

Final Report – End of Life Care for Seniors: Canadian Initiatives

Symposium held at International Association of Gerontology's 17th World Congress of Gerontology, Vancouver, July 5, 2001



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In Canada, end of life care is slowly becoming recognized as an important issue in institutional health practice and government policy. In a symposium sponsored by Health Canada on July 5, 2001, in Vancouver as part of the International Association of Gerontology's 17th World Congress of Gerontology, four individuals actively working in the area (Senator Sharon Carstairs, Dr. Rory Fisher, Dr. William Molloy, and Jane McNiven of Canadian Pensioners Concerned) highlighted some of the key issues in the area. Dr. Astrid Stuckelberger, from the Swiss Research Programme on Ageing in Genève Switzerland as discussant, framed the issues within an international context. Their insights provide several "lessons learned" on how to enhance and deliver better care toward the end of life and in effect "how to create a 'good death'".

This report of the symposium summarizes the four presentations and the discussant's remarks, audience questions and comments, as well as offering the author's interpretation of gaps in policy, practice and knowledge. In the final section of this report these are brought together by the author as points for further consideration at federal or provincial levels.

The National Direction

In her talk entitled "*Quality End of Life Care: The Right of Every Canadian*", Honourable Sharon Carstairs, Minister with Special Responsibility for Palliative Care described the progress made by government to respond more effectively to end of life care. In Canada, quality end of life care is the responsibility of both federal and provincial governments, and thus requires a coordinated approach to the issue.

Part of the impetus for consideration of quality end of life issues in Canada arose from legal cases during the 1980s and 1990s. The cases considered persons' "right to die" (i.e., turning down treatment, control over the timing of death, passive and active euthanasia). The focus of early discussions operated within the context of personal autonomy, withdrawing and withholding of end of life treatment, pain control, advance directives, and quality palliative care. The highly controversial cases led to subsequent national Senate hearings on euthanasia and assisted suicide which, in turn, highlighted the need to change the medical structure to provide better end of life care, and in particular for a compassionate, comprehensive approach to care in the latter stages of living. Up to that point, much of the health system focus was on "cure", an approach not always as well suited to providing the type of care needed where people were dying or had long term chronic problems or slowly deteriorating cognitive abilities. Since the 1990s, Canada has gradually begun recognizing the need for new models of care for the end of life, ones that were flexible, broad based in character, and suitable to a range of medical conditions that a person may have towards the end of living.

Carstairs pointed out that while there may have been a lack of societal agreement on some of the issues related to euthanasia and assisted suicide during the 1990s Senate hearings and subsequent discussions, consensus has been achieved in many other areas related to end of life care. The Senate Subcommittee on Palliative Care has developed fourteen recommendations in areas of federal jurisdiction. Outlined in a June 2000 report, these centred on five key areas:

- developing a national strategy for end of life care;
- offering income protection for those providing informal care;
- assuring education and training for health care providers;
- providing adequate home care and pharmacare; and
- having adequate research on end of life care matters and disseminating those findings.

On June 5, 2002, the federal government established the Palliative Care Secretariat, now renamed the Secretariat on Palliative and End of Life Care. The role of this body is to aid dissemination of knowledge and information on the issue of palliative care and end of life matters. It currently identifies palliative care initiatives that are in place or under way across Canada. Other longer term aims of the Secretariat are to develop national standards of palliative care and provide consultative services.

Lessons Learned In Canada

In Senator Carstairs' talk and those of the other three speakers, three main themes emerged:

A. *A Broadening of the Framework:* Over the past decade, the general framework for viewing both end of life and palliative care has shifted. In Canada, there is a growing acknowledgement that dying can take many different forms and routes, and that there are important physical and emotional needs of people (the patient, family, health care providers) that must be met in order to have "the good death". End of life care approaches in this country must also be framed within the geographical (rural/urban differences) and cultural diversity of Canada.

In his talk entitled "*A Guide to End of Life Care in Canada*", Dr. Rory Fisher pointed out that cancer deaths often framed much of the early discussion about end of life care (and particularly in the context of pain control, and types of treatment which were, or were not, considered appropriate for the individual at this stage of living). The traditional treatment model was often framed in the context of "curing people". If surgery could not "cure" the individual, it was seen as neither necessary nor appropriate when providing end of life care. The newer, broader approach to end of life care considers surgery and other approaches as acceptable not as means to cure, but as means to relieve pain for the individual.

Surgery and other approaches become treatment for comfort, and part of compassionate care.

It has also become evident that the concept of “palliative care” will need to be broadened. Dr. Fisher pointed out that until relatively recently, the dominant conceptualization of palliative care has been a special type of care limited by time, to a place, and to specific conditions. The classical approach tended to be “The person is dying of X. Therefore, we will provide her or him with palliative care in a special ward for a set period of time (e.g. “the last two weeks of her life”).

Dr. Fisher went on to state that it is also increasingly being recognized that people can have a much broader set of physical conditions that can lead to death and end of life care must meet these people’s needs. The newer approach to end of life care expands beyond the individual’s physical needs and includes the emotional support for the person, and those around her or him. Palliative care should not be seen as limited to a place, such as a palliative care “centre”, but as a broader approach to the last phases of life.

Senator Carstairs pointed out that palliative care is often not a linear process, in the sense of inevitable deterioration of a terminal condition. The reality of dying is also more complex. Some conditions lead to death in a straightforward manner. Other conditions, such as AIDS, do not have a linear aspect. Senator Carstairs noted that the federal AIDS Strategy led by Health Canada helped broaden the thinking about end of life care. In many chronic health conditions or severe illnesses affecting older adults, these may slowly progress to a terminal phase or wellness may ebb and flow.

New models of palliative care are being tried in Canadian communities (for example, some nursing homes are providing this care). In his talk “*Let Me Decide’ – An Advance Health Care Directive*” Dr. Molloy described research comparing care given in a nursing home to care given in hospital. Preliminary findings indicate that the outcomes of this care are better in the nursing home (in terms of getting better, dying well). As well, the costs are less. However, he noted that this is not an area in which cost cutting should be the driving force.

The vastness and diversity of Canada significantly affects the discussion of end of life care and the needed approaches. Senator Carstairs identified the special challenges in rural communities in providing palliative care. At present, transportation costs to remove a person from the community to receive care represents 75% of the health budget in the northern territory of Nunavut. Technology such as tele-health and telecommunication offer promise in bringing palliative care and other end of life care approaches to the Northern Canada so that the person will not need to be uprooted from the community simply to receive care in order to die. Relatively new initiatives such as those on Rural Palliative Care in Atlantic Canada have shown that there is a role for

telecommunication in providing palliative care in rural places. This work has underscored that a central location for information on end of life and palliative care issues is a must.

B. Promoting Choice and Personal Control for End of Life through Education and Future Planning: In Canada, decisions about health care rest with the individual. The person maintains control over whether or not to have a specific treatment being suggested. In some cases, people will have difficulty expressing their wishes because of their health condition or they have a significant cognitive impairment. Others then have to assume responsibility to speak on their behalf based on the person's wishes, values and beliefs. Substitute health care decisions by individuals are largely governed by provincial statutes and common law.

Advance health care directives are one way in which people can let family, physicians, health care providers and others know what kinds of care they would want if they became unable to express those wishes and beliefs directly. With these documents, the person either appoints someone to make health care decisions for him or her in the event of incapacity (a proxy directive) or sets out specific instructions or general principles about health care (an instructive directive), or a combination of both. Advance care directives can be of benefit to people of all ages, however they may have a significant role in the health care of older adults.

In her talk by the same title, Jane McNiven of Canadian Pensioners Concerned (CPC) described the development of "*My Plans for Me: Educational Information Packages and Training Workshops on Advance Health Care Directives*". This CPC initiative was funded by the federal government under the New Horizons initiative in the mid 1990s. McNiven pointed out how it is important to understand both the perceived benefits and the limitations of advance directives. Both McNiven and Dr. Molloy in his presentation "*Let Me Decide*" point out that advance health care directives need to be understood less as legal tools that protect or instruct health professionals, and more as a communication tool for family, physicians, and other health care providers to have a common understanding of what the person receiving care would like to happen.

In workshops held by CPC across Canada, older adults saw advance directives as having many positive features, in that they felt the document could extend autonomy and help to maintain personal dignity and control, and provide the opportunity for people to state their own wants, preferences and values in an enduring form of communication. Advance directives may alleviate worry about unwanted treatment. Very importantly, the process of developing a directive may encourage communication and strengthen trust between older persons, their families and their physicians. Expressing the wish to not be a burden, some older adults also felt that the directives could reduce the cost of end of life care.

At the same time, the *My Plans for Me* workshop facilitators uncovered several common misunderstandings that older persons can have about the need for advance directives. Older adults found the terminology in this area confusing. There were also many legal, medical, social, and ethical issues related to the use of directives that were of concern to them. To help allay fears, address the misconceptions and better inform older adults about advance directives, CPC developed a training package which includes an information guide, facilitators' manual, information on how to talk about advance directives with family and friends, and a provincial information kit tailored to the different laws across the country.

In the workshops leading to the development of the *My Plans for Me* materials, older adults raised a number of concerns about advance directives that will need to be recognized and properly addressed at the interpersonal and systems levels in the future. These included

- older people's ability to understand legal and medical terminology to be able to prepare a directive;
- unease that advance directives prepared may not be followed, and may have unintended outcomes;
- concern that people may focus unduly on legal concerns, to the extent that it may diminish moral and personal concerns that arise towards the end of life;
- the narrow focus of the directives tend to overlook important issues such as pain (an important consideration for older adults with chronic illness or terminal illness)¹;
- a failure to take into account multicultural diversity or different levels of literacy in Canada, especially among older adults.

Advance Directives and Beyond

Research such as Dr. Molloy's indicates that the vast majority of people (over 90%) want to have a say in their own treatment. From an analytical perspective, it will be important to continue to ask, Does this finding necessarily mean that most people want advance directives for end of life care? Are there other ways to assure that people will continue to have a say about their care throughout their

¹ For example, in Somogyi, Z.E., Zhong-Zhenshao, L. & Hamel, M.B. (May, 2000) "Elderly persons' last six months of life: findings from the Hospitalized Elderly Longitudinal Project", *Journal of the American Geriatrics Society*, 48 (No. 5, Suppl.): S131-S139, it was found that among patients aged 80 and over participating in the project, severe pain was reported by a substantial number during the entire 6 months preceding death. During the month before death, at least one in three patients reported severe pain.

lives and will their wishes be respected? How do we help older adults know what their health care rights are, so that they can express their own wishes?

Towards that goal, Ontario recently developed “*A Guide to Advance Care Planning*”, a plain language booklet for seniors, which is part of education training going on in the province. The Ontario Ministry of Citizenship describes advance care planning as an important step in both protecting the rights of seniors and enhancing their quality of life.² The Guide describes advance directives and the advantages of advance care planning, but within a broader context of helping people understand:

- health care consent (e.g., that the decision belongs to the individual), and who the physician is required to ask regarding consent or refusal of treatment for the person, if the individual is unable to do that,
- that they are not legally obliged to state their wishes in any form before they can get health care, or move into a care facility, and
- that a substitute cannot make an advance directive for the person.

It will also be important to recognize that health care decisions at any point of life including end of life care reflect individual choices and preferences. It will be important to carefully avoid generalizations about “what seniors want...”, as Canadian seniors are not a homogeneous group. There is considerable diversity between groups and within groups.

Looking at the research in the area of advance directives presented during the session, there also appears to be a gap between information or education and action. While many people may be willing or interested in receiving education on advance directives, far fewer will sign one. For example, in Dr. Molloy’s study of 150 veterans, he found 70% of those approached were willing to receive education on the directives. Of these, 82% received education and of those 62% completed directives. In other words of the original 150 veterans, only 50 decided to prepare a directive. It will be important to learn more about why this is the case. It may be that older adults consider the education sufficient for their purpose (that is, it has aided communication of their wishes to family, physician and others).

Other research in this area indicates that there may be challenges in the process that we fail to recognize, such as fear of making a decision or fear of abandonment having signed a directive; literacy or comprehension difficulties; the education process used for the directives; the complexity of the instruments;

² *A Guide to Advance Care Planning*. Available on the Internet: www.gov.on.ca/citizenship/seniors/english/advancecareguide.pdf

The Guide was developed as part of the Ontario Strategy on Alzheimer Disease and Related Dementias.

or not having a trusted person to choose as a proxy.³ It may be that we fail to recognize that not making an advance directive (not deciding) is still a decision. In his presentation, Dr. Molloy notes that the rate of signing is much higher among seniors in nursing homes (where people are older, frailer, and more likely to be cognitively impaired) than among those in retirement communities, or supportive housing. Thus there may be timing issues, certain points at which people are more likely to think about end of life decision making, or there may be other less positive influences at play, such as subtle pressures within the institutional setting.

C. Placing End of Life Care in the Context of Competing Ethical and Medical Principles and Social Expectations

Reviewing some of his end of life care research conducted in Canada, the United States and other jurisdictions, Dr. Molloy pointed out the dissonance between what doctors say about active treatment and care they would want for themselves in given hypothetical situations compared to what they would likely provide a patient in those same circumstances. Physicians tend to be much more aggressive in treatment for others. That is, they would provide more treatment for patients than they would want for themselves if they were experiencing those health problems. When comparing results between countries, Dr. Molloy found a lack of societal consensus between countries in terms of kinds of care and treatment health care providers would provide to older adults. There were also important differences between younger and older adults about treatment for reversible conditions.

Dr. Molloy pointed out that a health system geared to “curing” can come under stress and lead to less than optimal results for patients and family when trying to acknowledge and come to terms with death and dying. He asks people to consider: How can we better determine quality of life in the context of people dying in nursing homes or of incapable and capable persons living in different settings, in order to improve quality of care to them?

D. A Clear Framework for End of Life and All It Entails

³ Felt, D. Heilman, E.J. & Welk, T.A. (Nov-Dec 2000) Attitudes, values, beliefs, and practices surrounding end-of-life care in selected Kansas communities. *American Journal of Hospice and Palliative Care*, 17 (6), 401-406.
Hopp, F. P. & Duffy, S.A. (June, 2000) Racial variations in end-of-life care. *Journal of the American Geriatrics Society*, 48 (6), 658-663.
Hoffmann, D.E., Zimmerman, S. I. & Tompkins, C. (Spring-Summer 1997) How close is enough? Family relationships and attitudes toward advance directives and life-sustaining treatments. *Journal of Ethics, Law and Aging*, 3 (1), 5-24...

Another fundamental part of the end of life discussions that have been occurring in Canada is the developing trend to place end of life care within broader systems. Dr. Rory Fisher describes the development of *A Guide To End of Life For Seniors* in an “End of Life” project funded by Health Canada.⁴ The endeavour bridged the fields of gerontology/geriatrics and palliative care, groups which in Canada had started off distinctively.

The goals and objectives of the Guide were to improve end of life care for seniors by: consolidating “best practices” in this area of health care and social service delivery; providing a national guide for everyday practice; developing a common language for the practice of care; and facilitating increased autonomy and independence in decisions by seniors. Dr. Fisher pointed out the critical need for the Guide, in light of an aging society with more older people, more disability and a protracted period of disability, as well as multi - pathologies in the dying process. He noted the common myths and misconceptions that surround the area including

- everyone is going to die anyone, so what can we do about it.
- older people die in long term care institutions, so their end of life care needs are taken care of,
- older people do not suffer.

Aimed towards health care providers, *the Guide* includes chapters on “Toward Optimal Care”; “Living and Dying Well In Later Life”; “Maintaining Comfort”; “Ethical Issues”; “Delivery of End of Life Care”; “Care for the Caregivers”; “Spirituality”; “The Cultural Context for Palliative and End of Life Care for Seniors”; “Aboriginal Issues”; and “Continuing Challenges”, summarizing recommendations for practice in each area.

The *Guide* takes an integrated bio-psycho-social approach, discussing among other things, the symbolic meaning of withdrawal of food and the importance of helping others understand that not feeding the person at the end of life is not the same as abandoning the person. The *Guide* touches upon palliative care within the broader context of futility, and who will decide that.⁵ It asks and answers important questions such as “What can be done to promote excellent end of life care for seniors?” looking both to increased resources for end of life and improvements in the ways in which systems work. The National Advisory Committee responsible for developing *the Guide* would like to have the publication produced in a secondary format suitable for the general public and seniors.

E. Looking Beyond Canada

⁴ Available on the Internet: <http://www.rgp.toronto.on.ca/iddg/eol-english.pdf>.

⁵ See for example, Weijer, C. (1999) “Why I am not a utilitarian”. *Canadian Medical Association Journal*, 160, 869-70.

Dr. Astrid Stuckelberger pointed out that “Dying well is important to the world” in that death is the subject of life and a society can be measured by the way it treats dying and death. An economy-driven society will value being well. In contrast, a human-driven society recognizes wellness, illness and dying as interrelated parts of the social fabric and social reality.

Stuckelberger stressed that although it is impossible to ask the person “Did you die well?”, we can ask those who remain how well this person died. Stuckelberger cautions us to recognize that we need to consider responses to dying in the broader picture of how we treat older adults within society. Older persons can easily feel themselves to be an economic burden. They are currently seen as a cost to society, because technology costs. Economy should not determine how people die.

She noted that to this point, recognition of dying as a part of life has not received much attention at the international level. For example, the United Nations’ *Principles for Older Persons* currently do not address death issues. There is a need for quality of life at the end of life. At the same time there are important differences in the scale and circumstances of death around the world. Stuckelberger pointed out that there are currently 13.2 million AIDS orphans in Africa and 70,000 in North America. Thirty-two million children will live with the image of life and death management because of AIDS.

To some extent, Africa appears to have a different philosophical attitude toward death and the dead than others parts of the world, in that death is integrated into life. She observed that we know very little about the impact between generations of how people die (for example, how does the way a grandmother dies affect her grandchildren?). Internationally, we need new ways of looking at the issue of dying (for example within the context of human rights and older refugees who are dying; within the context of freedom and security).

Stuckelberger noted the ethical strain in some countries between making choices about living and care, and the “right to choose death”. The Netherlands, for example, has seen the development of “Exit”, a group that embraces not only a right of personal autonomy to commit suicide but also “a right to assisted suicide” in whatever setting the person prefers (e.g. a nursing home or hospital). This is antithetical to caring. She pointed out the importance of understanding the difference between a “good” and “bad” bereavement. The rituals and process of death will affect whether those who remain experience depression in the first year after death. In some countries, poverty negatively affects being able to afford the rituals of death and thus, whether there has been seen to be a proper death.

Dr. Stuckelberger commended the federal government for its recognition of end of life issues and care needs and suggested that Canada can serve as a model

for Europe and the other parts of the world. It can help the issue of quality end of life to gain more prominence and recognition internationally by bringing the Canadian model to the United Nations' *Action Plan on Aging*, and placing it in the context of "attentive care for the terminally ill". Canada can also help by sharing its research, guides, and practices.

F. Lessons Learned

The symposium presentations and audience questions highlighted the need

- for a broad societal recognition that end of life care and its many facets is important, and that dying is a part of life;
- for an integrated approach and working towards consensus, developing formal structures to address and legitimize the role of good end of life care;
- to understand how the subtle and overt forms of ageism and paternalism may affect how aging in general, older adults' quality of life and their end of life, in particular, is viewed;⁶
- to understand the benefits and limitations of legal documents such as advance directives, and placing these within a broader approach to advance care planning and delivery;
- for understanding about the effect of life and death on the individual, family, and community;
- to recognize that end of life care encompasses physical, emotional, and spiritual dimensions.

G. A View to the Future

Throughout the symposium, the participants and the audience directly and indirectly posed a number of important ethical, legal, policy and practice issues which are not being adequately addressed at present. Below, the author offers these as questions for further consideration by federal and provincial governments, professional associations, older adults as a group, and Canadian society generally:

- **Economics:** One of the rationales used for trying different care planning alternatives for end of life care is that it would be less costly than the current approaches. How do we assure that "cost effective dying" does not become the driving force in Canadian society?⁷ What are the opportunities for seniors at all socio-economic levels to receive quality end of life care?

⁶ Tadd, T & Bayer, A. (Winter, 2000). Commentary: medical decision making based on chronological age--cause for concern. *Journal of Clinical Ethics*, 11 (4), 328-333.

⁷ Dey, I. & Fraser, N. (Nov. 2000). Age-based rationing in the allocation of health care. *Journal of Aging and Health*, 12 (4), 511-537.

How does low income and poverty affect end of life care? ⁸ How do we assure equitable access to quality end of life care so that seniors of all incomes are able to get the care that they do want?

- **End of Life Care is a Gendered Issue:** Among people aged 80 and over, two out of three are women. What do we currently know about end of life as a gendered issue? Does end of life and its care look different for older women than for older men? What are the information and research gaps about (a) age, gender and dying, and (b) gender of the people giving care to those who are dying?
- **Ethics:** What are the appropriate ethical models for end of life care? What do we need to do to avoid treating older adults as a burden on society? Can we avoid treating older adults as having less of a right to life than other persons? How do we improve “the quality of their dying”? What is the meaning of autonomy in the context of later life and dying? How do we avoid turning tools such as advance directives, which are intended to give people the opportunity to *express choice*, into *forced decisions* for older adults, by making them system requirements, a trend which is already occurring in some jurisdictions?
- **People Who Are Cognitively Impaired:** Many seniors will become cognitively impaired in the later years of their lives. It will be important to consider: How do we develop an understanding of quality of life and futility in the context of their lives? During the symposium, audience members pointed out that advance care planning and end of life care will need to address that reality. How can we assure that the oral and written wishes of people who have some degree of cognitive impairment will be properly respected? Important work such as *Advance Directives on Care Choices: The Advance Care Planning Project*, a collaborative effort of the Ontario Alzheimer Society and health practitioners has already begun in this area.⁹ What are the steps needed to share and adapt these types of efforts with the rest of Canada?
- **Information and Education:** How can we teach family and others about the dying process? How do we assure that accurate information is available on health care consent and substitute decision making? How do we correct existing misinformation (e.g., the erroneous belief that once an advance directive is made there is no need to get consent from the person or the substitute decision maker, or the belief that family can sign an advance directive on behalf of an incapable senior)? Again, the Ontario

⁸ Kapp, M.B. (2001). Economic influences on end-of-life care: empirical evidence and ethical speculation, *Death Studies*, 25 (3), 251-263.

⁹ Identified as *Ontario's Strategy on Alzheimer Disease and Related Dementias*. Alzheimer Society of Ontario (January, 2002). Ontario Seniors' Secretariat of the Ministry of Citizenship.

Advance Care Planning Project has begun some of this work within their province, opening up opportunities to share the ideas throughout Canada.

- **Policies affecting Medical Practice.** Older adults with chronic conditions continue to be under-treated for pain, reflecting both stereotypes about aging and pain, and misconceptions about pain, drug tolerance and drug dependency. While there has been some effort to address pain issues in terminal illnesses, there is a lack of evidence-based guidelines on what kinds of pain treatment work for older adults with different health conditions. There is also a lack of support by government and medical associations for physicians so that they can properly address chronic pain without having their medical practices questioned or risking their professional livelihood.¹⁰

- **Policies on Resources and Supports:** Caregiving is largely gender influenced. Eighty percent of the care in later life is given by “informal” sources, largely by wives, daughters and daughters-in-law. For family members still working, giving care may mean reducing participation in the work force or retiring early, with long term adverse financial consequences for the person. What are the economic and support needs of family who are giving care during the end of life? What is the role of governments in making it possible for family to take on this responsibility so that they do not risk their own wellbeing in order to provide care at the end of life? Giving care carries emotional, physical and financial consequences for the spouse or family giving care.¹¹ What policy efforts can be made to recognize the value of caregiving and to reduce the burden on family giving care?

¹⁰ On the issue of persistent pain, see for example:

- Teno, J.M., Weitzen, S., Wetle, T., & Mor, V. (2001) Persistent Pain in Nursing Home Residents. [Research Letter]. *JAMA*. 285 (16) 2081
- American Geriatrics Society. (June, 2002) The management of persistent pain in older persons. *Journal of the American Geriatrics Society*. 50, S205-S224.
- Medical Association Communication. Pain Management in the Elderly Population. Online at www.macmcm.com/ags/ags4.htm.
- Portenoy, R.K.(1996). Opioid therapy for chronic nonmalignant pain: clinicians' perspective. *Journal of Law, Medicine & Ethics*. 24, 296-309. Online at: http://208.234.16.94/research/mayday_ilme/24.4g.html
- For international discussion, see *Availability of Opiates for Medical Needs, Report of the International Narcotics Board, United Nations Special Report* prepared pursuant to Economic and Social Council resolutions 1990/30 and 1991/ 43 (New York,1996). Online at : www.incb.org/e/ar/1995/suppl1en.pdf
- On the issue of physicians' licenses, see Jones, C. “Painkiller politics”. Now On. 2000-7-13. Online at : www.nowtoronto.com/issues/2000-07-13/newspread.html

¹¹ Cranswick, K, Fast, J., Frederick, J. Keating, N., Perrier, C.,& Perrier, C. (1999) *Elder care in Canada: Context, content and consequences*. Statistics Canada. Cat. No. 89-570-XPE

Throughout the symposium, each of the participants clearly showed that while considerable progress has been made in improving end of life care in Canada, the process of understanding and responding well to the issue of end of life care requires a continuing process. Community and government commitment in Canada continues through further efforts such as the *National Action Plan Workshop on End of Life Care* which was held in Winnipeg in March 2002, and has begun the process of setting specific long and short term action planning.¹²

¹² Health Canada, *National Action Plan Workshop on End of Life Care, Workshop Report*. (Secretariat on Palliative and End of Life Care, Winnipeg, Manitoba, March 2-4, 2002). Online at : <http://www.hc-sc.gc.ca/english/care/workshop.html>