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Proceedings of
OUR LORDS THE SICK, OUR LORDS THE POOR

A Symposium in Honour of the
900th Anniversary Year of the
Order of Malta

April 25, 2013

Bridget Campion, PhD
Rory Fisher, O.Ont., MB, FRCP(Ed)(C)
Editors

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TABLE OF CONTENTS

Introduction	5
The Frail Elderly and the Health Care System <i>Rory Fisher, O.Ont., MB, FRCP(Ed)(C)</i>	7
Our Lords the Sick, Our Lords the Poor: An Introduction to the Social Determinants of Health <i>Bridget Campion, PhD</i>	19
Power of Attorney for Personal Care: A Catholic Overview <i>Valentine Lovekin, JD</i>	29
Power of Attorney for Personal Care: Balancing Private Rights and Public Interest <i>Valentine Lovekin, JD</i>	35
Author Profiles	43

INTRODUCTION

In 2013, the Sovereign Military Hospitaller Order of St. John of Jerusalem, of Rhodes, and of Malta celebrated the nine-hundredth anniversary of the Papal Bull, *Pie Postulatio Voluntatis*, by which Pope Paschal XI recognized the Order. 2013 also marks the sixtieth anniversary of the Canadian Association of the Order. In honour of these events, the Canadian Association and the Canadian Catholic Bioethics Institute held a Symposium, “Our Lords the Sick, Our Lords the Poor.” Attended by persons in health care, community outreach and pastoral care, it was a gathering of goodwill to be sure, but the conversations generated during the afternoon also contained continued commitment to attending to the needs of the poor and the sick.

The Canadian Catholic Bioethics Institute has had the support of the Order of Malta from its inception in 2001. In gratitude, it is publishing this collection of papers presented at the Symposium: Dr. Rory Fisher, “The Frail Elderly and the Health Care System”; Dr. Bridget Campion, “Our Lords the Sick, Our Lords the Poor: An Introduction to the Social Determinants of Health”; Valentine Lovekin, “Power of Attorney for Personal Care: A Catholic Overview.” We also include a paper circulated, although not presented, at the Symposium: “Power of Attorney for Personal Care: Balancing Private Rights and Public Interest” by Valentine Lovekin.

We are very grateful to Bambi Rutledge and Thalia Flood whose considerable skill and work made the publication of the *Proceedings* possible.

We offer this volume as a tribute to the work of the Order of Malta on the nine-hundredth anniversary of Papal recognition of the Order.

Bridget Campion, PhD
Rory Fisher, O.Ont., MB, FRCP(Ed)(C)
Editors



THE FRAIL ELDERLY AND THE HEALTH CARE SYSTEM

Rory Fisher, O.Ont., MB, FRCP(Ed)(C)

Introduction

As the baby boomers reach old age, the aging of society facing Canada is a part of a world-wide phenomenon which has been called “the silver tsunami” and “the demographic time bomb.” According to Statistics Canada, the number of people aged one hundred and over increased 50% between 1996 and 2006, and is set to triple to more than 14,000 by 2031. Japan will have the oldest population by 2020 with 31% over sixty years of age. The developing countries are showing the most rapid aging, with Brazil, India and Pakistan set to be in the top ten of countries with the largest elderly populations by 2020.

The impact will be most felt in the increasing numbers of those over the age of seventy-five and, more particularly, those over the age of eighty-five. Aging is not a disease, and there are many examples of active seniors in their eighties and even nineties taking part in intensive physical activities such as competing in marathons. With aging, however, there is an increase in the number of degenerative diseases such as the dementias, cancer, osteoarthritis, osteoporosis, and cardiovascular disease. At particular risk are the frail elderly, who have diminished reserves and functional impairments due to these degenerative diseases. As it is, the elderly utilize the major amount of health care resources, particularly hospital services.

Reports

With the anticipated impact of an aging population, the current pressures on the health care system have given rise to many recent reports on all aspects of health and community care. The Special Senate Committee on Aging Final Report, “Canada’s Aging Population: Seizing the Opportunity”¹ calls for the right to age in place, and condemns ageism. It identifies major non-medical problems experienced by seniors, such as isolation, inadequate housing, transportation, and inadequate current support for caregivers. It

recommends that the federal government promote active aging, develop a National Integrated Care Initiative, a National Caregiver Strategy and a National Pharmacare Program, and ensure financial security for the elderly.

The report, “Alternate Level of Care in Canada” produced by the Canadian Institute for Health Information (CIHI)² showed that, in 2007/2008, 5% of hospitalizations and 14% of hospital days were taken up by Alternate Level of Care (ALC) patients. Dementia was a key diagnosis. The Registered Nursing Association of Ontario (RNAO) released a report in 2012, addressing problems in community care. Entitled “Enhancing Community Care for Ontarians,” the report recommends adopting a better model of community care by reducing duplication, and eliminating Community Care Access Centres (CCACs).³

“Seniors in Need, Caregivers in Distress” issued by the Health Council of Canada, April 2012, notes that home care is an integral part of health care and must be treated as such.⁴ As it is, many seniors in need are receiving limited hours of care, and therefore many family members are stretched beyond capacity. The report notes that in Canada, more money is spent on long-term care (LTC), where other countries spend more on home care. In Canada, home care is not an insured service. For single seniors without family caregivers, it may be difficult to avoid LTC even though home care may be cheaper than long-term care.

The Ontario Long Term Care Association assembled a Long Term Care Innovation Expert Panel which published “Why Not Now,” in March 2012, addressing the many real issues in LTC.⁵ The Canadian Centre on Substance Abuse recently published “First Do No Harm: Responding to Canada’s Prescription Drug Crisis,” addressing medication-related problems, and calling for a pan-Canadian surveillance system, as well as a prescription monitoring program.⁶

The Ministry of Health and Long-Term Care (MOHLTC) publication, “Ontario Helping More Seniors Live at Home Longer,” was

focussed on keeping seniors healthy at home, and recommended funding to increase house calls, and to provide three million more hours of personal support workers (PSW) care.⁷ This was a precursor to the MOHLTC report “Living Longer, Living Well” of December 2012.⁸ Based on wide-ranging input from stakeholders around the province, the report identifies five principles of care: access, equity, choice, value, and quality. It notes that over half the hospital costs in acute care are for elderly patients and that there is a need to decrease ALC hospital days. The report supports Community Paramedicine Programs, Hospital at Home Models, the adoption of Senior Friendly Hospital principles, and the enhancing of Ontario LTC home environments, and notes the need for much more in the way of Elder Friendly Communities, partnerships, accessible affordable housing, transportation, and health care options. Aging in place is to be supported, which requires the promotion of health and wellness, healthy aging, physical activity, volunteer work, continuous learning, and meaningful employment. Aging in place also requires communication about services available to seniors, as well as an increase in elderly persons’ centres, more exercise and falls-prevention programs, health promotion, and better financial support.

Primary care for all seniors is necessary, with quality improvement plans to focus on care of the elderly. The report recommends that Community Care Access Centres (CCACs) assume the task of keeping primary care providers better informed, that there be more funding for house calls, and that an increase in community spending be directed to the provision of home/community care, focussing on an Aging at Home strategy. The most recent response to this report by MOHLTC is an increase in the availability of community physiotherapy.

The Current Situation

Acute-care hospitals are under considerable pressure and are ill-positioned to respond to the additional pressure generated by an aging population. The public is becoming more and more aware of long waiting times in emergency departments, and for hospital admis-

sions. ALC patients are perceived as an ongoing problem, for which the elderly patients themselves are blamed. Hospital administrators and physicians are feeling the push to discharge patients as soon as possible, leading to a revolving door type of medicine as problematic discharges may lead to readmissions. Indeed, acute-care hospitals may provide a “hostile environment” to the frail elderly.⁹ Poor hospital design can lead to minimized function, social isolation and increased delirium for elderly patients. Functional decline occurs, which can lead to “a cascade to dependency.”¹⁰ By the time they are discharged, approximately one-third of older patients will have lost independent functioning in one or more activities of daily living.¹¹

This functional decline is not related to acute illnesses but to the adverse effects of modern therapy and current hospital practices which are designed for younger people, and which can cause the loss of function and independence in the elderly. Iatrogenic complications, adverse drug reactions and nosocomial (hospital acquired) infections are common consequences of hospitalization of the elderly.¹² Polypharmacy is the most consistent and powerful predictor of adverse drug reactions. Nosocomial infections contribute to increases in hospital morbidity, including cost and length of stay. Older adults suffer a disproportionate burden of hospital-acquired infections, accounting for half of all cases. Delirium is another common problem faced by the frail elder in the acute-care setting.

The frail elderly make up the majority of the ALC patients. Uninformed ageist attitudes lead to a lack of recognition of their potential for improvement. Much time is spent in trying to prevent admitting patients from emergency departments who are not deemed to have appropriate acute medical or surgical problems, the so-called “social admissions.” Time pressures lead to a lack of diagnosing and treating underlying chronic conditions, conditions which may be obstacles to independent functioning, and patients are discharged back into the community where the diagnostic and treatment services of the hospitals are not available, leading to readmissions. Many health professionals see these patients as a problem that can only be resolved by discharging or transferring

them as quickly as possible to somewhere else—often, inappropriately and unnecessarily, to long-term care. As had been said, hospitals are very bad places for frail elderly people.¹³

Solutions

Specialized geriatric services in acute-care hospitals can do a great deal to meet these challenges. The fundamental premise of such services is that much of the disease, disability and dependence in old age is preventable, treatable or manageable. Seniors with complex health problems have unique needs and present specific challenges for accurate diagnosis and assessment. Inaccurate diagnosis may result in inappropriate treatment, leading in turn to further unnecessary loss of health and independence, premature placement, and unnecessary long lengths of stay in acute care.¹⁴ Focussed on restoring and maintaining independence and based on a comprehensive geriatric assessment supported by a spectrum of services including acute geriatric units, internal consultation services, geriatric rehabilitation units, geriatric day hospitals, and geriatric outreach teams, specialized geriatric services have been shown to be beneficial in improving outcomes and returning patients to the community.

The United States has witnessed the development of units for Acute Care of Elders (ACE) which are designed to prevent the dysfunctional syndrome caused by acute hospital admissions. In this concept the physical environment is modified to enhance patients' independent functioning. Care is patient-centered with multi-dimensional assessments and guidelines combined with interdisciplinary team rounds and discharge planning. Such units have been shown to produce shorter hospital stays at lower cost while maintaining patients' functional status.¹⁵ This model has been increasingly adopted in Canada, particularly in British Columbia¹⁶ and also in Ontario.

In Ontario, the Regional Geriatric Programs (RGPs) and Local Health Integration Networks (LHINs) are championing the concept of Senior Friendly Hospitals, in which hospitals provide a

physical environment, culture, and ethical framework focussed on maintaining patients' functional independence.¹⁷ The prevention of delirium and functional decline are two priorities. The Hospital Elder Life Program (HELP)¹⁸ relies heavily on volunteers and concentrates on early mobilization and therapeutic activities. These programs have shown improvement in clinical outcomes, with a decrease in delirium and functional decline.¹⁹ A key factor is the adoption of a team approach with the inclusion of disciplines other than medicine in improving the care of the frail elderly. Here, nursing is particularly helpful. The Geriatric Interprofessional Practice and Interorganizational Collaboration (GiiC) provides valuable information about ways of achieving this.²⁰

Although rehabilitation programs have been shown to benefit the health and functioning of elderly patients, not enough rehabilitation is provided in acute hospitals, and rehabilitation units are often disease-specific and do not meet the more general needs of the frail elderly.²¹ Specialized geriatric rehabilitation units are crucial elements of comprehensive acute-care services but are expensive.²²

Long-term care facilities are asked increasingly to take on more complex patients with dementia and behavioural problems, without sufficient trained staff to manage them adequately. Increased episodes of violence are occurring, with the recent death of a patient at the Wexford Home in Toronto resulting in a murder charge.²³ The lack of accessibility to specialized services for violent patients has been noted and the RNAO and the Canadian Union of Public Employees (CUPE) have called for a Coroner's Inquest.

Community services are a key factor in maintaining and allowing the frail elderly to be discharged from hospital. Pressures on acute-care hospitals have led to a redirection of community services, giving priority to more acutely ill patients recently discharged rather than to the ongoing support that frail seniors require in order to remain in the community. The report "Seniors in Need, Caregivers in Distress"²⁴ notes that much of the non-medical, ongoing support is being provided by informal caregivers such as family members

and friends, at great personal cost. The report also notes successful programs that are in place such as the Veterans Independence Program (VIP) which provides a wide range of community services to eligible veterans. Other successful programs that make it possible for the elderly to remain in the community include the Programs for All-Inclusive Care of the Elderly (PACE) introduced in the United States²⁵ and adapted in Edmonton as the Comprehensive Home Option for Integrated Care of the Elderly (CHOICE)²⁶ and the Program of Research to Integrate Services for the Maintenance of Autonomy (PRISMA and SIPA in Quebec).

Discussion

The Health Care System is currently under pressure on all fronts, from acute care to community care. The acute-care hospitals are hostile places for the elderly, a problem that will increase with the aging of society. A recent plethora of reports has noted that the issues exist in all sectors of the system. The report "Living Longer, Living Well"²⁷ is particularly significant because it clearly demonstrates that care of the elderly is a much broader issue than just hospital care. However, the recommendations of reports like these are worthless unless there is the will to act upon them and provide the necessary resources to implement them. The current very worthy attempts to address these problems will not be enough without this commitment. Hospitals must refocus on meeting the needs of their major clients, which means that there will need to be major changes in approaches at all levels. The radical suggestion has been made that acute-care hospitals should be made good for older people.²⁸ It is the best interests of hospitals to support the provision of community care and to work collaboratively with community agencies, so as to decrease the numbers of ALC patients.

European countries have managed to deal with their aging population, but they were much better prepared than Canada is now, with far more in the way of specialized geriatric and community services. Lessons can be learnt from countries such as Denmark, which stopped building LTC Homes in 1987. Municipalities are charged daily fees when patients are ready for discharge from

hospital and twenty-four hour care services are available. Nursing care, meals, day care, financial assistance, and transportation are all provided with integrated coordinated case management. There are annual preventive home visit for persons over seventy-five.²⁹

Even as institutional changes are required, seniors themselves need to take more responsibility for their own care, adopting appropriate preventive measures. In particular the benefits of moderate exercise are frequently overlooked. Planning for end-of-life care with the use of advance directives is to be encouraged. A regular review of medications is valuable, and pharmacists have an important role in this.

Improved education is needed for all health care providers, since poor medical attention leads to premature dependency on family or the government, earlier mortality, or disability, depression, despair, and isolation.³⁰ The current financial restrictions are a major challenge to achieving the necessary changes. Hospitals, pharmaceutical corporations and the medical establishment are obstacles because they wish to maintain the status quo, with its emphasis on costly technological advances and diagnostic and treatment innovations. Teaching hospitals, in particular, emphasize research and teaching rather than care as priorities. An encouraging sign is a recent document from the Canadian Medical Association entitled “Physicians and Health Equity: Opportunities in Practice” which outlines steps that doctors can take to help patients overcome social or economic barriers to good health care.³¹ The most important catalyst for change needs to come from public advocacy. There are already organizations such as the Canadian Association for Retired Persons (CARP)³² and the Advocacy Centre for the Elderly (ACE)³³ that are very active in this field, but advocacy from all levels of society will be needed to obtain an appropriate balance between the resources needed for acute-care hospitals, and those required for the other sectors of the health system and the community. If this balance is not achieved, acute-care hospitals will remain dangerous places for the frail elderly and there will be an increasing disparity in community care, particularly between the

wealthy and the poor.

It has been said that eternal vigilance is the price of Liberty. It will also be the price of ensuring that “care” is a major component of the health care system in times of increasing pressures, ongoing financial restrictions, and an aging society.

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- 24 http://www.healthcouncilcanada.ca/rpt_det_gen.php?id=348.
- 25 See: www.pace4you.org.
- 26 See: www.albertahealthservices.ca.
- 27 http://www.health.gov.on.ca/en/common/ministry/publications/reports/seniors_strategy/docs/seniors_strategy_report.pdf.
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OUR LORDS THE SICK, OUR LORDS THE POOR: AN INTRODUCTION TO THE SOCIAL DETERMINANTS OF HEALTH

Bridget Campion, PhD

Introduction

Inspired by the motto, “Our Lords the Sick, Our Lords the Poor” I will be talking about the social determinants of health, particularly poverty and hunger. I will discuss how they influence individual health and wellbeing and I will consider what a response of faith might elicit from us.

I should point out that this is very much a work-in-progress, as is all work that we undertake in our lives. Each “answer” leads us to further questions on our journey to truth and knowledge, which of course is a journey to Real Truth and Full Knowledge that we can know only imperfectly in this life. I thank you for giving me the opportunity to pursue questions about the social determinants of health today.

Social Determinants of Health

Poverty is bad for people’s health. Studies show again and again that people who are poorer fare worse than people who are richer—they are more vulnerable to ill health and have shorter life spans than people who are richer.¹ This is clear when we compare the health of people who live in developing countries with the health of people who live in the developed world. For instance, the mortality rates in children under five is five or fewer per 1000 in Japan, Finland and Iceland, and 316/1000 in Sierra Leone.²

However, these kinds of health inequities exist not only among countries, but within countries, with richer people living longer and enjoying better health than poorer people do.³ In other words, health and wellbeing are not simply affected by biological factors such as genetics or exposure to germs and bacteria; instead, social and economic factors also influence health and wellbeing. These are the social determinants of health.

The World Health Organization defines them as: “the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness.”⁴ These factors include income, social status, social support, education, housing, employment and conditions of employment, and food security.⁵

How important are the social determinants of health? According to a recent Canadian Medical Association Report, “evidence suggests that 15% of population health is determined by biology and genetics, 10% by physical environments, 25% by the action of the health care system, with 50% being determined by our social and economic environment.”⁶ To repeat: fifty percent of population health is determined by social and economic factors. And of all the social determinants of health, the one that most undermines health and wellbeing is poverty. And one of the most serious consequences of poverty is hunger.

Hunger

The first thing to say about “hunger” is that the term has very different meanings depending on whether one is talking about hunger in developed countries or hunger in developing countries. In developing countries, the term used to denote hunger is “malnutrition” which is defined as “the failure to achieve nutrient requirements, which can impair physical and/or mental health.”⁷ One can see the effects or evidence of malnutrition in stunted growth, for instance, or other physical effects. In developing countries, getting food is a priority; without food, without adequate nutrition, people in developing countries die. They die of starvation; they die of malnutrition.⁸

In developed countries like Canada, the term used to denote hunger is “food insufficiency” or “food insecurity” which is “the inability to acquire or consume an adequate diet quality or sufficient quantity of food in socially acceptable ways, or the uncertainty that one will be able to do so.”⁹ One normally cannot see evidence of food insufficiency (although I believe that as we take social determinants of health more seriously, this may change); instead, evidence to determine the extent of food insecurity in countries like Canada

is collected through questionnaires, analysis of food banks usage and so on.¹⁰ As well, in developed countries like Canada, securing food is not the priority that it is in developing countries. We do not suffer from famine, for instance, or the ravages of war. In fact, in Canada, securing shelter is more likely to take precedence over securing food.¹¹ There is a sense in Western countries that compromises can be made in obtaining enough to eat—compromises that simply are not possible in developing countries. In this paper I will confine my remarks to food insecurity or food insufficiency as it exists in Canada.

Food insecurity exists as a continuum, from people being genuinely worried about where their next meal is coming from, to those who, at the end of the month, may make compromises in food choices because they have no money, to those who actually go hungry either because there is no food for themselves or not enough food for their household. In developed countries, the most extreme form of household food insecurity is child hunger because almost always a parent will go hungry in order to ensure that her children are fed.¹² When children go hungry, it usually means that there is no food in the household for anyone.

Food Insecurity in Canada

Who are most likely to be food insecure in Canada? Studies show that those who are most likely to be food insecure are people in households headed by a single parent, receiving most of their income from some form of social assistance (unemployment insurance or welfare, for instance), and who are not owners of their own homes.¹³ Households are even more vulnerable when the single parent is female.¹⁴

It is generally accepted that the poorer one is, the more likely it is that one will be food insecure, with the poorest among us experiencing the most food insecurity. In the lowest income group, “more than two out of five (42.8%) food insecure households were considered severely food insecure.”¹⁵ However, hunger in Canada is not restricted to the most economically disadvantaged. In fact, “the majority of food-insufficient households were in the lower middle

and middle income adequacy groups.”¹⁶

Why would the middle classes be so statistically significant, bearing the brunt of food insecurity? Studies about hunger exclude the poorest of the poor in Canada—the homeless. These studies also exclude Aboriginal persons living on reserves. Within the study cohort, then, only a small percentage of households in Canada are in extreme poverty. More to the point, since the 1990s, the middle class, particularly the lower middle class, has been losing ground economically with the removal of social safety nets, a decrease in real wages and increasing economic inequity.¹⁷ In other words, since the 1990’s, “Canada [has] witnessed increasing food insecurity as one manifestation of growing poverty and inequity.”¹⁸

How many Canadians experience food insecurity? According to the Office of Nutrition Policy and Promotion, from 2007-2008, 961,000 Canadians (7.7% of households) were food insecure. Of these, 629,600 Canadians (5.1% of households) experienced “moderate” food insecurity insofar as there was “compromise in quality and/or quantity of food consumed” while 331,900 Canadians (2.7% of households) experienced “severe” food insecurity insofar as there were “reduced food intake and disrupted eating patterns.”¹⁹ In Ontario in 2005, 7.6% of households experienced food insecurity; in 2009, 9% of households were food insecure.²⁰

It should be noted that food insecurity can be concentrated in high poverty neighbourhoods. According to one report, “a 2006-2007 survey of almost 500 low-income families in 12 high poverty neighbourhoods in Toronto revealed that two-thirds of the families were experiencing food insecurity, *nearly 10 times the provincial average*. In 10% of these families, adults had gone whole days without eating to give what food they had to their children.”²¹

And what do people do when they are hungry in Canada? According to one study, “one-fifth sought food from charitable sources, almost half reduced the quality of their foods, and about a quarter skipped meals or ate less.”²²

Reducing the quality of food and reducing nutritional intake can have serious consequences for health and wellbeing. As one researcher put it: “nutritional adequacy would be regarded as the single most important determinant of health.”²³

Food Insufficiency and Health

People who live in food-insufficient households have poorer physical, mental and emotional health, and regard themselves as having “poor” or “fair” health.²⁴ They suffer from chronic health conditions like diabetes, heart disease and food allergies;²⁵ they suffer from depression and anxiety. One U.S. study found that “Food insufficiency has also been shown to be associated with ... negative psychosocial outcomes in American children ... and with depressive disorders and suicidal behaviors in American teens.”²⁶

While it is difficult to determine which comes first, the chronic health conditions that impair functioning and wellbeing that can lead to poverty or the poverty and attendant food insufficiency that lead to poor health, it is nevertheless the case that chronic health conditions can be managed to a certain extent by diet—something that is likely unattainable for most food insufficient households.²⁷ One Canadian study examining a group of low-income patients with type 2 diabetes found that three-quarters of the study subjects could not afford the required diet that would help them manage their diabetes. This may account for the fact that not only are poorer people more likely to have type 2 diabetes than richer people are, but that they are also at a higher risk of experiencing the complications of diabetes.²⁸

Food insecurity affects the health and wellbeing of children. In food insecure households, children, aged ten to fifteen, are more likely to suffer from poor health generally while youth aged sixteen to twenty-one are more vulnerable to developing chronic health conditions, including asthma. Some researchers speculate that this may stem from the fact that children in food insecure households are under a great deal of stress, stress that in turn may weaken their immune systems.²⁹ At the very least these researchers conclude that: “hunger is a serious risk for long-term poor health among

children and youth, pointing to the relevance of food insecurity as an identifiable marker of vulnerability.”³⁰

Crafting a Christian Response

Social determinants of health, hunger, hundreds of thousands of Canadians including children living in households where there is not enough to eat; ill health, anxiety, depression, chronic diseases brought on or exacerbated by poverty and hunger—at some point this afternoon we may talk about practical solutions to a scandalous injustice. However, I would like to end this talk with a reflection on a Catholic or Christian response to the social and economic factors that can undermine human health and wellbeing, particularly the factors of poverty and hunger.

When I started this paper, I did not expect to address the issue of hunger and health in Canada. But, as I began to think about what a response of Faith might require, things began to unfold. Within the Christian tradition, we are exhorted to feed the hungry. Think of Isaiah 58:7, where we are told “to share [our] bread with the hungry.” Think of Jesus as being the one who is hungry: “For I was hungry and you gave me food” (Mt 25:35). Think of the example Jesus gives us when he feeds the crowds with the loaves and the fishes (Lk 9:12-17; Mk 8:1-9). We can speak of the spiritual hunger experienced by our neighbours but these examples call us to attend to their physical hunger as well.

We have these exhortations, but more to the point (and here I am using as my foundation the work of David Hollenbach³¹ which I read many years ago and which stays with me still), at the centre of our faith as Catholics is the Eucharist, which means at the centre of our faith is food, and the sharing of food—the sharing of the Bread of Life.

The Eucharist becomes a gathering point. We come together as a community to the Eucharistic Table. We share in the bread and wine, in the Body and Blood of Our Lord. We partake in the covenant that is fulfilled in Jesus, the covenant that God has established with all of humankind. And it is a sharing that moves outwards

from the Eucharistic Table to all who are hungry.

If Catholics have a tradition of social justice, it is rooted here in the Eucharist and these roots are very deep. I would like to share a description of a Eucharistic celebration written by Justin Martyr nineteen centuries ago. The Apostles were dead, Christianity was no longer a Jewish sect and there was no expectation that the world was going to end any time soon. Instead, we have a community of believers trying to be true to the Gospel in-the-world:

“And on the day that is called Sunday, all who live in cities or in the country, gather together in one place; and the memoirs of the apostles and the writings of the prophets are read as long as time permits. Then the reader concludes and the president verbally instructs and exhorts us to the imitation of these excellent things. Then we all rise up together and offer up our prayers. And, as I said before, when we have ended our prayer, bread is brought and wine and water; and the president in like manner offers up prayers and thanksgiving according to his ability and the people give their assent by saying ‘Amen.’

“And there is a distribution and a partaking by everyone of the Eucharist. And to those who are absent a portion is brought by the deacons. Those who are well-to-do and willing, give as they choose; each as himself purposes. The collection is then deposited with the president who supports widows, orphans, those who are in want owing to sickness or any other cause; those who are in prison, and strangers who are on a journey. In a word, he takes care of all who are in need”³²

At the Sunday gatherings in the time of Justin Martyr, the community is nourished spiritually but care is also taken to ensure that those in need are nourished physically. Particular attention is given to the marginalized: the widows, the orphans, those in prison. Their wellbeing depends on this form of care and it is care that flows from the Eucharistic Table. As Hollenbach says, when we regard

the Eucharist as the reality meant to inform our decisions and actions when we are confronted with hunger, we may not be given specific solutions; nevertheless, the Eucharist “does provide a basis for corporate prophetic action by the Church as a whole.”³³ At the very least we are called to share our bread and do what we can to ensure that no one goes hungry.

1 Canadian Medical Association, “Physicians and health equity: Opportunities in practice” (2012), p. 5; http://healthprovidersagainstpoverity.ca/system/files/CMA%20Report%20on%20Physicians%20and%20Health%20Equity%20282012%29_pdf (accessed April 2013).

2 Michael Marmot, “Social determinants of health inequalities,” *Lancet* 365 (2003) p. 1099; http://www.who.int/social_determinants/strategy/Marmot-Social%20determinants%20of%20health%20inequalities.pdf (accessed August 2009).

3 Public Health Agency of Canada, “Are poor people less likely to be healthy than rich people?” <http://www.phac-aspc.gc.ca/ph-sp/determinants/qa-q1-eng.php> (accessed August 2009). This holds true for child mortality as well. See Marmot, p. 1100.

4 http://www.who.int/social_determinants/final_report/key_concepts_en.pdf (accessed April 2013)

5 The National Health Forum, “What Makes Canadians Healthy or Unhealthy?” <http://www.phac-aspc.gc.ca/ph-sp/determinants-eng.php#income> (accessed August 2009).

6 CMA, “Physicians and health equity,” p. 5.

7 Lynn McIntyre, “Food Security: More than a Determinant of Health,” *Policy Options Politiques* (March 2003), p. 46; <http://www.irpp.org/po/archive/mar03/mcintyre.pdf> (accessed April 2013).

8 Ibid., p. 47.

9 Ibid., pp. 46-47.

10 Ibid., p. 47.

11 Ibid.

12 Statistics Canada, “Household food insecurity, 2007-2008” www.statscan.gc.ca/pub/82_625x/2010001/article/11162-eng.html (accessed August 2013).

13 Nicolas T. Vozoris and Valerie S. Tarasuk, “Household Food Insufficiency Is Associated with Poorer Health,” *The Journal of Nutrition* 13 (2003), p. 122; <http://jn.nutrition.org/content/133/1/120.full.pdf+html> (accessed April 2013).

14 “Household food insecurity, 2007-2008.”

15 Health Canada Office of Nutrition Policy and Promotion, “Household Food Insecurity in Canada in 2007-2008: Key Statistics and Graphs” <http://www.hc-sc.gc.ca/fin.an/surveill/nutrition/commun/insecurity/key-stats-cles-2007-2008-en.php> (accessed April 2013).

16 Vozoris and Tarasuk, p. 122.

17 McIntyre, p. 47.

18 Ibid.

19 “Household Food Insecurity in Canada in 2007-2008.”

20 Recession Relief Coalition, “Hunger Crisis: Report of the Hunger Inquiry” (2011), p. 5; <http://recessionreliefcoalition.yolasite.com/resources/Hunger%20Crisis%20Report%202011.pdf> (accessed April 2013).

21 Ibid.; italics in original.

22 McIntyre, p. 49.

23 Ibid., p. 47.

24 Vozoris and Tarasuk, p. 122.

25 Ibid; see also David Rankin, et. al., “The contextual development of healthy living centres services: An examination of food-related initiatives,” *Health and Place* 12 (2006), p. 646; <http://journals2.scholarsportal.info.myaccess.library.utoronto.ca/tmp/9148060016252725604.pdf> (accessed April 2013).

26 Vozoris and Tarasuk, p. 124.

27 Ibid.

28 “Hunger Crisis,” p. 8.

29 Sharon I. Kirkpatrick, Lynn McIntyre and Melissa L. Potestio, “Child Hunger and Long-term Adverse Consequences of Health,” *Archives of Pediatric and Adolescent Medicine* 164 (2010), p. 760; <http://www.ucalgary.ca/lmcintyre/hun->

ger%20consequences.pdf (accessed April 2013).

30 Ibid., p. 762.

31 David Hollenbach, "A Prophetic Church and the Catholic Sacramental Examination" in *The Faith that Does Justice*, ed. John C. Haughey (Paulist Press, 1977), pp. 234-263.

32 Francis X. Murphy, "Moral Teaching in the Primitive Church," (Glen Rock, N.J.: Paulist Press, 1968), pp. 97-99.

33 Hollenbach, p. 258.

POWER OF ATTORNEY FOR PERSONAL CARE: A CATHOLIC OVERVIEW

Valentine Lovekin, JD

I own a dog. Or as I am sometimes told, a dog owns me. Six days of the week, I meet other dog owners and pets for a walk in a nearby ravine. One day, one of the fellows told me a story about his grandparents, which is an instructive way to start my presentation today. His grandmother made coffee every morning. At some point after the couple's diamond anniversary, she took ill and died. Grandfather lived on for several years. Like many men of his generation, he had to learn a lot about homemaking, which he had formerly left to his wife. His grandson offered help. He said, "Grandpa, I'll teach you how to make coffee." "Don't bother," said the grandfather. "But Grandma made it for you every day and you don't know how to use the coffeemaker." The grandfather looked at him and said, "I don't like coffee. I just never told your grandmother."

And so on this cautionary note, I open discussion about substitute decisions-makers.

The Power of Attorney for Personal Care is still sometimes better known by a foreign or colloquial description as a Living Will. I find this description problematic. A Will is a document which is made during the testator's lifetime, that does not take effect until death. To describe the Power of Attorney as a Living Will suggests to my ears that the document is to be used principally for the regulation of the grantor's death rather than the enhancement of the grantor's quality of life. While I do not ignore the role of the Personal Care Power of Attorney for the treatment of individuals in palliative care, I believe that when our language is reductivist, our thinking follows suit and the public may not recognize the breadth and scope of the tools which the Legislature has conferred through the Substitute Decisions Act.

The Substitute Decisions Act (hereinafter "SDA") was enacted in 1992.¹ The SDA created the Power of Attorney for Personal Care.

Prior to the SDA, a Power of Attorney was only usable for business matters and not for health issues. Such issues were the prerogative of the next of kin. The Legislature gave individuals authority in two respects: first, by conferring power to appoint a decision-maker who is not a next of kin; and secondly, to empower the grantor to make health care decisions.²

I refer you to the text of the SDA concerning incapacity for personal care:

A person is incapable of personal care if the person is not able to understand information that is relevant to making a decision concerning his or her own health care, nutrition, shelter, clothing, hygiene or safety, or is not able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.³

The function of the Power of Attorney for Personal Care is to make decisions on behalf of the grantor concerning the issues identified in section 45, subject to limitations set by law and any limitations articulated by the grantor in the document.

It may be tempting for the grantor to simply delegate decision-making authority to an attorney through a Power of Attorney for Personal Care. But for those of us who are a little more particular about what kind of care is received—and I count myself as a member of this group—the Power of Attorney can and should do more than to simply delegate decision-making. Let us consider several decision options, following the list of decision-making issues listed in section 45 of the SDA:

Health Care

The grantor may wish to express preferences in the choice between homecare and institutional care. This is a sensitive subject and one that also touches on the safety of the grantor and also the care provider. A family home setting may become dangerous because of stairs, bathroom access and egress, access to medical care and any number of other considerations. While some people would prefer

to remain at home, many are also content to be moved to a care facility, where superior care may be available at a lower financial and emotional cost to care providers during a time when the patient may be less sensitive to his or her surroundings.

Nutrition

Menus at restaurants are replete with food selections for customers. For example, there are vegetarian meals, diabetic meals, lactose-free diets, nut-free diets and gluten-free diets to name some of the more common variations. While the POA-Personal Care may be familiar with these food preferences, the attorney will not always be present and the Power of Attorney document will be a useful tool for care providers to tailor nutrition to suit the individual. It is entirely appropriate to mention specific dietary preferences or food allergies in a Power of Attorney for Personal Care.

Shelter

Many persons don't really consider what options are available for shelter. It is not a matter of simply having it or not. It is more often a question of what kind of shelter. On occasion, I have detailed discussions on topics like colour preferences. One client is distressed by red so that palette is noted for avoidance. In certain circumstances, I even consider what kinds of music the grantor enjoys most. All of these are appropriate extrapolations of shelter.

Clothing

As a practical concern, clothing needs to be replaced from time to time and is often the responsibility of a caregiver. Sidestepping any strong feelings on questions of fashion, it is sometimes helpful to be aware that the person who holds Power of Attorney for Property and the person who holds Power of Attorney for Personal Care may be different. Clothing is a specified area of consideration for the Personal Care decision-maker but as a budgetary item, it is also under the supervision of the Property decision-maker.

What then, when the former wants to buy three new sets of sleepwear and the latter questions the cost? This issue has been contemplated by the SDA which provides as follows:⁴

Duties of guardian

A guardian of property is a fiduciary whose powers and duties shall be exercised and performed diligently, with honesty and integrity and in good faith, for the incapable person's benefit.

Personal comfort and well-being

If the guardian's decision will have an effect on the incapable person's personal comfort or well-being, the guardian shall consider that effect in determining whether the decision is for the incapable person's benefit.

Personal care

A guardian shall manage a person's property in a manner consistent with decisions concerning the person's personal care that are made by the person who has authority to make those decisions.

Exception

Subsection (1.2) does not apply in respect of a decision concerning the person's personal care if the decision's adverse consequences in respect of the person's property significantly outweigh the decision's benefits in respect of the person's personal care.

In short, where there are separate attorneys for Personal Care and for Property, the former has the upper hand in settling disputes over expense unless a significant adverse consequence can be proven.

Hygiene

It is obvious that the caregiver would be responsible for ensuring that the grantor is kept in hygienic circumstances. But think beyond the obvious: many women, if asked, might ask that their hair be washed and set once a week. Or many men might express a preference to remain clean shaven or bearded. There may be preferences or intolerances for fragrances. All of these choices are opportunities for the grantor to express a care plan rather than

delegating all decisions to someone who may not have paid close attention to the grantor's preferences in carefree days.

It is obvious that there is much to discuss when taking instructions for a Power of Attorney for Personal Care. The issue that I wish to underscore most emphatically is that the document has a lot to say about how people live and it is not simply a document which dictates who gets to "pull the plug" as people so prosaically describe it. Also, I note that there may be a significant benefit to an individual to discuss the issues governable by a Power of Attorney for Personal Care with an experienced solicitor because an outsider asking the right questions is frequently more successful in getting a clear answer than a spouse or a family member.

I was recently struck by the applicability of John 6:28-29 to my theme today. I quote:

Then they said to Him, "What must we do to perform the works of God?" Jesus answered them, "This is the work of God, that you believe in Him whom He has sent."

As professionals and persons with an interest in bioethics, we focus on Our Lords the Sick and Our Lords the Poor. But how do we bring that faith into practice? The Gospel says that the work of God is to believe in Him whom He has sent. The work of God begins with Faith. But Faith is not passive; rather, it inspires a love for knowledge. It is not enough to have good intentions; we must know the people we serve. And yet knowledge is still not enough; the Gospel speaks of the work of God. I cannot help but conclude that our destiny is not to reflect on our Faith but to act on it in our lives, inspired by an awareness of Christ.

A Power of Attorney for Personal Care is no more a Catholic tool than is a pen, which is used to write a homily; the first is a legal document and the second is a writing instrument. However, both are capable of communicating Catholic values, especially when the grantor is prepared to canvas issues which touch upon the Faith at the time of giving instructions. And proper instructions, whether

they touch on matters of faith, care or comfort, will inform the usefulness of the legal document in the hands of others.

Having offered this primer on the Power of Attorney for Personal Care, I invite you to read my paper, which reviews two decisions of the Ontario Court of Appeal: *Neill v. Pellolio* [2001] and *Rasouli v. Sunnybrook Health Sciences Centre* [2011]. It is a pleasure to consider rights on a theoretical plain; but what an untheoretical world we live in. Rights are never created in a vacuum; rather they rebalance the relationship between the few and the many; that is: between the individual and society. What happens as a result of creating those rights, specifically the introduction of the Power of Attorney for Personal Care, is often unpredictable and always interesting.

1 There was a delay in the law's proclamation, which occurred eventually in 1995.

2 Presently, hospital senior management teams debate and promote "Patient Centred Care". This does not mean that patients have a complete say in how and when they receive treatment but it is indicative of a general trend towards patient empowerment which can be traced back to the Power of Attorney for Personal Care.

3 Substitute Decisions Act, 1992 S.O. 1992, c. 30, section 45.

4 Ibid section 32 (1), (1.1), (1.2) and (1.3).

POWER OF ATTORNEY FOR PERSONAL CARE: BALANCING PRIVATE RIGHTS AND PUBLIC INTEREST

Valentine Lovekin, JD

When I was invited to address this conference on Our Lords the Sick, Our Lords the Poor, Benedict XVI was the leader of the Universal Church. Since his retirement, I find it almost impossible as a Catholic to engage in any serious discussion touching Catholicism without acknowledging the remarkable times in which we live. I therefore wish to open my address by quoting from His Holiness, Pope Francis who made the following comments on 19th March 2013 as part of his homily at the Inauguration of Petrine Ministry Mass. I quote:

The vocation of being a “protector,” however, is not just something involving us Christians alone; it also has a prior dimension which is simply human, involving everyone. It means protecting all creation, the beauty of the created world, as the Book of Genesis tells us and as Saint Francis of Assisi showed us. It means respecting each of God’s creatures and respecting the environment in which we live. It means protecting people, showing loving concern for each and every person, especially children, the elderly, those in need, who are often the last we think about. It means caring for one another in our families: husbands and wives first protect one another, and then, as parents, they care for their children, and children themselves, in time, protect their parents. It means building sincere friendships in which we protect one another in trust, respect, and goodness. In the end, everything has been entrusted to our protection, and all of us are responsible for it. Be protectors of God’s gifts!¹

I am grateful for my own good fortune that His Holiness set me on my path for this paper.

I propose that the comments made by Pope Francis are not only sound theology; they also point to the just application of the

Substitute Decisions Act for Powers of Attorney for Personal Care. In thinking of the just application of the law, I am particularly interested in the tension between personal aspirations and community goals, or as I have also described this, private rights and public interest.

In creating rights, there is always a conflict between an individual's private rights and the public interest. Two decisions of the Ontario Court of Appeal provide poignant illustrations of this tension.

The older decision is in *Neill v. Pellolio*.² In this case, Ms. Neill was a daughter of Geraldine Pellolio. In August 1994, Geraldine Pellolio signed a power of attorney for personal care (the "Power of Attorney") which appointed her husband, Maurice Pellolio, as her attorney and named her daughters, Ms. Neill and Ms. Pellolio, as co-attorneys if Mr. Pellolio was unwilling or unable to act. The Power of Attorney provided a relatively common clause which read as follows:

If at such time the situation should arise in which there is no reasonable expectation of my recovery from extreme physical or mental disability, I DIRECT that I be allowed to die and not be kept alive by medications, life support systems or other artificial means or "heroic measures"....

In October, 1999 Geraldine Pellolio was hospitalized with admitting diagnoses which included advanced Parkinson's disease, aspiration pneumonia and dehydration. Her initial treatment involved use of a temporary nasal gastric tube. Although Geraldine Pellolio recovered from the aspiration pneumonia, the prognosis was unfavourable for recovery of her ability to swallow.

The main choices for future feeding care were between initiation of permanent gastrostomy tube feeding (hereinafter "PGTF") or cessation of gastrostomy tube feeding and pursuit of a long-term palliative plan of care. Under the latter option, it was anticipated that Geraldine Pellolio's death would occur within one or two months. Ms. Neill opposed commencement of the PGTF treatment and sought to have paragraph 4 of the Power of Attorney enforced.

Maurice Pellolio and Ms. Pellolio supported PGTF.

More significantly, in mid-November 1999, Geraldine Pellolio's treating physician, Dr. Heather MacDonald, conducted an assessment under the Health Care Consent Act (hereinafter "HCCA") to determine Geraldine Pellolio's capacity to provide informed consent to PGTF. Dr. MacDonald concluded that Geraldine Pellolio clearly indicated her wish to proceed with the PGTF treatment and understood the implications of this decision. Geraldine Pellolio received a permanent gastrostomy tube and was discharged to her home.

Afterwards, Ms. Neill commenced an application under the Substitute Decisions Act (hereinafter "SDA") and the HCCA to compel a capacity assessment of her mother and to obtain visitation rights.

The lower court and the Court of Appeal both denied the daughter's efforts to require her mother to undergo an assessment. In coming to this conclusion, the court offered a narrow, jurisdictional reading of the SDA and the HCCA. It also affirmed the importance of the assessment of the treating physician. In my respectful opinion, the Court's decision is helpful for distinguishing between what the patient regarded as a reasonable medical option and what the daughter regarded as an extreme physical disability, justifying the cessation of care.

The decision is also interesting for discussing visitation rights. I quote directly from the Court of Appeal's decision:³

Ms. Neill correctly points out that an attorney for an incapable person under a power of attorney for personal care is obliged to foster regular personal contact between the incapable person and supportive family members and friends (see ss.66(6) and 67 of the SDA). Similarly, such an attorney is obliged to consult from time to time with supportive family members and friends of the incapable person who are in regular personal contact with the incapable person (see ss.66(7)(a) and 67 of the SDA). However, these obligations only arise under the SDA where a finding of incapacity has been made.

A similar objective is identified as one of the purposes of the HCCA when a person lacks the capacity to make a decision about a treatment (see para. 1(e) of the HCCA). As relevant to this case, however, this objective only applies under the HCCA when a person “lacks the capacity” to make decisions about his or her treatment. In this case, in respect of the PGTF treatment, an express finding of capacity resulted from a capacity assessment conducted under the HCCA.

The motions judge concluded that she had no jurisdiction in the circumstances of this case to order visitation rights for Ms. Neill. I agree with this conclusion having regard to the nature of the application commenced by Ms. Neill.

It is complicated to facilitate visitation rights in normal circumstances and especially in situations such as were found in *Neill v. Pellolio* because the visitor’s attitudes towards later life care were at odds with the patient and her primary attorney. The case has been cited twice since publication but neither subsequent decision argued the resolution of family disputes over visitation rights.⁴

More generally, the case shows how a next of kin attempted to use the provisions of the Power of Attorney for Personal Care and the SDA to influence the care of the grantor notwithstanding that the applicant was an inactive, substitute decision-maker. In a very real sense, Geraldine Pellolio’s private decisions, committed to a legal document, thrust her into the public realm to determine the nature and ambit of a Power of Attorney for Personal Care.

The second decision which I wish to discuss has already been mentioned many times at Canadian Catholic Bioethics Institute: I am referring to the case of *Rasouli v. Sunnybrook Health Sciences Centre*.⁵

Hassan Rasouli is hospitalized at the Sunnybrook Health Sciences Centre. He has been there since October 7, 2010, when he underwent surgery to remove a benign brain tumour. Unfortunately,

post-operative complications occurred and he developed bacterial meningitis. The infection spread throughout his brain leaving him with severe and diffuse brain damage.

On October 16, 2010, Mr. Rasouli was placed on a mechanical ventilator. He is receiving artificial nutrition and hydration through a tube inserted into his stomach. These life-sustaining measures are keeping him alive and he may survive for some months if they are continued. Without them, it is expected that he will soon stop breathing and die.

The case came before the Court of Appeal because the doctors responsible for Mr. Rasouli's treatment and care concluded that the patient is in a permanent vegetative state which means that he will never again regain consciousness. This opinion is supported by an independent neurologist and by a process which permitted the family to obtain an independent neurological opinion. In framing the discussion, I quote from the decision which reports:

The appellants acknowledge that they need Ms. Salasel's consent, in her capacity as substitute decision-maker for her husband, to administer palliative care to him. They maintain, however, that they do not need her consent to withdraw the life-sustaining measures as those measures have spent their course and are no longer medically indicated.⁶

Parichehr Salasel, wife of the patient, litigation guardian and substitute decision-maker, disagrees. By her analysis, where there is life, there is hope and she has argued that her husband has reacted on occasion to her voice and to the voices of their family.

The application judge ruled in favour of the patient's family and against the doctors. The doctors appealed, arguing that the case would be a dangerous precedent because it would require doctors to obtain consent of patients before withholding or withdrawing treatment that they consider to be of no medical value. In staking this position, the doctors affirmed that their service has to fall within the requisite standard of care, failing which they would be accountable.

“But that is a far cry from saying that a doctor must provide treatment to his or her patient that the doctor believes is medically ineffective or inappropriate, without first obtaining the patient’s consent that such treatment can be withheld or withdrawn”.⁷

The Court of Appeal did not allow the doctor’s appeal. It is important to note that the fiscal concerns of patient care were not argued and therefore had no bearing on the Court’s analysis. The Court of Appeal also remarked elsewhere in the decision that if the Legislature intended that there be consent for the withholding or withdrawal of life support measures that are considered to be medically ineffective or inappropriate, the Court would require clearer language to that effect.⁸ Thus, the decision may be seen as one that was narrowly reasoned and was intended to throw the debate on end of life care back to the Legislature for determination.

Still, the case illustrates the point that a grantor’s personal instructions and the implementation of them by a substitute decision-maker may become the focus of a very public debate as they are re-examined by care providers, the Court and perhaps ultimately by the Legislature.

When a health care directive is scrutinized, what considerations prevail? For now, the patient’s wishes are paramount. This may be re-examined when the economics of treatment are given further analysis. The Court also gives weight to the opinion of the substitute decision-maker. However, as is suggested by the Neill case, the substitute decision-maker may have to show flexibility with respect to visitation rights by non-decision-makers, substitute or otherwise. Moreover, we are waiting for the Supreme Court to pronounce on the extent to which a patient or the patient’s substitute decision-maker can or should trump the judgment of a doctor acting within the sphere of his or her professional competence. Finally, the opinion of the Court may be re-evaluated by the Legislature as the patient’s private rights become a matter of public policy. To that extent, the private and the public remain inseparable. May we move the debate forward, ever mindful that our task is to protect one another in trust, respect, and goodness.

1 Mass, Imposition of the Pallium and Bestowal of the Fisherman’s Ring for the Beginning of the Petrine Ministry of the Bishop of Rome: Homily of Pope Francis, Saint Peter’s Square, Tuesday, 19 March 2013, Solemnity of Saint Joseph published at http://www.vatican.va/holy_father/francesco/homilies/2013/documents/papa-francesco_20130319_omelia-inizio-pontificato_en.html.

2 *Neill v. Pellolio et. al.*[2001] CanLII 6452.

3 Ibid at paragraphs 31-33.

4 *Woolner v. D’Abreau*, 2008 CanLII 70463 (ON SC) — 2008-12-17 Superior Court of Justice — Ontario; and *Kischer v. Kischer*, 2009 CanLII 495 (ON SC) — 2009-01-12 Superior Court of Justice — Ontario.

5 At the time of writing this, the case had been argued before the Supreme Court of Canada but the decision had not been published. The Court of Appeal citation is *Rasouli v. Sunnybrook Health Sciences Centre*, 2011 ONCA 482 Docket C53442.

6 Ibid. paragraph 5.

7 Ibid paragraph 12.

8 Ibid paragraph 41.



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