mail* last May, you said the lack of end-of-life care in Canada:

> ...is a national failure to address dying with dignity from an ethical, funding and continuum-of-care perspective. This failure must be acknowledged and corrected in the current discussions around a new health accord between Ottawa, the provinces and territories and our indigenous peoples.

What would you like to see in the new health accord to correct that failure? I'll ask either of you.

Basically, the last question I have is this. What is the most basic, fundamental, and profoundly important advice you would give us as federal representatives to help address this important issue?

Dr. J. David Henderson: We need the leadership and somebody holding the rudder of the ship, so with Bill C-277, it's having a secretariat, starting to form a work group. We can have that oversight to start to put in the standards, to make sure the indicators and so on are in place so that we can gather the proper data so that we can see where the real gaps are, and then really start to fill those.

We have a lot of recommendations on how the gaps can be filled, but we need that oversight and the authority to start saying, “Okay, this has to happen.” There has to be an investment of some monies, and I know there have been promises of monies going towards home care.

I was in Nova Scotia when the last health report came around and there was the basket of services. Within that, there was supposed to be a fair bit of money for palliative care issues within the provinces. I know in Atlantic Canada it was years before we saw anything happen. We did eventually, in Nova Scotia, start to see some improvements in the amount that home care patients with palliative care needs could have. It was just two years ago that we actually had medications, what we call palliative care medication entitlement, in place, so it was that long after to get anything happening.

Those are very basic things. We haven't had any increase in staffing for our programs since 2004 despite having a 400% increase in referrals. We need human resources. We need the specialty teams who can then start to work out, fan out, provide the education, the mentorship, the capacity building to raise the tide so that all the ships rise and we can all do this better.

● (1300)

Mr. Don Davies: The time's up.

Dr. Martin Chasen: I speak often to David, who is the president of our association, but it really needs to come onto the front burner. That's what we need. Palliative care is not an add-on. It is part and parcel of what medicine is. It needs to be brought right onto the front burner with a vision, with the implementation, with the auditing, and with continual improvement.

The Chair: Mr. Ayoub.

[*Translation*]

Mr. Ramez Ayoub (Thérèse-De Blainville, Lib.): Thank you, gentlemen.

That is very worrisome and your presentations were very informative.

[*English*]

How long do I have? How many minutes?

The Chair: You have seven minutes.

Mr. John Oliver: I think it was my round.

The Chair: Do you want to...?

Mr. Ramez Ayoub: I don't mind. If you have more, go ahead.

Mr. John Oliver: First of all, thank you very much for your presentations, excellent content.

To be clear about the committee, we're reviewing the bill. Many of your comments were very important and I think very insightful, but they're probably for the next phase. If the bill gets approved, then the minister would convene provinces and territories and palliative care providers such as you to talk about how to build the framework, and then how to move that framework forward across Canada. A lot of your comments and some of the questioning from the committee is really, I think, in that broader, second-stage context.

Our job is to review the bill and modify it or approve it. I guess that's my first question to you. You've both seen the bill. Were there any amendments, any changes, that you thought would be appropriate to it?

Dr. J. David Henderson: Yes, and we've submitted our document. We have really one change.

Mr. John Oliver: But that was about data-gathering, wasn't it?

Dr. J. David Henderson: Actually, the one change was take out “develop” and move straight to implementation because so much has been—

Mr. John Oliver: Sorry, what was your amendment again?

Dr. J. David Henderson: In our submission to this committee, the only recommended amendment would be to delete the words “develop and” from subclause 2(1) and just have “implement a framework designed”.

Mr. John Oliver: The issue, just so you're aware, with that amendment is that there's federal and there's provincial and territorial, so implementation of a palliative care program is absolutely provincial-territorial responsibility. The role federally would be to work to make sure there's a framework put in place to have definitions around it, but implementation or operationalizing is territorial-provincial territory. I'll just provide you that feedback.

The preamble of the bill doesn't talk broadly about the benefits of palliative care and why we need it. Much of your presentations were around the significant shortfalls we have. It is more couched against this: since we now have physician-assisted dying, we need to have a full palliative care program around it. Personally, I would like to have seen a broader endorsement of palliative care, not because we have PAD or MAID, but because we need this regardless.

Did you read through the preamble? Did you have any thoughts on that?

Dr. Martin Chasen: I fully agree with you. It seems as if this is in reaction to the medical aid in dying when it actually should have been the primary care that should have been given to the patients, with palliative care, as Carter said, as a basic human right. That should have been the model presented, and then later....

However, it didn't happen that way, so we now move forward and say, yes, we need to present palliative care as a viable option, but understanding, of course, what palliative care is. That's why I think the public health help is very important in this. It's to make the populace aware of what palliative care is and that it doesn't mean just a one-way ticket.

Dr. J. David Henderson: Going back through the years, there was the former secretariat, and there was Sharon Carstairs who served. There was so much work done much prior to MAID that was outlining the need for palliative care.

The reality is that those of us working in palliative care knew for years that the only thing that was going to put palliative care on the minds and eyes and tongues of Canadians was euthanasia becoming an issue. That's really the only thing that has brought it to the public's attention to push this forward, which is I think why we are kind of tailing onto it. We don't want to see palliative care fall off again, which is a big concern we have had. Our concern is that as soon as the MAID propaganda dies off—no pun intended—palliative care will be shoved back in that box and back into the corner and won't be looked at again.

● (1305)

Mr. John Oliver: That's an excellent perspective on this. Thank you.

Under paragraph 2(1)(d), the wording in the bill is “collects research and data on palliative care”. This is the role. This is the framework. You had some wording changes to that. Did you not say “collect standards”, or was that the people before you? Did you have a wording change on that?

Dr. J. David Henderson: We need to have the standards clearly defined. Even at Accreditation Canada right now, they're creating standards for looking at palliative care within facilities, and even within facilities, you must have a 10-bed-plus unit before they start to look at some of those standards. I received an email a couple of weeks ago saying that they are now looking at developing standards for the community part of the care as well, which is great. I've offered to help with that as well.

Again, we need the national standards to measure things by. A lot of the questions that come up are hard to answer because there aren't these national standards that need to be there. We've been working on it for years in terms of national indicators and deciding what the specific indicators are that we need to be measuring that are going to be beneficial to the patients and families, because they truly will carry that kind of information away, as opposed to indicators that are going to show, yes, you're worth your weight in salt kind of thing.

Mr. John Oliver: It would be collecting research and data on palliative care, which is valid in and of itself, and then you would look for another clause to develop national care standards or national...?

Dr. J. David Henderson: That's right, national care standards.

Mr. John Oliver: It would be national care standards and quality indicators—

Dr. J. David Henderson: Yes, exactly.

Mr. John Oliver: —for improvement.

Dr. Martin Chasen: If I may say so, I don't know what they mean by “collecting research”. I would say that it's “encouraging research and collecting data” or “stimulating research”—

Mr. John Oliver: Or promoting research—

Dr. Martin Chasen: Yes, promoting research.

Mr. John Oliver: —and collecting data.

Dr. Martin Chasen: Yes.

Mr. John Oliver: That's good. Thank you very much.

That's all I have, Mr. Chair.

The Chair: All right. That completes our session.

I want to point out to the members of the committee that Dr. Henderson was scheduled for Tuesday, and he spent Tuesday at the airport in Halifax. He called me just before the committee meeting and said that he was between cancelled flights and couldn't get here, so he spent that day for the committee but not at the committee.

Here you are again today, Doctor. I appreciate your commitment. I know that in the long term you've been devoted to palliative care. It won't fall off the table as long as Ms. Gladu is here, I can assure you of that.

Dr. J. David Henderson: Thank you.

The Chair: Dr. Chasen, it's interesting that you're from South Africa and one of our witnesses yesterday had roots in South Africa as well. I don't know what the South African influence is, but it's interesting.

We very much appreciate your contributions. They've been very helpful to us. I think we're making significant headway here.

Dr. J. David Henderson: Thank you very much.

I'd like to make one comment, which I'd like to offer to this committee. Palliative care is a complex entity, as I'm sure you're gathering. It crosses hospital acute care, community and long-term care, homeless people everywhere, rural and urban.... It's so diverse. It includes spirituality and so on.

Pallium has a module on it. It's the LEAP “Taking Ownership” module. It's under “LEAP Core”. It's a one-hour module. I will offer that, if you as a group would like to get it. Again, it's a one-on-one on palliative care. It's appropriate for people who aren't physicians. We've provided that as part of the LEAP core presentation that we give to nurses, physicians, social workers, pharmacists, and so on. It gives you a good perspective of what we talk about, and I think it would give you a better understanding of palliative care in general.

I'll throw that out there as an offer. I would be happy to make myself available at any time if you want to do that, just to try to give a better foundation if you felt you needed something like that.

The Chair: We'll discuss that, but thank you very much.

Now we have a little committee business we have to do, as quickly as we can. We have all-party agreement, I think, on changing the schedule. The next meeting is going to be clause-by-clause. That's settled. The meeting after that will be on M-47, on March 23.

Would somebody move the adoption of the budget for Bill C-277, to help pay our witnesses?

That's moved by Dr. Carrie.

(Motion agreed to)

The Chair: Thanks for that.

Just before we leave, one last thing. We need to adopt the work plan for M-47. Everybody has a copy of it. Do I have a motion to adopt the work plan for M-47?

Thank you, Mr. Viersen.

(Motion agreed to)

The Chair: That's it. The meeting is adjourned.

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