Equal Access Comox Valley

Petition for Secular Long-term Care in the Comox Valley

Addendum - Background and Supporting Arguments

9/7/2017

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Introduction

This document contains supporting information for the "Petition for Secular Long-Term Care in the Comox Valley" and forms a part of the submission of that petition to the Minister of Health and to the Vancouver Island Health Authority. Two thousand, eight hundred and sixty nine (2,869) signed in support of the following statements.

> We the undersigned hereby petition the Minister of Health and the Vancouver Island Health Authority to ensure that:

1. Residential and hospice care be available from secular institutions as is the case everywhere else on Vancouver Island. It is imperative that Valley citizens who desire access to Medical Assistance in Dying (MAiD) be able to do so without encountering faith-based restrictions or transfers imposed by the institution providing the care.
2. The Minister of Health prevents the impending transfer of the assets/and or operations of the Glacier View Lodge to a faith-based organization.
3. Any new residential care beds created in the Comox Valley are granted to a secular institution.
4. All six community hospice beds are located together on a secular site.

Island Health committed on 22 June 2017 to co-locate four existing and two additional hospice beds in a secular site. Supporting information and arguments for item 4 above therefore have not been included.

Two thousand, eight hundred and sixty nine (2,869) signatures were gathered:

a. Two thousand, one hundred and ninety two (2,192) were collected, in person, throughout the community. Copies of the signed petitions are attached to this submission.
b. Six hundred and seventy-seven signatures (677) were obtained through an electronic petition on Change.Org. [1]

This document was prepared by the members of Equal Access Comox Valley – a group of citizens concerned that our right to access medical assistance in dying in our publicly funded healthcare institutions is being denied by objecting faith-based institutions.

1 Background

1.1 MAiD Access Issue

In the Comox Valley, the ability to exercise the legal right to Medical Assistance in Dying (MAiD) as an end-of life option in publicly funded residential care facilities is severely limited because of the MAiD policy enacted by the Roman Catholic (RC) Church. Its policy requires that those in its care transfer to another facility, likely permanently, if they wish to become fully informed about MAiD or if they wish to be assessed for eligibility for MAiD or to actually receive physician assisted dying. Currently, this restrictive policy affects residents of 31% of our long-term residential care beds. This could rise to 58% percent if Providence Health Care, a large RC healthcare service provider, is allowed by the Minister of Health to take over our two largest residential care facilities -- Glacier View Lodge and St. Joseph's General Hospital - The Views. This is not acceptable.

1.2 Residential Care in the Comox Valley

Comox Valley has 374 long-term residential care beds funded by Island Health in four facilities.

St. Joseph's General Hospital (SJGH) - The Views

The Views is a 116-bed RC facility currently operating under the Hospital Act. MAiD services are not permitted anywhere on the site -- according to its policy, residents and their records must be transferred to a non-objecting facility for continued exploratory discussion and assessment.

In October 2017, acute care services delivered by SJGH, co-located with the Views, will be transferred to the new secular Comox Valley Hospital.

Following the decision by Island Health that the new acute care hospital would be built elsewhere, SJGH's board announced that its long-term goal would be to evolve the site to a Campus of Care which would provide a range of services and support for seniors. Because the Views is old and does not meet the requirements of the Community Care and Assisted Living Act, the first phase would be to build a new residential care facility.

Glacier View Lodge (GVL)

Glacier View Lodge is a secular non-profit complex care facility where Island Health funds 102 residential care beds.

The lodge sits on 10 acres surrounded by a further 37 acres of undeveloped land – the land was gifted to the community and there are covenants requiring it to be used in perpetuity for seniors care and/or for public purposes. The Bylaws of the GVL Society require that the Minister of Health approve any merger plans and that any capital investment is repaid to the Ministry should the society be dissolved. GVL contracts with SJGH for administrative services. Since 2013, GVL and the Views share the same Executive Director and until very recently shared a board member.

Comox Valley Seniors Village

The Comox Valley Seniors Village has 90 residential care beds where care is provided by a for-profit secular organization.

Cumberland Lodge

With 66 residential care beds, Cumberland Lodge is a secular facility owned and operated by Island Health.

Seventy Additional Long-term Care Beds

Island Health has plans to add a further 70 residential care beds to serve our community, but to date no contract has been awarded. A year ago, an RFP was issued and bids were received and presumably evaluated; the RFP was cancelled in August 2017 and Island Health stated that it intended to re-evaluate the needs of our community.

1.3 Possible Merger – Providence Health Care/Glacier View Lodge/St. Joseph's General Hospital - The Views.

In February 2017, GVL and SJGH announced that they were exploring a partnership/merger with RC based Providence Health Care which is a large mainland health care service provider. Together they would undertake a joint planning and due diligence process over the ensuing months to determine if a partnership would go ahead.

It was envisaged that over a period of years residential care services would be consolidated into a Campus of Care on the 17 acre SJGH site managed by Providence Health Care -- with independent and assisted living co-located alongside long-term residential care. The first phase would rebuild The Views, which currently doesn't meet Community Care and Assisted Living Act standards; a subsequent phase would move all GVL residential care services into the SJGH site.

Public information about the final disposition of the 47 acre GVL site has not been forthcoming - there is speculation that 37 acres of undeveloped GVL land could be sold off to raise the capital needed to develop the new Campus of Care. Setting aside the impact on MAiD accessibility of such a merger, there is considerable concern that assets gifted to our community for public use could potentially end up owned or controlled by the RC Church and sold off for purposes not congruent with the covenants under which it was gifted.

To date, there has been no community involvement in this process with only a single announcement since February when the Comox Valley Record reported, on the 25th July, that "Providence Health Care has decided to temporarily suspend amalgamation discussions with Glacier View Lodge until the board and society have concluded internal discussions."[2]

1.4 Roman Catholic MAiD Policy

The MAiD policy used by Providence Health Care has been referred to in our arguments as it is the one that would affect our community. SJGH refused to divulge its procedures but was forthcoming with its policy.

We note that there is a wide range of variously restricting policies adopted by different Christian denominations making generalization impossible - secular vs. non-secular, faith-based vs. non-denominational, etc. For example, the United Church, the Anglican Church and the Lutherans, all

Christian denominations, permit MAiD: the Baptists will provide all information about MAiD, will allow eligibility assessments and will permit residents to stay in their care home during the 10 day reflection period, but residents must move out for the actual act of assisted dying.

RC MAiD policy apparently flows from a renewal of consecrated life made by the Second Ecumenical Council of the Vatican in Rome in the 1960's that "….no one is permitted to ask for this act of killing, either for himself or herself or for another person entrusted to his or her care, nor can he or she consent to it, either explicitly or implicitly, nor can any authority legitimately recommend or permit such an action.[3] The RC 146-page Health Ethics Guide, published by the Catholic Health Alliance of Canada, reflects this teaching and strict adherence is apparently expected by all institutions.[4]

RC-based Providence Health Care provided us with its "CPF3100: Responding to Requests for Medical Assistance in Dying Policy" from its Corporate Policy Manual. This policy then has been used as typifying what would be used in all RC institutions.[5]

The language in the policy is plain; the procedures flow from an over-arching principle stated in the policy that "personnel will not enable the provision of Medical Assistance in Dying." The following is reproduced from the procedure section of Providence Health Care's policy -

"1. If a patient makes a request to any of his or her providers for Medical Assistance in Dying, this matter will be brought to the attention of the Most Responsible Provider (MRP).

2. The MRP will explore with the patient their concerns with the current situation and prognosis, and ensure the patient is made aware of all possible standard end-of-life care and treatment options, including adjustments to the current treatment plan, and palliative and comfort care.

a. If the patient accepts these services, they will be provided to every extent possible.

b. If, despite the provision of these treatments and interventions, the patient determines that his or her needs and concerns have not been adequately met, and remains interested in Medical Assistance in Dying, the MRP will consider whether there is any indication that the patient is incapable of making a decision concerning Medical Assistance in Dying.

c. If the MRP determines the patient to be incapable of decision-making regarding health care in general, or Medical Assistance in Dying in particular, the request for Medical Assistance in Dying will not be pursued. Subsequent decisions about health care will be made either by a substitute decision maker, and/or with the aid of an advance directive if one exists.

d. If the patient requests a second opinion regarding his or her capacity, this will be provided.

3. If there is no concern about the patient's decisional capability, the MRP will initiate a transfer to a non-objecting centre/setting by contacting medicalassistanceindying@vch.ca or by phone at 1-844-550-5556 for continued exploratory discussion and assessment.

4. Patients may be transferred to another facility of their choice in accordance with their wishes at any time if there is an admitting provider willing to assume care.

5. If at any time the patient abandons interest in Medical Assistance in Dying, and seeks to return to PHC for care, re-engagement with PHC services will be expedited. If it is the wish of the patient to return to PHC during a waiting time, PHC will accept the patient back if appropriate to their ongoing care needs. "

2 Supporting Arguments for Secular Residential Care

We present the following arguments to support our case for secular long-term residential care.

1. RC MAiD policy is a breach of our Charter Rights and those rights granted by the Supreme Court under Bill C-14.
2. We have a right to accessible and universal services under the Canadian Health Act and the BC Medicare Protection Act.
3. There is no legislative foundation for institutional conscientious objection.
4. RC MAiD policy is unrealistic and places an additional burden and expense on the health care system.
5. As MAiD eligibility criteria expand, more citizens will be denied their right to choose.
6. Residential care should reflect community demographics and contemporary public policy.
7. Glacier View lodge should remain a community asset.
8. Seniors' care and dignity are a BC Government priority.

These points are expanded below.

2.1 RC MAiD policy is a breach of our Charter Rights and those rights granted by the Supreme Court under Bill C-14.

There is incontrovertible evidence, as illustrated below, from physicians and patients that RC MAiD Policy, in forcing those wishing to pursue the option to relocate from their long-term care home, represents a fundamental breach of the security of the person guaranteed under Section 7 of the Canadian Charter of Rights and Freedoms. Further, RC MAiD policy places an undue burden on individuals wishing to access their constitutional right to medically assisted dying.

In Carter v Canada, the Supreme Court held that the laws prohibiting physician-assisted dying interfere with the liberty and security of the person of individuals who have a grievous and irremediable medical condition. They interfere with liberty by constraining the ability of such individuals to make decisions concerning their bodily integrity and medical care, and with security of the person by leaving such individuals to endure intolerable suffering. The Court also held that the laws deprive some people of life by forcing them to take their own lives prematurely for fear that they would be incapable of doing so when they reached a point where their suffering was intolerable.[6]

2.1.1 RC MAiD policy interferes with the security of the person

Section 7 of the Canadian Charter of Rights and Freedoms states that "Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice." As per the Supreme Court Carter decision, Section 7 encompasses life, liberty and security of the person also during the passage to death.[7]

A publicly funded residential care facility is the last place that many call home. The average stay in a long-term residential care home in Island Health is 850 days. [8]

By permitting and facilitating RC MAiD policy, Island Health and the Ministry of Health interfere with our right to security of the person, as guaranteed under Section 7:

- The physical transfer of frail and dying residents from their homes into an unfamiliar setting inflicts unnecessary and inhumane physical and psychological suffering.
- Insisting that dying persons abandon the security and familiarity of their final home in order to exercise a constitutional right inflicts unnecessary psychological suffering on individuals and on their immediate caregivers, families and friends.

The 2002 Community Care and Assisted Living Act (CCALA) requires that service providers protect the health, safety and dignity of persons in their care and, in the case of adults, the rights of those persons in care. The RC MAiD policy does not fulfill this legal requirement as exemplified in the following section.

2.1.2 Examples of suffering and loss of dignity affecting security of the person

Listed below are reports from physicians, patients and their families to illustrate the inhumane effects of transfers on the sick and dying.

Reports from Physicians

*"*Even a patient so ill that they would, under different circumstances, be deemed unfit to be transferred must submit to an uncomfortable and unnecessary ambulance journey accompanied by distressed family members. In the case of patients who request an expedited medically assisted death due to the extremity of their condition, the delay caused by the need to make the arrangements for transfer may be sufficiently great that the patient loses legal capacity and thus, their right to a medically assisted death. This is the cruelest hospital policy that I have ever encountered in over thirty years of medical practice. St. Joseph's motto 'Care with Compassion' rings hollow now." Dr. Jonathan Reggler. [9]

Eighty local doctors signed a letter to Island Health asking to establish a new hospice that offers medically assisted death.[10]

"… forcing someone to be transferred out of the hospital to receive MAiD …is neither kind, nor compassionate, nor medically necessary."[11] Dr. Tanja Daws

"When people are in any kind of elder care facility be it assisted living to complex care for advanced dementia patients, this is now their home, and it is not right to have any faith based control of our own directives in our own homes" Dr. Barbara Fehlau[12]

Reports from patients

- "It's horrible to transfer a dying man…I was very concerned about him losing capacity and access to MAiD." Liza Saffarek[13]
- "I can still clearly hear his screams"[14]
- "…forcing a transfer…emotionally and physically traumatic for the patient and family members." Catherine Carston. [15]
- "The last few days of her life were miserable. That was because of the policies of the hospital " George Kirkwood[16].
- "Mom said she now wants to consider moving – leaving her friends – to live where she will have her wishes respected".[17]

Difficulty of transfers recognized by Parliamentary Committee

The Canadian Parliament's Special Joint Committee of 2016 recognized the problem of transfers; "A number of witnesses argued, and the Committee also believes, that if a health care facility is publicly funded, it must provide MAiD. The difficulty in transferring a patient from one facility to another was highlighted.[18]

2.1.3 Rights under the Carter Decision and Bill C-14

The Supreme Court of Canada in the Carter decision granted the constitutional *right* to physician assisted dying – this cannot be trumped by a baseless claim for institutional religious *freedom*.

Bill C-14 requires that two independent physicians/nurse practitioners assess whether individuals are capable of making decisions with respect to their health and that a written opinion must be provided. Under RC MAiD policy however, only one opinion is given and the individual must insist on a second – with no guarantee of independence and with nothing in writing. If judged incapable, then subsequent decisions about health care will be made by a substitute decision maker and/or with the aid of an advance directive if one exists. We note that an assessment of capacity is only made after discussions about other care options. Given the RC aggressive stance on this issue, we worry that its policy could be used by the zealous service provider to completely deny all access to MAiD. Further, with no MAiD request form, the reporting requirements at the provincial and federal level are not being met.

Without the checks and balances inherent in Bill C-14 provisions, the procedures in the RC MAiD policy interfere with the liberty of individuals to make decisions concerning their bodily integrity and medical care – contrary to Section 7 of the Charter of Rights and Freedoms.

2.1.4 RC MAiD policy puts an undue burden on the individual trying to access MAiD

To successfully pursue MAiD in an RC facility, suffering residents are first subjected to a capacity assessment; if judged competent, they then must move out of the place that they may have called home for years. They will lose the relationships they've created and enjoyed there and will possibly have to relocate to another town or city while facing a possibly excruciatingly painful and inhumane transfer to a non-objecting facility. In a strange new location, they must then find two independent witnesses to attest their MAiD request form. If it turns out that the resident is not eligible (for every eligible resident,

between 5 and 10 are ineligible[37]) then the resident would have gone through that entire trauma for naught.

This psychologically debilitating and daunting process would make a frail resident think more than twice before proceeding – a form of emotional blackmail. These barriers deny an individual the liberty, guaranteed under Section 7 Charter Rights, to choose medical assistance in dying.

In some cases, the barriers to assisted dying could cause some to consider suicide as a preferable choice.

2.2 Rights to accessible and universal services under the Canadian Health Act and the BC Medicare Protection Act.

BC's Medicare Protection Act (Sections 5.4 and 5.6) and the Canadian Health Care Act (Sections 10 and 12) both require Accessibility and Universality in health care service delivery. MAiD is considered a health care service, as is palliative sedation (inducing coma); the former is prohibited by the RC Church while the latter is accepted.

Accessibility assures that benefits are delivered on uniform terms and conditions on a basis that does not impede or preclude reasonable access. *Universality* assures that health care plans apply to 100% of beneficiaries on uniform terms and conditions.

RC MAiD policy presents huge individual obstacles to accessibility as expanded in section 2.1.4 above. At the community level, MAiD is not accessible in 31% of our residential care beds. It is patently unfair that one individual who happens to be placed by the health authority into a non-objecting institution would have no problem with MAiD access, while another placed in an RC facility less than two miles away would face such enormous hurdles.

Island Health has a "first appropriate bed" policy. This means that, even if it's not the facility requested, individuals are required to accept the first appropriate bed that becomes available anywhere within their local health services area. The BC Seniors Advocate's "Monitoring Seniors Services 2016"[19] report showed that in 2015/16, only 30% of those requiring residential care got their preferred bed on initial placement and only 16.5% were moved to their preferred facility after initial placement.

This is clear evidence that we rarely get to choose our "last home" or that we are able to avoid those institutions objecting to MAiD should we think we might want that option -- choice is illusory.

With respect to universality, in the Comox Valley only 69% of residents of long-term care are in non-objecting facilities -- this compares to 94% in the Greater Victoria Area and 100% everywhere else on Vancouver Island.[20] We computed these numbers by cross-matching the Island Health Residential and Assisted Living inventory report[21] against those facilities allowed to opt-out under Appendix A of the 1995 Master Agreement.

Physicians are willing and able to provide MAiD services in Comox – only the RC MAiD policy prevents universal access.

2.3 No right to institutional conscientious objection either provincially or federally

2.3.1 No supporting legislation

While rightly protecting individual religious freedoms, neither federal nor BC legislation supports institutional conscientious objection. The courts have generally rejected claims of institutional religious rights or conscientious objection, with a narrow exception for religious educational institutions to teach their religious viewpoint. Notably in the Loyola ruling, an RC high school was not granted a universal opt-out from government policy. Publicly funded faith-based care facilities cannot make a similar claim as they service the entire community, regardless of religion. Furthermore, their own staff is comprised of people of various faiths or no faith at all. Their focus is not the narrow promotion of a religious worldview but in providing healthcare to everyone regardless of religion. As such, they ought to be treated equally with any other publicly-funded healthcare facility.

Quebec's physician assisted death law, Bill C52, was enacted in 2014; it states that individual physicians can refuse to provide assisted death, but that publicly-funded institutions cannot. A few provinces have enacted legislation allowing faith-based institutions to opt out of MAiD – BC has not enacted such legislation.

The Canadian Parliament's Special Joint Committee on Physician Assisted Death in 2016 concluded "A number of witnesses argued, and the Committee also believes, that if a health care facility is publicly funded, it must provide MAID." Its Recommendation 11 was that "the Government of Canada works with the provinces and territories to ensure that all publicly funded health care institutions provide medical assistance in dying."

"It is only a matter of time before the right of faith-based hospitals to refuse medical assistance in dying is challenged in court, said Sen. Serge Joyal. And provinces should take the lead, he said, rather than leaving such an important policy question to individuals." October 2016 [22]

2.3.2 The Master Agreement Opt-Out Clause

In BC, the RC Church bases its right to opt out of MAiD on a single clause of the "1995 Master Agreement between the Minister of Health and the Denominational Health Care Facilities Association". Clause 3.8, it claims, permits it to refuse to provide any services that are inconsistent with its declared mission and values. The Master Agreement was created as part of the regionalization of Health Care services in the mid 1990's -

"….with the advent of regionalization in 1995, the hospital developed a new model of affiliation with the government. A denominational master agreement was signed in 1995 by 32 faith-based providers of healthcare in BC." …extract from History of St. Josephs.[23]

Its main purpose, according to the preamble, was to provide a standard set of terms/requirements that should be included in any service agreement struck between the then new regional health authorities and specific denominational service providers in their region. Things like dispute resolution, annual funding mechanisms and requirements for boards of trustees are contained therein. Master Agreement

clauses are carried by the Local Health Authorities into specific service agreements. The opt-out clause 3.8 was likely included because of the uncertainty surrounding abortion that existed at that time. However, this later became a moot point when the 1996 Hospital Act Section 24.1 prescribed that only certain named hospitals could deliver abortion services – thus providing legislative legitimacy to those choosing to opt out.

We believe the Master Agreement and any service agreements contracted by Island Health which permit the denominational service provider to opt out of the provision of MAiD are on very shaky legal ground.

- The Master Agreement was negotiated at a time when the only services inconsistent with the Health Ethics Guide of the Catholic Alliance of Canada were those that did not threaten the security, wishes, dignity and constitutional rights of frail individuals at end-of-life. While inconvenient, patients requiring abortion, contraception, IVF or sterilization would more than likely be able to travel with dignity and security of person to a non-objecting institution with no breach of their Section 7 Charter rights.
- There is no precedence for using this clause to restrict a specific right prescribed by law such as the right to assisted dying in Bill C-14.
- The 2002 Community Care and Assisted Living Act (CCALA) requires that service providers protect the health, safety and dignity of persons in their care and, in the case of adults, the rights of those persons in care. The RC MAiD policy forcing transfers does not fulfill this legal requirement.
- Section 2.2 of the Master Agreement stipulates that the denominational provider must follow provincial standards for health care -- the RC MAiD policy follows neither the provincial standards[24] nor those of the BC College of Physicians and Surgeons[25] related to MAiD.
- A contract (agreement) must be fair and have certainty; it must be precise and definite. [26] Opt-out clause 3.8 gives the denominational service providers carte blanche – they are the sole decision maker in what is and what is not consistent with their values. We believe the contract may be considered unfair and therefore void.

The above arguments could likely be expanded to include consideration of matters such as income tax legislation, consumer protection, and licensing regulations. Traditionally, statutes and regulations are revised every fifteen to twenty years. Periodic revision should apply equally to long-standing agreements like this one.

2.4 RC MAiD policy is impractical and places additional burden and expense on public health care

Timely transfers to non-objecting locations for MAiD, as required by RC MAiD policy, are highly unlikely in our smaller community where there is a huge backlog of pressing and urgent requests for both long-term residential care beds and acute-care beds.

For Island Health, the average wait time in 2015/16 for a residential care bed was 62 days and only 40% of requestors were admitted within the provincial target maximum wait time of 30 days. The average length of stay in a residential care bed within Island Health was 735 days in 2015 and 850 days in 2016. [27]

Health authority placement personnel should not have to make a choice between giving the next available spot to someone in desperate need of care or a transfer from an acute care bed and someone who already is in care but needs a spot elsewhere so that they can explore their legal right MAiD.

Residential care service providers are required to maintain a 99% or better occupancy rate or risk losing funding -- they are hardly likely then to have beds hanging around unoccupied. BC Emergency Health Services have told us that it has a high demand for medical transport services in the Comox Valley.

Transfer to acute care is even more unrealistic.

- Acute care occupancy is currently running at 104% within Island Health. SJGH has one of the highest Alternate Level of Care (ALC) rates in the province at 28% - 17% over Island Health's target of 11%. This means that almost three out of ten of our acute care beds are not available to those needing acute care but instead are filled with patients whose condition has been stabilized but have nowhere else to go.[28]
- The stricter RC policy requires the patient to go to acute care for the two required assessments. If found ineligible, they would have to return to long-term care. If eligible, they would then have to wait 11 days in the acute care facility (Bill C-14's 10 clear day waiting period will apply), or return to long-term care only to come back to acute care after 11 days. Thus, there would be two unnecessary journeys.
- There would be no guarantee that an acute care bed would be available on the agreed date for MAID and delay/postponement would be quite possible. This would make planning very difficult for family and potentially cause ineligibility should the individual's condition deteriorate while waiting.
- The cost of treating a BC senior in hospital ranges from $825 to $1,968 per day, whereas the cost of residential care is approximately $200 per day.[29]

Hospice beds should not be seen as destinations for medical assistance in dying. In an ideal world, persons with a life-limiting illness would receive optimal hospice palliative care in the hope that no one would ever desire to hasten their own death.

Shuffling frail and dying patients between care facilities based on a dogma demonstrably not shared by most of the population is neither compassionate nor an astute use of taxpayer dollars.

The expense of catering to RC MAiD policy, to the best of our knowledge, has not been factored into any RFP financial evaluation criteria. Additional costs for MAiD coordination offices, residential care placement staff, transportation costs and use of acute care facilities all add needlessly to our health care bills.

Doubling the number of beds subject to RC MAiD policy would enormously aggravate this situation.

2.5 Future expansion of MAiD eligibility criteria will only exacerbate the problem

Eligibility for MAiD could be widely expanded in upcoming years which will further exacerbate this situation. With more and more individuals eligible for access to MAiD, it is incumbent on the government to ensure that its citizens are able to access that right.

A landmark Ontario case recently clarified the definition of "reasonably foreseeable" and eligibility under existing legislation will likely expand because of that.[30] The Council of Canadian Academies, on behalf of the Government of Canada Department of Health, is currently examining three complex types of requests that were identified by Parliament for further review and study. These cases are: requests by mature minors, advance requests, and requests where mental illness is the sole underlying medical condition. Earlier this year, Quebec announced that it is considering advance requests for dementia patients.[31]

A 2015 report by academics, advocates, and officials recommended that the federal government allow for advance requests[32] as did a 2016 report by senators and members of parliament from the three major Canadian parties.[33] Those facing dementia may want to have assisted dying as a choice – will MAiD-objecting providers refuse to take dementia patients with advance consent orders?

2.6 Services that reflect our community demographics and current public policy

The Comox Valley is home to approximately 66,000 people of whom 9.8% are aged 75 and over. Over the next 20 years, the population is expected to grow by 30% and the number over age 75 is expected to nearly double.[34] In the 2011 National Household Survey, 52% in our census area identified as having no religious affiliation and only 12% identified as being Roman Catholic.[35]

Even this number is likely to be an over-estimate as the survey asks to identify religion even if it is not practiced. A 2016 Insights West poll found that 73% of people on Vancouver Island do not practice a religion or faith and only a quarter of the 20% (or 5% of people) who claimed to be religious said they were Catholic.[36] Using demographics as major criteria, only 5% of long-term beds should be subject to RC MAiD policy.

2.6.1 Strong Citizen Support for Medical Assistance in Dying on Vancouver Island

A recent Times Colonist survey of provincial coroners, health ministries and health authorities found that British Columbia ranked among the highest in the country for occurrences of medical assistance in dying in 2016. Our most recent information is that the current MAID rate on the Island has been 24 per month -- this equates to just over 4% of all expected deaths.

Island Health reported that for each assisted death performed, between 5 and 10 patients requesting MAiD are currently deemed to be ineligible[37]. The chart at right shows the latest data from the BC Coroner's Office – clearly islanders want MAiD as a choice.

January 1, 2016 - July 31, 2017 - MAiD Deaths	
Island Health	236
Interior Health	91
Fraser Health	77
Northern Health	17
Vancouver Coastal	147
Total:	**568**

An IPSOS poll taken February 2016 showed that 85% of Canadians support the Supreme Court's decision vs. 15% who oppose it. Ninety-three percent of those identifying as having no religious affiliation supported MAiD as did 83% who identified as Roman Catholics.[38] There is no reason to believe that Vancouver Island residents would not share these same views -- to the contrary, the statistics in the preceding paragraph would suggest stronger support here than elsewhere.

In the 2016 Insights West poll[36] only 13% of Vancouver Islanders support publicly-funded healthcare institutions being able to refuse providing certain services such as MAiD. This compares to 83% opposed – 67% strongly opposed – to the idea. This is the strongest opposition in the province or among any measured demographic.[36]

These figures explain why our petition has received such strong support in the community and why there have been so many letters and articles in our newspapers supporting our right to access MAiD.

2.6.2 Current Public Policy

Public policy has changed radically since the Master Agreement was penned in 1995. In 2016, Bill C14 introduced support for assisted dying. The Civil Marriages Act in 2005 gave support for same-sex marriage. More recently in June 2017, gender identity or expression was added to the Canadian Human Rights Act after already being added to the BC Human Rights Code in July 2016. Society has moved on but the RC Church remains steadfast in its opposition. This is adequately demonstrated in SJGH MAiD policy which states "The organization's ethical and moral opposition to provide Physician Assisted Suicide needs to be recognized, respected and honoured by all persons served by, or working within St. Joseph's General Hospital including, but not limited to funders, regulatory bodies, advocacy groups and the larger community".

Less publicized than its opposition to physician assisted dying is the Roman Catholic position with respect to gender identify. The Catholic Health Alliance of Canada's Health Ethics Guide, Article 36 states that those suffering from any form of gender difficulties are to receive objective counseling and that surgical intervention, hormonal therapy and referral for gender reassignment surgery are not allowed in RC facilities. This implies that, under the cover of opt-out Clause 3.8, RC service providers could legitimately refuse transgender persons their daily hormone medications in a residential care home. In the case of a legally married same-sex couple, would the RC Church use Clause 3.8 to preclude co-habitation in their Campus of Care or to block the couple from being housed in the same residential unit?

The Ministry should not qualify suppliers of publicly funded health services as compliant when the supplier's ethical stance obstructs the delivery of services and takes away the rights of the individual. Public funding should follow societal consensus and the Ministry, in fairness to taxpayers, should take every opportunity to switch from suppliers refusing to accept Canadian public policy.

2.7 Glacier View Lodge should remain a community asset

Glacier View Lodge has deep roots in the valley being built by the generous donations and hard work of the community.

Started by the Women's Institute in 1946 on land owned by the Marslands, the property was sold to other prominent figures in the community, Menzies and Sims. Covenants were established to make sure that the land would be used in perpetuity to provide a home for the use and benefit of elderly citizens and which would restrict the land to public use only. Menzies and Sims donated the land to the City of Courtenay, which then transferred it to the Regional District in 1968. From 1968 to 1981, the seniors home was operated by the Regional District. In 1979, the Glacier View Lodge Society was created and the property transferred to its custody.

Valley Citizens have demonstrated the importance they place in keeping GVL in the community. Five thousand valley residents, supported by the municipal councils of Comox and Courtenay, petitioned the Minister of Health in the late 90's to prevent the compulsory amalgamation of GVL with the Comox Valley Community Health Council. A Supreme Court Justice on the GVL v Minister of Health case noted that "history does such credit to the people of the Comox Valley I cannot forbear from stating it".

The most current Courtenay Official Community Plan (OCP) Bylaw 2387, developed in consultation with residents, designates the 48 acre GVL site for institutional/community use. The OCP policy for the site actually supports expansion of the lodge and the construction of senior's residential units for congregate care. [39]

The United Church in June 2017 invited St. Joseph's, Providence, GVL and Island Health to participate in a community forum on the issue of MAiD accessibility – all four declined to participate. A forum, hosted by the Equal Access Committee in the local community centre drew more than 200 community members who were mostly supportive of secular care, in particular at GVL.

If asked, the community would likely respond that GVL should remain independently secular.

To date, neither SJGH nor GVL has asked for community input or approval for amalgamation. The boards of both organizations have not shared any details of the plans -- especially with respect to asset transfer, ownership and management board structure.

The current GVL Board of Directors, St. Josephs Board of Directors and Providence Health Care should not dictate the future of 58% of publicly funded long-term residential care facilities or of the disposition of assets gifted to our community for seniors care – the community's voice should be paramount.

2.8 Seniors Dignity and Quality of Care is a BC Government Priority

An interim report was tabled from the Select Standing Committee on Health to BC's 40th Parliament in October 2015. The NDP and Liberal MLAs on that committee received 374 submissions from the public and ultimately recommended that the government incorporate equitable access to physician-assisted dying across the health care spectrum, including home care, support living, acute care, extended care, hospice and palliative care. The Health Minister at the time chose to wait for federal legislation.[40]

The new BC Government, through the Minister of Health's Mandate Letter, has set as a priority to "Work with the Parliamentary Secretary for Seniors to improve and strengthen services to ensure seniors receive dignified and quality care"

Secular residential care services in our valley would represent an important step forward by permitting everyone in our community to explore all end-of-life choices in the safety and security of their care home.

3 Unique Opportunity for Change

The timing is unique for the Minister and Island Health to remedy this situation.

- Glacier View Lodge, with investment, could become a wonderful Community of Care – it has ample room for expansion and the site is close to the new Comox Valley Hospital.
- SJGH - The Views facility is old and requires complete reconstruction to meet modern residential care standards.
- The RFP for 70 new residential care beds allows Island Health to select service providers who are fully supportive of contemporary Canadian values and public policy.

Endnotes

[1] https://www.change.org/p/british-columbia-ensure-equal-access-to-medical-assistance-in-dying-in-the-comox-valley

[2] http://www.comoxvalleyrecord.com/news/providence-health-care-suspends-discussions-with-glacier-view-lodge/

[3] http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19800505_euthanasia_en.html

[4] This publication is not available online. A copy can be obtained by mail order for $20.

[5] See here for Providence Policy http://www.equalaccesscomoxvalley.ca/uploads/1/0/9/6/109639101/cpf3100_responding_to_requests_for_medical_assistance_in_dying_policy.pdf

[6] http://www.justice.gc.ca/eng/rp-pr/other-autre/ad-am/p1.html

[7] http://www.justice.gc.ca/eng/rp-pr/other-autre/ad-am/ad-am.pdf

[8] Source: BC Seniors Advocate, Monitoring Seniors Services Report, 2016

[9] http://www.cbc.ca/news/canada/british-columbia/b-c-doctor-resigns-from-catholic-hospital-board-after-it-refuses-to-offer-medically-assisted-death-1.3812379

[10] http://www.cbc.ca/news/canada/british-columbia/over-80-comox-valley-doctors-want-to-keep-new-hospice-beds-away-from-st-joseph-s-hospital-1.4018504

[11] https://www.comoxvalleyrecord.com/news/doctor-questions-st-josephs-hospitals-sgo/

[12] Letter from Dr. Barbara Fehlau to EAC, June 19, 2017

[13] http://www.cbc.ca/news/health/medically-assisted-dying-access-one-year-later-1.4165936

[14] http://www.cbc.ca/news/canada/calgary/medically-assisted-dying-calls-1.4166707

[15] Comox Valley Record May 11, 2017

[16] https://www.comoxvalleyrecord.com/news/hospice-beds-one-possible-solution/ sidebar at end of article

[17] http://www.comoxvalleyrecord.com/opinion/phone-call-to-mom-about-local-maid-situation-appals-kootenay-resident/

[18] See http://www.parl.ca/DocumentViewer/en/42-1/PDAM/report-1/page-ToC Recommendation 11

[19] https://www.seniorsadvocatebc.ca/app/uploads/sites/4/2016/12/OSA-MonitoringReport2016.pdf%20%20

[20] These figures were calculated by cross-referencing the Vancouver Island residential care facilities allowed to opt-out in the Master Agreement Appendix A with Island Health's HCC inventory found on their website then applying the appropriate mathematics.

[21] http://www.viha.ca/NR/rdonlyres/8FF9FE83-7375-4854-AA73-CCD355B1ED55/0/hcc_beds_inventory.pdf

[22] http://ottawacitizen.com/news/local-news/faith-based-hospitals-right-to-refuse-assisted-death-will-be-challenged-joyal-says

[23] http://www.chac.ca/about/history/books/bc/Comox_St.%20Joseph%27s%20Hospital%20100th.PDF

[24] http://www2.gov.bc.ca/gov/content/health/accessing-health-care/home-community-care/care-options-and-cost/end-of-life-care/medical-assistance-in-dying

[25] https://www.cpsbc.ca/files/pdf/PSG-Medical-Assistance-in-Dying.pdf

[26] https://en.wikipedia.org/wiki/Certainty_in_English_law

[27] Source: BC Seniors Advocate, Monitoring Seniors Services Report, 2016

[28] https://www.viha.ca/NR/rdonlyres/E3ADD2C4-42FD-4A72-834F-2EBB421BDBA4/0/PFAlternateLevelofCare.pdf

[29] http://www.bccare.ca/wp-content/uploads/BCCPA-White-Paper-QuIC-FINAL-2015.pdf

[30] Source: Reasonably Foreseeable Ruling

[31] https://www.thestar.com/news/canada/2017/03/24/quebec-considers-assisted-death-for-dementia-patients.html

[32] http://www.health.gov.on.ca/en/news/bulletin/2015/docs/eagreport_20151214_en.pdf

[33] http://www.parl.ca/DocumentViewer/en/42-1/PDAM/report-1/page-24#2

[34] Source: Island Health, Comox Community Profile

[35] Source: Statistics Canada National Household Survey 2011, Comox Valley, Religion

[36] [36] http://www.bchumanist.ca/religious_and_secular_attitudes_2016
[37] http://www.timescolonist.com/news/local/one-sailing-wait-on-tsawwassen-swartz-bay-route-due-to-mechanical-problems-1.22190064
[38] Source: Dying with Dignity Ipsos Poll Feb 2016
[39] City of Courtenay Official Community Plan (Appendix "A"to Bylaw No. 2387 February 17, 2016) page 134
[40] https://www.leg.bc.ca/content/CommitteeDocuments/40th-parliament/4th-session/health/reports/PDF/Rpt-Health-40-4-Interim-Report-2015-10-28.pdf