

CCEL Conference 2012

November 17, 2012

“Advocacy and Aging: From Storytelling to Systemic Change”

DO THEY SERVE COFFEE ON THIS TRAIN?

*Marion Allan**

The theme of this year’s conference is “Advocacy and Aging: From Storytelling to Systemic Change.” So, I am going to tell you a story. It is a story about my ninety-six-year-old mother’s last three months in the hospital last year. It is, as you may anticipate, a sad story. She died on December 12, 2011 in the Lady Minto Hospital, which is a very small hospital on Salt Spring Island. Her journey in the hospital highlighted a number of ways in which our current healthcare, housing, and guardianship policies are failing our aging seniors. I suggest that there are many lessons to be learned from her experience, and I hope that you, as passionate advocates for the elderly in a wide variety of professions, will continue to work to redress these failings.

I have called my story: “Do they serve coffee on this train?” I realize that you may have trouble concentrating if you are

* Honourable Marion J. Allan was called to the Bar of British Columbia in 1978, and practiced at Russell & DuMoulin (now Faskens) until 1988. She was appointed to the County Court of Vancouver in 1988, and elevated to the Supreme Court of BC in 1990. She has held several titles throughout her career, such as an adjunct professor of Civil Procedure at UBC Law School (1984-1988) and Chair of the Rules Revision Committee. She is active in teaching courses for the NJL, CLE, CBA and the TLA. She retired from the Bench in April 2012, and failed at retirement miserably. She was reinstated as a lawyer by the BC Bar in September 2013, and joined Clark Wilson, LLP, as Associate Counsel. Currently, she is enjoying a busy mediation practice, mentoring young lawyers, and writing and lecturing—primarily in wills and estates, family law, and civil procedure. Additionally, she was recently admitted to the Civil Roster of the Mediate BC Society in September 2014.

wondering why my story has such a seemingly nonsequitorial title, so I am not going to start at the beginning of my story. I am going to start close to the end.

Lady Minto Hospital is a small but very busy, rural hospital. As you may know, Salt Spring Island has a large elderly population and, demographics being what they are, most of those aging and increasingly frail people are women. Residents of the Gulf Islands have a higher life expectancy than those in British Columbia. In 2008, life expectancy in the Gulf Islands averaged 83.46 years (compared to 80.90 years for the Vancouver Island Health Authority and 81.14 years for British Columbia). Of course, we would expect the life expectancy for women to be higher than for men, and, indeed, elderly women far outnumbered men in the hospital while my mother was there.

In 2008—2009, although people older than seventy-five years of age accounted for around twelve percent of the population on Salt Spring Island, they comprised approximately forty percent of hospital cases.

The Lady Minto Hospital has an Extended Care Unit of thirty-one subsidized units. It is always full and has an extensive waiting list. Each of those units has two or four beds. The hospital has a very small emergency department. The odd maternity case whisks in and out. My mother was in the acute care ward, which has nineteen beds. Some patients' rooms are single; most are double.

The nurses confirmed to me that about nineteen percent of the patients in the acute ward are elderly people waiting for placement in extended care, in either the hospital or elsewhere in the community. They are classified as receiving an Alternate Level of Care —i.e., care for people who no longer require acute care or who have been assessed for eligibility in residential care but who remain in an acute care ward pending transfer to a suitable facility.

The Vancouver Island Health Authority (VIHA) conducted a SSI Health Review in May 2010. It found that in 2008 to 2009, thirty-five percent of those in the Lady Minto who were waiting for placement were aged seventy-five to eighty-four, and sixty-two percent were aged eighty-five or older.

When I was at the hospital, I was told that most of the remaining ten percent of the patients suffer from psychiatric or drug-related problems. In the acute ward, the patients' rooms all line up on one side of a long narrow corridor. Each morning, most of the patients are taken from their beds and sit in huge vinyl-padded chairs outside their doors along the corridor wall. There they sit until it is time to go to bed again. They eat their meals there; they may look at a book or a magazine; only a few have the occasional visitor; the nurses give the patients whatever attention they can spare; but mostly, the old people just sit quietly and wait.

My mum was in palliative care for about two weeks before she died. One day, while she was apparently in a coma, the fire alarm went off. The thought of getting all of the patients out of the hospital was daunting. But fortunately, it was a false alarm. Of course, fire alarms are loud and seemingly endless. I think they are less alarming to the deaf elderly and most alarming to the young with psychiatric problems.

With the alarm, all of the doors automatically slammed shut. That was alarming to everyone. One young woman pulled a cigarette out of her housecoat—she had no matches except when the nurses gave her one a few times a day so she could smoke outside. Seeing her with the cigarette, two old men started screaming that she had obviously started the fire and insisted that she immediately leave the hospital.

By that time, I had spent most of two-and-a-half months in the hospital every day and knew many of the patients and nurses. I helped when I could. I did my best to mediate the cigarette dispute and calm a hysterical patient who could not stand that her door was

closed. She did not want to be inside her room by herself, and she did not want to be outside in the hall with so many anxious people.

Then, I thought I should check on my mum just in case she emerged from her coma and became confused. It was unlikely, but none of us are immune from irrational thoughts at such times. As I walked down the hall, a small elderly lady in her huge comfy chair grabbed my hand and stopped me. She was not at all upset, but she was seemingly bemused by the frenzied activity. She looked up at me and asked: "Excuse me, dear. Do they serve coffee on this train?"

Yes, that is exactly what it must feel like, sitting in a chair lined up with all the other chairs, facing forward all day: a train! I told her I thought they did indeed serve coffee on this train and I would look for a waitress. I then reported accordingly to a nurse whom I thought had a good sense of humor and would oblige. It was an amazing insight.

But, what of my mother? Interwoven through this narrative is the regrettable fact that I learned too many lessons too late. It is ironic because in the past seven years I have helped organize Elder Law conferences for judges and lawyers; I have written articles on a number of Elder Law issues, particularly capacity; and I have learned a lot from listening to many marvelous professionals, including some of you here today. As a judge for twenty-four years, I heard a number of cases that involved disputes over whether a committee should be appointed in a particular case.

However, I have found that real life is much more complicated and untidy than theoretical knowledge. And when it is *your* parent who is aging, there is a constant struggle between respecting and building up her independence and ensuring that she is safe, physically and psychologically. It is hard to be very objective when it is your mother who is fighting hard to maintain

her independence, but you are deeply concerned that she is becoming at risk.

My mother had been an amazingly independent woman who lived by herself quite happily and very competently in a large two-story house on Salt Spring Island until her last hospitalization. Over the years, beginning with an elopement at age nineteen, she had been married four times but shed each husband long before they developed any health problems at all. She resisted any suggestions that she join any organizations for seniors because it depressed her to be around old people. She was an avid reader, finished the daily crossword, loved a glass or two of sherry each evening, and sparkled in the presence of any man younger than the age of seventy.

She cultivated a lovely garden on a couple of acres and worked on it until she was about ninety-three. Until she was ninety-four, she drove ten kilometers or so each week to get her groceries. After that, she insisted on being driven down to Ganges to shop herself. Eventually, she took advantage of Thrifty's senior-delivery service every Thursday. She dedicated a lot of time to perfecting her grocery list each week.

Any suggestion that my mum even consider assisted living was instantly and firmly rebuffed. In the last few years, she needed a pacemaker and was later treated successfully for lung cancer. I took her to either Victoria or Vancouver for her medical treatments. When she recovered, she just wanted to go home. I would take her home, stay a while, and then arrange for regular home care. Before the ferry berthed in Tsawwassen, she had usually fired the homemakers. Does that sound familiar?

My mum's insistence on independence was relentless, although gradually she began to rely heavily on one set of neighbors, who could only be described as saints, for assistance. And in any actual crisis situation, my mother would phone me, her only child, at any time of day or night to summon me or my

husband or both to deal with the problem. By that time, I was a supernumerary, or half time, Supreme Court judge, so I did have some flexibility unless I was in the middle of a criminal trial that simply had to proceed to the end. But as I began to take more and more time off my trial rota, I worried how I would ever make up that lost time.

I have read numerous reported cases, mostly in Ontario oddly enough, in which elderly parents have been removed from their children's homes in a desperate state—ill, filthy, and malnourished. The children, then charged with criminal neglect, often testify that their parents refused to go into care, to the doctor, or to the hospital. Of course, our response is horror—how could they possibly allow their own parents to deteriorate to that extent? I confess that I had some inkling of the adult child's predicament when my mother developed an aversion to having her hair washed a few months before she went into the hospital. I would think up ways to entice her to allow me to wash her hair, but it became increasingly difficult and it was always tempting to let it slide for just one more day. It gave me insight into just how difficult it could be to reason with someone who, although clearly as competent as me in most—but not all—~~aspects~~, presented as just damn unreasonable. Really, a lifetime of obeying and then respecting one's parents makes it very difficult to insist that they do something they adamantly refuse to do.

The last time my mother stayed with my husband and me in Vancouver in August 2011, I finally succeeded in getting her hair washed by putting on my bathing suit and getting into the shower with her. During that visit, she complained about feeling sick but would not or could not explain what exactly was wrong. When I took her to a clinic here, she told the doctor that there was nothing wrong with her and then brightly asked him if he did not agree that she was remarkable for ninety-six. Of course, the answer was always a resounding: "Yes, you are truly amazing." That unproductive visit convinced me that she was ready to go home.

Once back on Salt Spring Island, I immediately took her to her own doctor. By that time, in August 2011, she was probably suffering from difficulties that were to develop into a serious urinary tract infection and a bowel obstruction, but she gave no clues. Her doctor administered that GP's aide, the Mini-Mental State Exam, and you will not be surprised to hear that her score was off the charts for her age. I sat listening, thinking: "OK, she can count backwards from 100 in sevens faster than I can."

I expressed to the doctor some of the concerns I had about her apparently deteriorating mental state in some areas. She complained adamantly and persistently that her next-door neighbor, a crabby woman in her nineties, was stealing the plants from her garden. When her doctor asked me if that was possible, I replied (thinking of the answer a witness will always give eventually under persistent cross-examination): "Well, anything is possible." Some months after my mother died, the saintly neighbors actually observed the thieving neighbor in action.

But what blunt instruments there are on a gulf island for a GP to determine capacity! I had tried to get an appointment with a psychiatric geriatrician at Vancouver General Hospital (VGH) in August but was unable to get an appointment until February 2012, which was two months after she died.

As you know, an elderly adult's capacity is not a light switch. She is not totally competent, or "on," one day and completely incapable, or "off," the next day. Most people can be expected to lose capacity gradually and in certain areas before others. But that light-switch concept is, of course, the underlying and very false theory of the Patients Property Act, the statute that governs any legal determination of competence or capacity in British Columbia. That statute is a sadly outdated relic that harks back to the English Lunacy Laws of the nineteenth century.

There have been many efforts over the years to encourage or pressure the government to enact modern guardianship legislation. Part Two of the more modern Adult Guardianship Act (RSBC 1996), which deals with Decision Makers, Guardians and Monitors, was intended to replace the provisions of the Patients Property Act. However, Part Two of the Act is still not yet in force. That leaves British Columbia as one of the very few jurisdictions in at least the western world that has not progressed to the civilized appointment of guardians for adults according to need rather than the archaic appointment of *holus bolus* property or personal committees for patients.

After I left my mum at home in August, and phoned regularly, my mum would say she felt “sickish” but would not, or again could not, explain what she meant. I wondered if she was eating properly or enough, but she assured me she expected to be fine in a day or two.

In October, the kind neighbors became worried about her, and I began to become increasingly concerned that she was increasingly vague, confused, and paranoid. My husband and I tried to talk my mum into going to the doctor or the hospital. She would promise to do so until the next day, but the next day we realized that she had not done so.

I telephoned her doctor a number of times and asked if he would make a house call, but understandably, he was far too busy to leave his office and repeatedly suggested she come into see him or go to the hospital. I tried to get a community nurse to visit her but was told that such a visit just to check on my mother—without a doctor’s direction—was not within her mandate.

In retrospect, it was inevitable that events would spiral out of control. On the evening of October 24, her neighbors visited and found her usually immaculate kitchen in a terrible mess and uneaten food on a number of plates and counters. Clearly, the situation had reached crisis proportions.

Ironically, I had agreed to speak at Geriatric Medicine and Geriatric Psychiatry Rounds at VGH at 7:30 a.m. on October 25. I had met with Dr. Martha Donnelly several times and heard her present on capacity issues at Elder Law conferences for judges and lawyers. One of the things we agreed on was that in litigious proceedings, doctors often mistakenly believe that capacity is a medical determination. Of course, when there is a legal challenge to a person's competence, the finding of capacity or incapacity is a legal determination to be made by the judge, not the doctor. The doctor's opinion regarding capacity is useful evidence but not in itself determinative.

In addition, some doctors who are retained as experts on the issue of capacity in a legal proceeding view their role as the advocate of the patient or the party that retained them rather than as a neutral expert to assist the court. I had mentioned to Dr. Donnelly that it was fine being a judge hearing a lecture from doctors, but I thought that perhaps the doctors should hear a lecture from a judge.

The next thing I knew, Dr. Donnelly had set me up presenting on the topic of "The Role of the Doctor in Assessing Legal Competence: Patient's Advocate or Neutral Expert?" There were about fifty doctors present and many more from around the province over thirteen video screens.

I resolved to go ahead with my talk before dealing with my mum's crisis. Delivering the paper was easy, as I had thoroughly prepared for it. But when I was asked questions, I was so exhausted and worried that my mind was blank and my responses were totally inadequate. Of course, in retrospect, I should have told the audience exactly what my problem was and begged off answering questions.

As soon as I was finished at VGH, I telephoned my mother's family doctor and insisted that he make a house call. When he arrived, he called an ambulance to take her to the local hospital. He did not think it was necessary for me to go to Salt Spring Island at that time. In the hospital, the doctors performed many expensive tests and involved a visiting internist and radiologist. They seemed surprised that they could not find anything wrong with her. They were unable to explain why she was so suddenly confused and paranoid. The doctors decided that perhaps she had suffered a bleed in her brain, and she was taken by ambulance on October 26 to Saanich Hospital for a CT scan, but it proved negative. They performed more tests but reached no conclusions.

On October 27, her doctor telephoned me at work to say that my mum had gotten out of bed to go to the bathroom at about 6:30 a.m., and she had fallen and broken her hip. They transferred her to Cowichan District Hospital in Duncan, and I immediately left for Duncan. My mum looked awful, and she was in excruciating pain. They hoped to operate that day but their schedule was full. The following day, the surgeon replaced her hip. He told me that she was suffering from a bladder infection. He was the only person who ever gave me that information.

As you know, it is widely understood that urinary tract infections commonly cause confusion and temporary incapacity in elderly people. I would have thought that when she presented at the Lady Minto Hospital, a urinary tract infection would be high on the list of things to check for in any differential diagnosis. After the surgery, my mum was completely alert but in tremendous pain. She had had a remarkably high threshold for pain all of her life. From that day, she was never free from pain.

Tragically, as with so many elderly people, she never recovered from her broken hip. I believe the statistic is that twenty percent of Canadians older than the age of sixty-five who fracture their hip when they fall die within a year. In any event, the longer

she was in hospital, the more problems she developed. What is even more tragic is that most of those problems arose from the very fact that she was in hospital.

A few days after surgery, she was returned to the Lady Minto with the superbug— methicillin-resistant *Staphylococcus aureus* (MRSA). Serious staph infections, which are difficult to treat, are, of course, more common in people with a weakened immune system. She was placed “in isolation” in a small double room with an elderly gentleman who was not infected. Some of the nurses and doctors washed their hands, gowned, and gloved when they treated her; others did not. Those who gowned just threw their gowns and gloves into a large bucket between the beds; it was not regularly emptied.

A few weeks later, she also contracted *C. Difficile*, a bacterial infection. The symptoms of that infection are persistent diarrhea, fever, loss of appetite, nausea, and abdominal pain and tenderness. As time went on, my mother became less coherent and complained of pain constantly unless she was given so much medication that she lost consciousness. She suffered from severe edema, bowel difficulties, and later sepsis. When she was in palliative care for the last two weeks, she was either in extreme pain or unconscious.

While she was still coherent, she repeatedly said that she had slipped and fallen on a wet floor when she got out of bed. It seemed improbable at first. However, when I started to go to the hospital each morning at about seven, I saw that the cleaner washed the floors early in the morning and put a “Caution: Wet Floor” sign out in the doorway facing the hall, presumably to warn the nurses and doctors of the dangers of a wet floor.

I have to say that the nurses in the hospital were caring toward my mother and the patients, but they were so overworked that it was often impossible to get pain medication or other care for my mother in a timely fashion. My mother refused to undergo any

rehabilitation despite the valiant efforts of the physiotherapists. She told the doctor and the nurses that she just wanted to die. No one considered her capable of making that decision. She stopped eating about two weeks before she died. She stopped taking fluids several days before she died.

I have questions about the quality of palliative care in hospitals, but I must say that what impressed me most had nothing to do with our medical system *per se*. For the last two weeks of my mum's life, hospice volunteers from the community sat with her every single night in four-hour shifts. I would leave at about 9:00 p.m. and arrive at 7:00 a.m., and during that period there was always someone sitting with her. They were the most remarkable individuals—calm, kind, generous, and spiritual. I owe them a tremendous debt.

So, inevitably, my mother died on December 12, 2011.

A few weeks later, I was shocked when the Vancouver Island Health Authority sent her a letter asking her to complete a survey with respect to the inpatient services she received at the Lady Minto Hospital. It advised that her participation was very important and her opinions were valuable. Her feedback would be used to improve how they provided care.

I responded to say that I was offended that they would send such material, as a very cursory check of the hospital records would quickly reveal that she died in that hospital on December 12. However, I went on to set out my observations and opinions.

I actually did not expect to get any sort of meaningful reply. The doctors and nurses in the Lady Minto knew that I was a judge, and it was obvious, albeit unstated, that they were apprehensive that I would launch a lawsuit against the hospital. Cynically, I believed that VIHA would have any lawyer vet their reply to my letter to ensure that they did not make any potentially damaging admissions. So, I was very surprised to receive quite a

responsive letter from the Health Authority. It stated that they were aware that my mother's presenting problem was a urinary tract infection and regretted that such information was not communicated clearly to me. Now, that of course raises the issue of why the doctors advised me that none of the extensive testing they conducted explained her confusion and disorientation.

VIHA recognized the systemic issues such as overcrowding, the preponderance of elderly patients awaiting care in an extended-care facility, and the heavy workload of nursing staff. The letter said that they were making short- and long-term plans for the future to address those challenges. Well, I am not sure just what that means except that it takes a lot of money to redress those problems, and it is not likely that adequate funding is foreseeable. My concerns with respect to the delivery of pain medication and infection-control procedures were to be discussed with the nursing team as a learning opportunity.

However, the most satisfactory response to my letter concerned a concrete proposal regarding the floor washing in the patients' rooms. A new process was being put in place to replace wet mops with microfiber mops that will result in a dry floor almost immediately after washing. Staff would be requested to put any wet floor signs that may be necessary in the middle of the rooms rather than at the doorways.

So, what, if any, lessons can be learned from this story? The demographics are irrefutable. Our aging population has begun to swamp our healthcare system. I cannot provide any answers, but I want to try to identify some of the problems that I think need to be urgently addressed.

1. Resources Lacking in Rural Environments

Aging in a rural community presents additional challenges. We all recognize that elderly people are best served by sufficient home support to allow them to live at home for as long as possible.

That requires appropriate support from community and health services. Elderly people are obviously at a significant disadvantage in rural areas where services are not accessible. If they cannot drive, taxis to the doctor or the hospital may be scarce and too expensive. Doctors and nurses are too busy to do house calls. It has been estimated that one in three Canadians live in rural parts of the country, but only one in ten of Canada's family doctors, and far fewer specialists, practice there. Another gulf island, Galiano Island, has been without a resident doctor for almost three years.

Homecare workers can alert family or authorities if there are obvious signs of decline in an adult, but their services are limited and vary in quality. On the rare occasions that I did persuade my mother to utilize homecare workers, the experience was generally unsatisfactory. Their tasks seemed limited to things like washing dishes, making tea, and making beds, which my mother could do. According to her, they often tracked mud into the house on their shoes, which she would have to clean up when they left.

I think there is a need for more community nurses to visit frail elderly people who cannot easily access a doctor. Nurses can provide a certain level of care and even more importantly, assess whether the patient requires more serious medical intervention.

Conversely, there are many more resources in urban areas. For instance, the St. Paul's Hospital Falls Prevention Clinic was opened in 2007. It has geriatricians, a physiotherapist, an occupational therapist, and a social worker. It specializes in finding ways to prevent and address falls—which we all know is a leading cause of health decline (and eventual death) among elderly adults.

Services that support people to maintain their existing good health as they age will result in fewer people needing complex care and hospitalization as a result of age-related illness and disability. But those services are nonexistent in many rural communities.

When an adult's capacity is in issue, trained geriatrics who practice primarily in urban centers can perform appropriate assessments. The Salt Spring Health Study recommended exploring the feasibility of having visiting geriatricians and gerontologists come to Salt Spring Island. Clearly, such a practice would benefit all rural communities.

2. Inadequate Housing for Aging Seniors

Obviously, housing aging seniors who need assisted living or extended care in acute wards of hospitals is both inappropriate and unnecessarily expensive. Hospitals should be for the ill, and scarce acute beds should not be used as temporary housing for seniors who have special needs but are not ill. And given the predominance of hospital-acquired infections, those seniors are particularly vulnerable to illnesses they might not otherwise contract.

3. Assessing Capacity

If a geriatrician or gerontologist had properly assessed my mother in a timely fashion, could she have avoided the decline that led to hospitalization and the iatrogenic consequences?

In her struggle to remain completely independent, my mother had resisted any suggestion that she give me—or anyone else—a power of attorney. She declined to give any instructions in an advance directive. I think she was superstitious that any preparation for incapacity might hasten the process.

I mentioned earlier that British Columbia continues to labor under the archaic provisions of the Patients Property Act. One of the problems in my mother's case was that she did not lack capacity to the extent that I could have applied for an order of committeeship. Such an order requires a judicial finding that "the patient" lacks the necessary capability to manage him or herself, his or her affairs, or both by reason of mental infirmity or disorder

arising from disease, age, or otherwise. The test is high and requires the opinions of two qualified medical doctors that the patient is incapable.

In other jurisdictions, notably Australia, New Zealand, Japan, some American states, and some Canadian provinces, adult guardianship legislative reform has focused on the dignity and autonomy of the person with diminishing capacity as well as lack of capacity. When measures are required to protect the adult, the steps taken are more nuanced and layered than our system of committeehip in British Columbia. Those more flexible provisions of modern adult guardianship legislative schemes generally provide a spectrum of intervention to provide limited decision-making assistance where necessary while minimizing the intrusion into the adult's life. The individual's independence is maximized and governmental and judicial intervention is minimized. In contrast, the Patients Property Act provides no middle ground between an appointment of a committee and no intervention at all. British Columbia has had the legislation for adult guardianship since at least 1993 and revised it from time to time, but it has never enacted it.

The drafters of our Adult Guardianship Act clearly understood very well that capacity may gradually diminish and graduated assistance provided by guardianship orders should be the norm instead of the crude on-and-off light-switch approach mandated by the Patients Property Act. Part Two of the AGA provides the following guiding principles:

This Act is to be administered and interpreted in accordance with the following principles:

- (a) all adults are entitled to live in the manner they wish and to accept or refuse support, assistance[,] or protection as long as they do not harm others and they are capable of making decisions about those matters;

(b) all adults should receive the most effective, but the least restrictive and intrusive, form of support, assistance[,] or protection when they are unable to care for themselves or their financial affairs;

(c) the court should not be asked to appoint, and should not appoint, guardians unless alternatives, such as the provision of support and assistance, have been tried or carefully considered.

Alas, Part Two has not been enacted. When relief is sought under the Patients Property Act, the court is forced to decide between taking away all of the frail adult's right to make his or her property or personal decisions or both, or granting no relief.

Since 2005, whenever I talked about the Adult Guardianship Act, I have consistently said that I expected Part Two to be enacted within a short time. I have stopped saying that. After almost twenty years of inactivity, it is difficult to be optimistic. Dr. Robert Gordon has described the Adult Guardianship Act as a whale—it comes to the surface and spouts every once in a while but then sinks below the surface again and disappears.

4. Improving Hospital Standards of Sanitation and Safety

This issue is not new. When I was preparing this paper, I came upon a report entitled “Falling Standards, Rising Risks: Issues in Hospital Cleanliness with Contracting Out.” It was prepared in 2004 by the British Columbia Nurses' Union and the Hospital Employees' Union in consultation with the Health Sciences Association. This report examined cleaning services and monitoring mechanisms at St. Paul's Hospital in Vancouver. It

arose from concerns by nurses and other care providers in the Vancouver Coastal Health region who were alarmed by deteriorating standards in cleanliness and by communication difficulties with cleaning contractors. The observations and conclusions in that report closely mirrored my limited experience with hospital conditions in 2011, some seven years later.

This report stated that hospital staff were concerned that infection-control practices were slipping. They suggested that the Vancouver Coastal Health Authority did not have a monitoring system that could accurately gauge the cleanliness of facilities, the soundness of infection control practices, and the capacity of vendors to deliver knowledgeable, responsive, and stable cleaning services. The report recommended that the Vancouver Coastal Health Authority commission a comprehensive, independent audit of the region's housekeeping services, especially in the realm of infection control and other patient-safety issues.

That report estimated that the human cost of hospital-acquired infections was 8,000 deaths a year. They cited a study by Zoutman et al., that hospital-acquired infections in United States acute-care facilities were calculated to cost \$4 billion annually; in Great Britain, the figure was £900 million. There were no published Canadian data on financial costs, but they were understood to be comparable.

The authors noted that a shortage of single-occupancy rooms prevented isolation of infected and vulnerable patients. As a result, a person with a compromised immune system or a surgical patient with an open wound was often forced to share a room with an MRSA-infected individual. Overcrowding was identified as a known ingredient in the spread of MRSA. Improving bed management and isolation facilities was said to be essential to prevent and control hospital-acquired infections.

The report called for a coordinated strategy that included conservative use of antibiotics, more isolation rooms, less pressure on beds, careful monitoring of patients and staff, regular hand washing, and high standards of environmental hygiene. It reiterated the obvious—poor hospital sanitation is not just an enemy of good healing; it can be a leading cause of disease and death. It quoted microbiologist S.J. Dancer who has stated that hospital cleaning “is, in fact, likely to be a critical factor in infection control and the continuing fight against hospital-acquired infections.”

Presumably in response to that study, provincial standards were imposed in 2004 as a common measuring stick for cleanliness in British Columbia’s six health authorities. In 2008, nearly one-third of Vancouver Coastal Health hospitals, including Vancouver General Hospital, failed to meet those cleanliness standards.

In 2005, a CBC report estimated that in Canada about 250,000 people a year contract a hospital-acquired infection. In Canada, treating antibiotic-resistant infections costs hospitals \$100 million a year. Other countries, such as the Netherlands, have drastically reduced antibiotic-resistant infections thanks to strict patient-isolation policies and a “seek-and-destroy” approach to infection control. Those measures have reduced overall hospital costs.

In my opinion, the prevalence of hospital-acquired infections such as MRSA and *C. difficile* urgently requires that appropriate sanitation measures be taken in all of our hospitals. At a minimum, that requires isolation of infected patients, hand washing by hospital staff and visitors, proper disposal of used gowns, and effective surface sanitizing.

5. Palliative Care

Health Canada defines the focus of palliative care as achieving comfort and ensuring respect for the person nearing

death and maximizing quality of life for the patient, family, and loved ones.

In *Carter v. Canada*, the plaintiffs challenged the assisted-suicide prohibition in Section 24(1)(b) of the Criminal Code. I will not step into the controversy of the merits or dangers of physician-assisted dying today, but the case heard evidence from many experts on a number of issues including the state of palliative care in Canada. The Court noted that palliative care, although far from universally available in Canada, continues to improve in its ability to relieve suffering. However, Madam Justice Smith accepted the evidence of experts that even the very best palliative care cannot alleviate all suffering, except possibly through sedation to the point of persistent unconsciousness. She accepted evidence that some patients suffer pain that cannot be alleviated and some patients experience what is called "existential suffering," such as a profound sense of loss of dignity. Madam Justice Smith quoted Dr. Romaine Gallagher, a palliative care specialist, as saying:

Palliative care services across Canada have often been referred to as a patchwork of services across the country because there is little strategic planning of palliative care. There are many places in Canada, particularly in rural or remote areas, where there is little or no access to palliative care specialist nurses or physicians. If we could guarantee that every medical student or nursing student received adequate palliative care training we could assume that all primary care providers were capable of providing palliative care meeting the Canadian standards. However, the curricula and standards have only been developed in the last [ten] years in Canada.

I am sure that many hospices have developed useful and productive protocols and practices. My concern is how those goals are implemented in hospitals. I do not know where the Lady Minto

Hospital would stand on the spectrum of effective palliative-care services, but my sense was that every doctor and nurse had his or her own opinion as to what palliative care was and its limits.

There may be agreement that the primary treatment goal of palliative care is quality of life. However, it is clear that doctors and nurses may have very different views on what is best for the patient and how far they will go to ease or hasten the inevitable end. I suggest that there is a need for a strong consistent palliative-care model that everyone—doctors, nurses, patients, and family—understand. Evidence in the *Carter* case suggests that guidelines for the practice of palliative sedation are under development.

A Parliamentary Committee prepared an extensive report on Palliative and Compassionate Care on November 17, 2011. It found that while progress has been made, only sixteen to thirty percent of Canadians who need it receive palliative care. It recognized that as our population ages, health services directed toward seniors becomes increasingly more important and our present healthcare system is ill-prepared for this shift. It concluded that a national Palliative Care Strategy is desperately needed.

And so, that is my story, and those are some of my observations and my thoughts. I am mindful that all of you contribute to the betterment of seniors' lives in your different professions. I hope that by personalizing some of the problems that confront our aging population, my storytelling will contribute in some small way to encouraging you to continue your work in bringing about the necessary systemic changes in our aging society.
