



pluralages

VOL. 2, NO. 1, WINTER 2011

END OF LIFE CARE
PRACTICES FOR THE ELDERLY

Life until Death



Centre de recherche et d'expertise
en gérontologie sociale

Centre de santé et de services sociaux
Cavendish



Centre affilié universitaire

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Pluralages is published by the Centre de recherche et d'expertise en gérontologie sociale (CREGÉS) of the CSSS Cavendish – Centre affilié universitaire (CAU). This magazine is designed to inform the public and raise awareness of social issues surrounding aging by, among other things, presenting the research initiatives and expertise being developed by members of the CREGÉS. *Pluralages* also aims to promote and foster ties between the research, education, practice and citizen action – for and by seniors – communities. Issues related to aging are presented through the lens of social gerontology, touching on such themes as diversity in aging, social and citizen recognition of the elderly, experiences with social exclusions and solidarities, political concerns, State directives and public policy targeting the aging population and its needs.

Pluralages is published in French and English, in print and electronic versions. Please feel free to contact us for a paper copy in your preferred language.

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In regard to the feminization of the texts, the editorial board has chosen to respect the spirit in which they were written. Thus, some texts are feminized and others are not.

Life until Death

Palliative care, dying with dignity, assisted suicide and euthanasia are topics of current interest requiring public debate in these early years of the 21st century. People's living conditions at the end of their lives is an important item on Québec's agenda of social issues. In 2010, the Québec government launched the Special Committee on Dying with Dignity that received over 150 briefs from a variety of social spheres (diverse associations, professional orders and concerned stakeholders and individuals). Yet, even though issues related to an aging population are high-priority social and political concerns, they are rarely addressed in connection with the end of life.

As a group that is concerned with the issues of aging, CREGÉS wished to set up a dialogue between these two discussions and made this the theme of its annual symposium in the spring of 2010: *Les vieux meurent aussi: Pratiques d'accompagnement en fin de vie pour les personnes âgées et leurs proches* (Old people are dying too: Support practices in end of life care for older adults and their caregivers). This issue of *PluralAges* is in large part devoted to the speeches and discussions from this symposium that shed light on many issues related to the conditions in which our society's older members live at the end of their lives.

We are fortunate to be able to present some photographs from the superb exhibition by Walter Schels and Beate Lakotta, *Life Before Death*, as a companion piece to our reflection on the end of life, dignity and the support of the dying. The Musée des religions du monde (Nicolet, Québec, Canada) generously agreed to send us photos from this exhibition in which we see the faces of different individuals while they were still alive next to a photo taken a few hours after their death. The photographs are accompanied by a short written piece that presents the person and their thoughts about their imminent death. *Life Before Death* is also the subject of one of the articles in this issue of *PluralAges*.

By devoting this issue of *PluralAges* to questions concerning death and the elderly, we hope to stimulate further thought about the underlying fundamental social issues. What does it mean to "die with dignity"? What kinds of support practices do we want to put in place for older people at the end of their life and for their loved ones? Are we paying sufficient attention to the personal accounts of those who have experienced various types of support care? In what ways do social exclusion and solidarity manifest themselves in relation to older people who have reached this stage of their life? What are the issues surrounding assisted suicide, euthanasia and the other methods of avoiding the prolongation of life? Who determines the timing of death? Does an individual have the right to change their mind? What issues are specific to seniors? Why are some issues different for seniors? How can we change our understanding of age in order to qualify the discussions about palliative care now underway? Where does our society stand in terms of its attitude to life, illness, aging and death? How do we want to move forward?

We at *PluralAges* have not adopted a firm position on this subject, preferring to proceed with a healthy sense of ambivalence and frank and open debate. We take this opportunity to present a few aspects of the question so that you can, if not make up your mind, at least be informed about the many issues raised by these questions that remind us that we are truly alive right up to the moment of death—and as such, we hope, able to defend our life choices until our dying breath. <

The Many Faces of CREGÉS

CONFERENCE 2010

Old people Are Dying too.

Support Practices in End of Life Care for Older Adults and their Caregivers

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The CREGÉS, in partnership with Frontières, the Quebec Journal of the Study of Death and Dying at UQAM, la maison Victor-Gadbois, and the Center for Palliative Care at McGill University hosted more than 320 participants from the province of Quebec. Participants included multidisciplinary health care professionals from the public and community sectors, researchers, managers, volunteers, students and members of the public from diverse disciplines.

What follows is a hypothetical discussion between Sylvia and Nicolas. Sylvia is a senior palliative care social worker at a local hospital who had attended the 2010 CREGÉS Palliative Care Conference. Following the conference, she shares her notes with Nicolas, her social work stagiaire, and asks him to write up a report. In the following discussion, they try to get a sense of the key points and arguments made at the conference.

Discussion between Sylvia & Nicolas

Nicolas : I understand that the main debates of the 2010 conference surrounded palliative care, end of life care and dying with dignity, but I find the terminology confusing. According to my Oxford English dictionary, the term palliative comes from the verb "palliate" which means to relieve or lessen without curing, mitigate, alleviate. In your notes I see the terms palliative care, comfort care and end of life care...what is the difference?

Sylvia : All three terms refer to non-curative treatment. The difference is in the time line of each type of care. For example, end of life care refers to the care received during the last five days of a persons life,



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palliative care refers to the care received during the last three months. Comfort care occurs in both cases and includes all efforts to make the dying person more

comfortable, for example, the practice of administering morphine.

Nicolas : That seems odd to me putting a time line on each type



of care. What happens to people who have degenerative diseases such as dementia and have no idea how long they have left to live?

Sylvia : That is a good question that certainly inspired some heated debates at the conference. People with degenerative and chronic diseases do not typically qualify for palliative care because palliative care is limited to individuals who have stopped the fight against illness. Canadians who are suffering from an illness have the options of refusing or discontinuing treatment or the "double effect." Contrarily, euthanasia and assisted suicide are not options for Canadian citizens because, according to the law 241, assisted suicide is illegal and euthanasia is considered homicide according to federal law.

Nicolas : Ok, I'm a bit confused. First of all can you explain what you mean by the "double effect"?

Sylvia : According to Dr. Brian Mishara¹, a presenter at the conference, the double effect is when life expectancy is shortened by medication used to relieve pain and/or suffering.

Nicolas : Could you also explain to me exactly what the difference is between suicide, assisted suicide, homicide and euthanasia?

Sylvia : Another controversial topic! Some people think of assisted suicide as "killing" a person, whereas others consider it a humane act necessary to put an end to a person's suffering. Suicide is legal in Canada whereas assisted suicide and euthanasia are not; although they are legal in some other countries such as Belgium, Switzerland and the Netherlands.

Nicolas : Ok, now that we have the definitions cleared up, I want to

During the conference, Brian Mishara provided definitions for "The seven methods for intentionally shortening life":	
1) Suicide:	To kill oneself- only to stop suffering (theoretically ambiguous); acted by him or herself; 90% of people who commit suicide suffer from a mental disorder; Legal in Canada.
2) Refusal of treatment:	Short term "natural" death; Main intention is to not prolong life. Legal in Canada
3) Discontinuation of treatment:	Short term "natural" death; Main intention is to end life; Legal in Canada.
4) Double effect:	Life expectancy is shortened by medication used to relieve pain and/or suffering; Intention: reduce pain/suffering; Legal in Canada.
5) Homicide:	Being killed by someone with or without compassion; with or without intention to die; intentional or by accident; Illegal in Canada.
6) Euthanasia:	Killed by a doctor or another person by compassion; intention to die (theoretically less ambiguous) but always with the intention to end suffering or to die with dignity; people with mental disorders are usually excluded; Legal in the Netherlands, Belgium (in Australia was legal for 9 months in 1996-1997); Illegal – considered a homicide in Canada.
7) Assisted Suicide:	To kill oneself; intention to die (theoretically less ambiguous); doctor provides the means; legal in the state of Oregon, and in Switzerland was never illegal; Illegal in Canada.

focus on the theme of the conference: "Dying old." Old people die all the time, why would their experience be any different than anyone else?

Sylvia : That is indeed a central question! At the conference we discussed the concept of social exclusion and how it impacts older

peoples' experiences with dying and end of life care. Here is a definition of how the Centre de for research and expertise in social gerontology (CREGÉS) defines social exclusion:

"A process of non-acknowledgement of the rights and resources

continued on page 6 »

continued from page 5 »

of certain segments of the population (in this case, the elderly) that takes the shape of power dynamics between groups with divergent visions and interests. Such processes result in inequities and eventually, isolation from society in seven dimensions. 1) Symbolic: negative images and representations; 2) Identity: reduced to characteristics solely based on age; 3) Socio-political: barriers to civic/political participation; 4) Institutional: reduced access to services; 5) Economic: lack of resources; 6) Significant social ties: absence/loss of social network; 7) Territorial: reduced geographic living area" (for more details, see Billette et al., *PluralAges*, vol. 1, no. 2, p.4-7).

Nicolas : Ok, now I'm very confused. So you're saying social exclusion has something to do with older people's end of life care?

Sylvia : Yes. For example, take the cost of care. Palliative care is costly. With the aging of the population, some may argue that one way to cut costs is to exclude older adults from palliative care altogether.

Nicolas : Sounds harsh. So you are basically saying that older people can be treated as second class citizens in order to cut costs?

Sylvia : This would certainly be a key issue for you to tackle in your report! When we consider this question using a lens of social exclusion, we can observe that older people can experience exclusion, discrimination, inequalities and ageism in their everyday lives. Although social exclusion is not experienced by all older adults, nor in a homogeneous way, social exclusion linked to aging exists in several societies, including our own, an "exclusion of the old".² The process of exclusion is caused by overvaluing youthful-

ness and devaluing growing old. These ageist attitudes can lead to heightened experiences of symbolic exclusion, negative representations and feelings of invisibility for older people.

Nicolas : Ok, but before I get to writing, let's talk about the end of life services available in Quebec. I see that professionals from four settings presented at the conference: Hospitals, Centre Local de Services Communautaires (CLSC), a long term care home specialized in palliative care and a center of geriatric medicine. There seems to be a lot of important work being done to improve end of life care for seniors, is there not?

Sylvia : Significant efforts are being put forth in terms of end of life care but the need is greater than what is available. For instance, most people want to die at home but end up dying in hospitals. There is also a lack of services, such as grief counselling, for the families of those who are dying. Caregiver burnout due to lack of public support and services is also a crucial issue. It is also argued that health care professionals lack adequate training to work with end of life issues.

Nicolas : Wow, there are a lot of issues concerning end of life care for seniors. Do you feel hopeful about the future in terms of palliative care for older adults?

Sylvia : Yes and no. I am certainly left with more questions than answers. Dr. David J. Roy³, who also presented at the conference, eloquently brought forth crucial questions that need to be examined both in our professional and our personal lives. For example: "What do we mean exactly by dying in dignity?" "How to die with dignity when one is placed in the margins of society?" "Do

the elderly die under the logic of exclusion or under the logic of humanity?"

Nicolas : Sounds like there were a lot of interesting questions, discussions and debates at the conference. I never really thought about how complex end of life care can be; I am starting to see it in a whole new light.

Sylvia : It is a complex topic and we are only touching on a few of the issues related to end of life care. There are a number of questions surrounding public policy, the organisation of health and social care services, best practices to meet the needs of older adults – as well as more fundamental questions: How can one discuss end of life care without discussing care for the living? It is through this question that we begin to tap into the question of dying in dignity and other key issues: for instance, our view of life, of illness, of aging and of death, of social exclusion and solidarity, humanity, inequalities and strategies to combat them, etc. End of life is a controversial topic that perpetuates a multitude of views and opinions. However, it is important to keep in mind that differing points of view and debate are an essential component to advancement and change. Well, enough discussing, you had better get writing that report! <

1. Dr. Brian Mishara is a professor of psychology at the University of Quebec in Montreal and director of CRISE, one of the world's largest suicide research and innovation centres. His lecture is the subject of a report in this issue.
2. V. Billette et J.-P. Lavoie (2010), "Introduction : Vieillissements, exclusions sociales et solidarités", in M. Charpentier, N. Guberman, V. Billette, J.-P. Lavoie, A. Grenier and I. Olazabal, *Vieillir au pluriel. Perspectives sociales*, Presses de l'université du Québec, p. 16.
3. D.J. Roy, Director of the Laboratoire de recherche en éthique et vieillissement, Centre de recherche, Institut universitaire de Montréal; Editor-in-chief, *Journal of Palliative Care*. His lecture is the subject of a report in this issue.



Klara Behrens

age : 83

born : December 2, 1920

first portrait taken : February 6, 2004

died : March 3, 2004

Klara Behrens can tell that she hasn't go much longer. "Sometimes, I do still hope that I'll get better", she says. "But when I'm feeling really nauseous, I don't want to carry on living. And I'd only just bought myself a new fridge-freezer! If I'd known..."

It is the last day of February, the sun is shining, the first bluebells are flowering in the courtyard. "What I'd really like to do is to go outside, down to the River Elbe. To sit down on the stony bank and put my feet in the water. That's what we used to do when we were children, when we gathered wood down by the river. If I had my life over again, I'd do everything differently. I wouldn't lug any wood around. But I wonder if it's possible to have a second chance at life. I don't think so. After all, you only believe what you see. And you can only see what is there."

"I'm not afraid of death. I'll just be one of the million, billion grains of sand in the desert. The only thing that frightens me is the process of dying. You don't know what actually happens."

With the obliging collaboration of the Musée des religions du monde (Nicolet, Québec, Canada).
We thank the creators of the exhibition *Life Before Death*: Walter Schels and Beate Lakotta

Accompanying the Dying in Four Different Settings: Challenges and Promising Experiences

This article summarizes papers by Ms. Vasiliki Bitzas, Ms. Zelda Freitas, Ms. Jocelyne Lauzon and Mr. Fruan Tabamo presented at the CREGÉS Annual Symposium *Les vieux meurent aussi : pratiques d'accompagnement en fin de vie pour les personnes âgées et leurs proches* (Old people are dying too: Support practices in end of life care for the older adults and their caregivers), held in Montréal, May 7, 2010.

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The elderly want to die in the comfort of their home. Most of them, however, will be hospitalized in a palliative care unit or other ward. Vasiliki Bitzas, Head Nurse of Palliative Care at the Jewish General Hospital in Montréal, has shown it is possible to die with dignity in a palliative care unit in a Montreal hospital. Basically, families lack knowledge about the ministering of palliative care, and community resources are scarce (especially where equipment and home help are concerned). Consequently, a person at the end of their life may be hospitalized for the management of their symptoms but also

because the family is exhausted. According to Vasiliki Bitzas, when families turn to a palliative care unit, they should not see this as a failure. The diversity of multidisciplinary

teams (trained personnel) and access to on-site medical resources help ensure the comfort of the dying person and his/her family.



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Zelda Freitas, social worker and clinical supervisor at the CSSS Cavendish, discussed psychosocial issues to paint a realistic picture of dying at home. Despite their wish to die at home, the frail elderly are confronted with many hazards that may compel them to change their mind. The PALV (patients with loss of autonomy) program for age-related loss of autonomy is a crossroads where the diversity of users and life experiences force workers to change their perspectives and intervention approaches while dealing with the limits of the health and social services system. The situation raises many psychosocial challenges and issues across the care continuum, from intake to mourning. According to Zelda Freitas, hospitals tend to keep their patients even though some treatments could be provided in the community. This means that patients are referred to the PALV program rather late in the course of their illness. The PALV staff also respond to the needs of family caregivers and other family members. In addition to the many existing psychosocial problems, home care services deal with a set of basic needs (access to food and transportation, for example). The workers are also very concerned with respecting users' autonomy. Throughout the support process, the team assesses each older person's ability to make informed decisions. After the individual dies, team members do a follow-up with the family and friends as well as with the workers, who also experience a loss when their patient dies.

Jocelyne Lauzon, a psychologist at Maison Victor-Gadbois, reminded her audience that palliative care homes admit people with

cancer only. These centres may seem to be ideal, but they cannot meet the needs of everyone due to a lack of resources. The challenges vary depending on where patients come from. If they arrive directly from their home, their losses are more recent than those of older people from a CHSLD. The latter's functional autonomy will also be more compromised. Palliative care hospices are open environments and may not be suitable for patients with dementia or behaviour problems (wandering). The supervision and care provided by a palliative care hospice occasionally helps restore a patient's autonomy so that he/she may no longer need such specialized care. In this case the person may be relocated in what is approached as a gentle transition. Home care resources are then put in place again, although that person is given priority for readmission should his/her health deteriorate.

Fruan Tabamo, Head Nurse and Chairperson of the End-of-Life Committee at the Maimonides Geriatric Centre, described the bleak reality of dying in a long-term care facility (CHSLD). Families are often afraid of being held responsible for the death of a loved one living in such a facility and pressure staff to provide any assistance the older person needs. Staff must weigh both what is important for the older person and what is important for the family. The individual living in a facility whose life is ending does not want to be a burden for their family but simply wants relief from his/her symptoms. The family wants to be kept abreast of the care plan, to be informed of changes in their loved one's health status by discussing it with

the team (especially the doctor), and to maintain their relationship with the dying person while saying their goodbyes. Mr. Tabamo deplored the lack of personnel in all long-term care facilities. He estimated that, most of the time, the ratio is one nurse for about 130 residents. Employees are overworked and under-trained in palliative care, while organizational and financial constraints have an impact on service delivery. The quality of care is of course affected by these circumstances. Communication is incomplete and scant, and mistrust of staff regarding their provision of compassionate professional care may develop. Mr. Tabamo recommended that health professionals be trained in various disciplines to acquire skills and a human approach towards older people reaching the end of their lives and towards their family. There is a pressing need to educate the population about the reality of CHSLDs and end-of-life care. He also suggested establishing ties with other partners in the healthcare system to promote better palliative care. He then encouraged everyone to make five new contacts before the end of the Symposium. His appeal was warmly received by the audience. <

Letter to my Daughter: Development of a Leading- Edge Palliative Care Service

Patrick Durivage

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Dear Fanny:

You probably wonder what Daddy does at his job. When you were in Mommy's tummy ten years ago I had just started working as a psychosocial practitioner with the home support team at CLSC René-Cassin, known today as the *Programme perte d'autonomie liée au vieillissement* (loss of independence due to aging program, or PALV). Do you remember when grandpa needed help at home when he was sick? People came to help him at his house. I'm working with a group of people who are very interested in old people and concerned about the welfare of society's older members.

When you were still a baby, I took part in a research project to set up palliative care services at my workplace.¹ I suppose you're wondering what palliative care means. Well, that's a good question. When a person is very sick and close to death, she or he needs what is called "comfort" care to reduce pain and suffering. You remember when grandpa's lungs were sick and he couldn't breathe? He couldn't stay at home any longer and the people from the CLSC said he should go to the hospital. A few



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days later, he died in the hospital. During his illness, grandpa got help from lots of different people. So you see, now Daddy is helping sick people stay at home and get the care they need to be safe and comfortable.

When I was involved in the research project, Daddy met other health workers who shared his interest in palliative care: nurses,

occupational therapists, social workers and doctors who worked in hospitals. All these people want to give quality care, but they can't provide all the services that are needed because there's not enough money and resources. In spite of everything, they are committed to providing the best possible services so that old people don't have to suffer. Even when Daddy was at school, he



volunteered in a hospital, helping people who were dying. Dying means—oh, you already know that! No, it's not the opposite of living. The dying are still living. They are people who are experiencing the last moments of life before their death. Even though they're weak and sick, they have the right to ask for what they want. You know, grandpa wanted to die at home, surrounded by his things, but he was too sick to be able to enjoy them. When the nurse suggested that he go to the

palliative care services for the elderly who were still living at home. Since 2007, Daddy and a colleague (Zelda Freitas) have been talking about psychosocial practice in the area of palliative care. We discussed it with our colleagues at work. Everyone agreed that it was very difficult to provide palliative care. Not so long ago, only nurses and doctors could provide this type of care. All of us came up with a list of questions (to research) that we have been studying together.

their experiences with each other. There was a great atmosphere in the room, generated by all the presentations and the workshops. Everyone worked together to come up with recommendations to take to the Minister of Health. All the practitioners thought we should be providing more palliative care services. Despite everything being said about euthanasia and assisted suicide (see the article by Marijo Hébert), health practitioners are committed to supporting old people until the end—accompanying them through their suffering and, especially, helping to make their last moments of life comfortable. What makes people suffer? That's another good question. Sometimes suffering is part of life. When we help someone who is in distress, we come in contact with a part of what it means to be human and it gives life meaning.

Soon, we will form a steering committee to bring together all the people who are interested in the different questions connected with palliative care. The symposium participants wanted to share their experiences. Maybe they will come to the next gathering. As you can see, Fanny, Daddy's job is stimulating even though the subject matter is hard. Daddy also dreams of providing health professionals with training so they will be more confident about giving palliative care to the elderly, regardless of the current social challenges. I hope to rally people around the cause of palliative care for old people to help them die with dignity, whether they're at home or elsewhere. <

1. Mucci, F. et al. (2001) *Vers l'établissement d'un continuum de soins et services palliatifs à l'intention des adultes en phase terminale. Rapport 1998-2001*, Montréal, Régie régionale de la santé et des services sociaux de Montréal-Centre.

// We have been developing a leading-edge palliative care service since 2009. We think about the services that should be provided to old people who are dying and we work on developing new ideas so that we can adapt better to the different kinds of situations old people may find themselves in at the end of their life. //

hospital, he agreed. In my job, we listen to what the sick person wants and we also consider the family's concerns.

Besides helping people in the palliative care service, Daddy still does research and goes to conferences. He makes poster presentations on palliative care. Yes, he cuts and pastes things on to a big poster to show the problems faced by people who want to provide palliative care services in a CLSC. After going to these conferences, Daddy realized that he wasn't the only person who was looking for ways to provide better services to the very sick. You know, when Daddy started working, there was hardly any research being done about

We have been developing a leading-edge palliative care service since 2009. We think about the services that should be provided to old people who are dying and we work on developing new ideas so that we can adapt better to the different kinds of situations old people may find themselves in at the end of their life. Our team, made up of three practitioners and two researchers, offers training sessions, publishes articles and takes part in specialized conferences. Last May, we organized a symposium. You should have seen it! Over 300 palliative care practitioners from all kinds of settings and disciplines came. They really appreciated it because it gave them a chance to step back from their work and share

Exploring the Need for a Centre for Family Caregivers of Palliative Care Patients at Home

Zelda Freitas

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On July 28th, 2010, a first meeting to explore the need for a Centre for Family Caregivers of Palliative Care Patients at Home was organized with representatives of the Jewish General Hospital (JGH), *Hope and Cope*, key members of the community and health research professionals. Initiated by the JGH and *Hope and Cope*, the goal was to explore what is already being offered in the community and what challenges are encountered, as well as to provide an introduction of the vision for the centre thus far. Both clinical and volunteer components are envisaged, in an effort to meet any needs these family caregivers are experiencing despite the services already in place. This meeting served as an invitation, welcoming community participation in the design of a service centre that will be truly reflective of the needs of family caregivers.

Twenty-six people attended, representing public, educational and community-based services. Participants included Dr. Robin Cohen, Research Director in Palliative Care at McGill University, with three other researchers from the Canadian Institutes of Health Research (CIHR); a Family Caregiving in Palliative Care and End of Life Care New Emerging Team; as well as members of the JGH Palliative Care Service (Ms. Vasiliki

Bitzas, Head Nurse PCU and Dr. Bernard Lapointe, Director of Palliative Care, McGill University, Jewish General Hospital), The Executive Director of *Hope and Cope*, Mrs Suzanne O'Brien, was also present. Community representatives included Ms. Sharon Baxter, Executive Director of the Canadian Hospice Palliative Care Association (CHPCA), as well as representatives of three Health and Social Services centers (CSSS Cavendish, CSSS Dorval-Lachine-Lasalle, and CSSS de la Montagne), of Mt. Sinai Hospital Centre, Nova Montreal and Nova West Island, of the Palliative Home Care Society of Greater Montreal and of the Quebec division of the Canadian Cancer Society.

Following a brief description of the services and programs offered by the JGH Palliative Care Service and by *Hope and Cope*, an open discussion ensued, focused on examining the remaining unmet needs of family caregivers in the community. Several important points were discussed: ensuring the health of family caregivers; making sure they have the information and education they need in the format that best suits their learning style; recognizing their contribution, but not quantifying the caregiver contribution to the health care system; addressing the various needs for transportation; identifying the difficulties in transitioning from active to palliative care; and bereavement services and inter-establishment communication. Of particular interest were psychosocial and respite needs

and the shortage of home-visiting doctors.

The JGH representatives ended this productive encounter with an introduction to the current vision for the centre. In brief, the primary objective of the centre is to act as a "one-stop shop" to maintain the mental, physical, social and spiritual well-being of diverse caregivers of terminally ill individuals followed by the JGH Palliative Care/Supportive Care Service. These services to home caregivers are to assist them, both while they provide care and when they are in bereavement, by:

1. enabling caregivers to have the knowledge, attitudes, and skills they need to successfully care for the dying at home;
2. teaching them the practicalities of new roles and tasks they must take over from the patient;
3. supporting caregivers emotionally and spiritually; and
4. providing these services in a culturally sensitive manner to the large multi-cultural population served by the JGH.

The vision of the JGH Palliative Care service and of *Hope and Cope* to address the needs of family caregivers has long been a preoccupation of our CSSS. By bringing together the services that are involved and their vision of the centre, we are now one step closer to the partnerships that are necessary to address the unmet needs of our family caregivers. <



Caregiving in the Palliative Stage. A Training for Multidisciplinary Professionals

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As we are well aware, population demographics indicate a continual extension of longevity – more people live longer lives, and they continue to live in the community, whether it be in their own homes, or, in many instances, in Residences with graduated services. This approach is reinforced and supported by both family values, social norms and the formal health and social service network in Quebec which actively promotes the maintenance of adults in their own homes, despite losses in autonomy and the need for the input of health or social supports.

The inevitable result, however, is the increasing number of family caregivers who find themselves in a position of offering concrete or emotional support to someone with a physical or cognitive loss of autonomy, or mental health problem. Almost five (5) million adult Canadians call themselves 'caregivers'.¹ 80% of this care is delivered in the community, in the home, and mainly by women.² The contributions of caregivers to the healthcare system are estimated at \$5 billion annually!³

At the same time, population aging is dramatically increasing the numbers of annual deaths, in addition to

the deaths resulting from chronic, acute, and terminal illness. Whereas 75% of deaths take place in hospitals or long-term care facilities⁴, there is a growing trend for people to choose to die at home, or remain at home for the maximum time possible. Whatever the option at the end stage of life, palliative care as end-of-life care is a vitally important and necessary intervention approach which aims to respond to the myriad needs of the dying person – the medical, physical, emotional and spiritual needs – in a global and cohesive manner. Family caregivers are by definition a vital partner in this process.

Working with people at the end of their lives can be rich and rewarding, highly satisfying and exhausting. Interveners of all disciplines – nurses, doctors, social workers, rehabilitation therapists, volunteers, personal care assistants, to name but a few – often feel they are 'running on empty' at times. Burnout and a sense of powerlessness are constant 'black clouds'.

Within this context, the CSSS Cavendish, in its mandate as a University Affiliated Centre, has supported the Caregiver Support Centre and the Community Palliative Care team, both part of the PALV services, to join together in the development of a training program aimed at assisting practitioners in their work with caregivers whose family member is at a Pallia-

tive stage of their illness. The Caregiver Support Centre of the CSSS Cavendish has been a leader at the provincial, national and international levels in developing specialized service programs geared specifically for caregivers. The Community Palliative Care team, as well, has been actively developing its expertise and unique approach to intervention in Palliative Care situations.

The merger of these two service orientations has resulted in a multi-module training for Multidisciplinary Professionals who are concerned with *Caregiving in the Palliative Stage*. The training aims to help practitioners

- understand the challenges facing caregivers in the palliative stage
- learn about intervention strategies with caregivers in the palliative stage
- reflect on their own values and beliefs about end of life issues
- reflect on their own perceptions and assumptions about caregivers
- consider the context of palliative care in Quebec and Canada.

The training is divided into five modules, with Modules 1 and 2 being prerequisites to the other three.

Module 1 offers an introduction to *palliative care and caregiving*.

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It encourages practitioners to consider palliative care through a new lens, and to examine the ways in which palliative care impacts on the many aspects of a family caregiver's life – practical, emotional, physical, spiritual, ethical, and relational. This module aims to develop a good understanding of the role and status of caregivers in Canada, in Quebec, in the workforce, and as 'players' within the healthcare system, in general.

Module 2 focuses on *interdisciplinary intervention* and is conducted in a workshop format in order to give practitioners hands-on strategies for intervening with caregivers in the palliative stage, and for working with interdisciplinary colleagues.

Modules 3, 4, and 5 are still in development. These modules will cover *psychosocial intervention, ethical concern, and post-caregiving and bereavement*.

By the end of Modules 1 and 2, participants should perceive palliative care through a new lens, and ultimately feel more confident intervening with caregivers in the palliative stage. In addition, they will have had the opportunity to question their own fears, conceptions about, and values related to the dying process and incorporate this awareness into their response to their clients or patients, and also, as it relates to their work with their colleagues.

This training is for multidisciplinary practitioners who work with people at the end of life and with their caregivers. It is directed at all levels of experience, and is pertinent for intervenors in both the community and the institutional setting. The training approach combines didactic sharing of information and facts, audio-visual content, interactive

exercises and workshops, self-reflection and journaling techniques.

A first presentation of this unique training was offered at the CSSS Cavendish on October 29th, 2010. The feedback from the participants reflected a resounding satisfaction and pertinence! New sessions in both English and French will be planned in the coming year, with ongoing development of the Modules under construction. <

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Edelgard Clavey

age : 67
 born : June 29, 1936
 first portrait taken : December 5, 2003
 died : January 4, 2004

Edelgrad Clavey was an administrative assistant in the university's psychiatric clinic. She had lived on her own since her divorce in the early eighties. She doesn't have any children. From her teens she has been an active member of the Protestant church. For the past few weeks she has been bed-bound.

"Death is a test of one's maturity. Everyone has to get through it on their own," says Mrs Clavey. "I want so very much to die. I want to become part of that vast extraordinary light. But dying is hard work. Death is in control of the process, I cannot influence its course. All I can do is wait. I was given my life, I had to live it, and now I am giving it back."

"I've always worked hard, followed a similar path to a nun: poverty, chastity, obedience. Now, I am no longer able to contribute anything to society and this pains me terribly. I do not want to be a financial drain on resources, yet another living corpse that is only a burden. I want to go, preferably immediately. Always be prepared, just like the boy scouts."

With the obliging collaboration of the Musée des religions du monde (Nicolet, Québec, Canada). We thank the creators of the exhibition *Life Before Death* : Walter Schels and Beate Lakotta

Dying as an Older Person at the Beginning of the 21st Century

This address was given at the symposium *Les vieux meurent aussi. Pratiques d'accompagnement en fin de vie pour les personnes âgées et leurs proches* (Old people are dying too: Support practices in end of life care for the older adults and their caregivers), organized by the Centre de recherche et d'expertise en gérontologie sociale (CREGÉS), which was held May 7, 2010, in Montréal. I have complemented the remarks of David J. Roy with some of his writings.

David J. Roy

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Report by Véronique Billette

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At the beginning of the 21st century, do older people die in a context characterized by exclusion or humaneness? This is how David J. Roy began his address, inviting us to follow him in a sensitive and nuanced reflection on the end-of-life living conditions of the elderly in a society where exclusion is the "great social crime of our era."¹

Exclusion springing from fear

Older people mirror back to us what we are. The fear of old age can elicit the desire or need to make them invisible. We experience a sense of strength and power in relation to the very old, which leads us to believe that we are not like them, not one

of them. We have this tacit and rarely denounced presumption that the elderly are different from us. They are not part of "us." Obviously, these thoughts are never expressed so openly and brutally. Yet this premise runs through our public policy, programs and services.

Seniors reveal to us what we are and they die in a world marked by the fear of aging and old age.

A context of exclusion or humaneness?

Why is it that the elderly (also younger persons) end up on society's margins? How do we distance ourselves from old age? According to David J. Roy, exclusion occurs in seven stages: 1) Diminishment of the role and social significance of the person or group; 2) Amplification of difference; 3) Turning a blind eye; 4) Stigmatization; 5) Discrimination (you no longer have the same rights as everyone else); 6) Marginalization (you're pushed into the shadows of society); 7) Rejection (you become a repellent figure to others).

According to David J. Roy, this context of exclusion, which reduces individuals to negative traits, encourages and is reinforced by stigmatization and discrimination, is the opposite of a humanist approach, or the ethics of inclusion.²

And if we attempted to visualize a humane space, what would we find there? A space in which the most vulnerable individuals are heard, where people do not die in despair but rather are free of suffering and surrounded by caring people. A space where the broken find arms, hearts and loving souls to embrace them. A space where one dies surrounded by individuals who light the way with hope.

Diversity and ambiguity in attitudes to death

Our contemporary world is definitely not the one of the classical era. In the past, the notions of humanity and culture were generally more universal and homogenous: "a single set of beliefs, ideals and rules served as the model for all society."³ Today our world is extremely fragmented. We live in a multicultural

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world characterized by many points of view and beliefs that every day confront each other or simply co-exist, in, or free of tension.⁴ Faced with death, these diverse attitudes are necessarily represented in each of us. Even within the same person or group, we may find a mix of contradictions and similarities in terms of attitudes to death.

We live in a state of a deep-rooted psychological and cultural denial, a refusal to think of the unthinkable, to imagine death. Many people seem to find it impossible to think that one day they will not be there. There is much clamour when it comes to euthanasia, assisted suicide, and the different kinds of care, but silence in the face of death.

End-of-life services

David J. Roy recited an excerpt of a monologue by Marc Favreau (also known as Sol),

"Ils sont bien... Jamais ils sont pressés non plus. Ils ont tout leur bon vieux temps. Ils ont personne qui les force à aller vite; ils peuvent mettre des heures et des heures à tergiverser la rue... Et plus ils sont vieux, plus on est bon pour eux. On les laisse même plus marcher... On les roule..."

(Le crépuscule des vieux)

We roll them, but where to? To what extent do we support them? To what extent will we support ourselves? Because when we refer to the elderly, we're also talking about ourselves, our future selves.

Dr. David J. Roy believes there is a social separation dividing the old from the younger members of society. Us, for the time being. This distance means that there is less and less in common between old age and the other ages. It is as if older people suddenly represented a completely different group. The

"them" group as opposed to the "us" group.

And the number of seniors, the "them" group, is expanding faster than the younger people's group. This situation gives rise to alarm and consternation. We cling to economic arguments to justify our fear: seniors are a threat because they cost us a lot.

Should the very old fear euthanasia? Are we more open to discussions about euthanasia because we're hearing their voices or because we're listening to our fears and those of the market and economic discourse? Are the elderly dying humanely? Are all these discussions framed by the principle of humaneness?

For Dr. Roy, "as long as we have not defined the rules ensuring that the patient's wishes and needs are upheld, 'dying with dignity' will be nothing but a slogan."⁵ The necessary conditions must be met because "without these changes, people will continue to die under miserable circumstances."⁶ To this end, we must separate the notion of 'dying with dignity' from euthanasia, which Roy believes is "ending the life of a dying person" and not instituting the necessary conditions to help people die in a dignified and humane manner.⁷

Dying in dignity or destitution?

How will the old and the very old die? In destitution and isolation? In 1982 Roy wrote that "people rarely die alone today, yet they can still die abandoned."⁸ The place may be crawling with people but is it really inhabited? Will we have the financial and human resources to create a humane environment that promotes death as an "act of life, an act of integration and communication"? Because "one

cannot die without genuine human contact. Dying does not simply mean 'passing away.' Achieving these moments of connection is an integral part of the act of dying."⁹

The resigned acceptance of death is not the only way to die in dignity. Weakening, discouragement, fear, anger and rage can all form part of the end-of-life experience and they are not incompatible with dignity and humanity. As Roy emphasizes, "there are many ways of dying with dignity."¹⁰

Indeed, can one talk about dying in dignity when some people will die diminished by dementia? With no capacity for understanding? No autonomy? How can someone who is totally powerless and whose calls for help are ignored die in dignity? How can someone who has been shunted to the margins of society die in dignity?

Conclusion

David J. Roy's address and writings make us realize that the notion of dying in dignity encompasses more than the relationship to death, supportive or palliative care or euthanasia. To die in dignity one must first be able to live in dignity. <

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SEPARATING FACTS FROM FANTASY:

Issues in the Debate on Euthanasia and Assisted Suicide

This article is a summary of the address given by Brian Mishara during CREGÉS' annual symposium *Les vieux meurent aussi. Pratiques d'accompagnement en fin de vie pour les personnes âgées et leurs proches*, (Old people are dying too: Support practices in end of life care for the older adults and their caregivers), which took place on May 7, 2010, in Montréal, Québec.

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As revealed by the Special Committee on Death with Dignity launched by the Québec government in 2010, the questions of "dying with dignity," euthanasia and assisted suicide are hot topics requiring much discussion. The public is confused about the issues surrounding the legalization of euthanasia and assisted suicide. This was the view expressed by Brian Mishara, Director of the Centre de recherche et d'intervention sur le suicide et l'euthanasie (CRISE), whose speech at the symposium brimmed over with definitions, observations and conclusions and impressed all in attendance, helping to advance the thinking on this question.

Seven ways to intentionally end a life

Brian Mishara believes that to be in favour of legalizing assisted

suicide and euthanasia, these two methods must be considered morally acceptable and no other method of intentionally shortening a life is available that can meet the needs of the individual suffering from a terminal illness. Currently, suicide is not illegal in Canada, but very few terminally ill persons commit suicide and the disabled commit suicide less often than those who have no disability. All Canadian citizens have the right to refuse treatment, even if it is essential to prolonging their life. We also have the right to cease a treatment that is keeping us alive. In addition, we have the right to obtain enough medication to relieve our suffering, even if there is a possibility that this palliative treatment will shorten our life expectancy. This "double impact" is permissible, as are certain types of chemotherapy for cancer, which can also cause premature death.

Homicide, on the other hand, is illegal in Canada. Under our laws, homicide, even on compassionate grounds, is prohibited. Today, euthanasia is considered to be homicide and assisted suicide (when a physician supplies the means to a person who intends to end their life) is still illegal.

Are decisions made at the end of life more "rational" or "acceptable" than the decision to commit suicide?

In Canada, nearly 90% of those who commit suicide suffer from a mental disorder and their decision to kill themselves may be linked to mental illness. When it comes to euthanasia and assisted suicide, many consider the decision to die as having a more rational basis. Brian Mishara believes that all important life decisions are highly charged with emotion and are rarely rational (for example, the choice of a spouse). To have access to euthanasia or assisted suicide, it is generally required that a person be in the terminal phase of an illness and experiencing great suffering. When we are suffering, our ability to reason is altered. Furthermore, cancer research has shown that when physical and mental suffering can be relieved (which is almost always possible), the desire for premature death vanishes.

People frequently feel ambivalent and change their minds.

In the Netherlands, up to 66 per cent of euthanasia requests are rejected because of the prior obligation to do everything possible to relieve suffering rather than

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end a life. The ill rarely persist in requesting euthanasia when their suffering has been relieved. In the state of Oregon, where assisted suicide is legal, only 88 of the 32,000 people who die every year requested assisted suicide. Assisted suicide was first legalized in Oregon in 1998. Since then, once they had obtained the medication that would kill them, 37 per cent of those who had persuaded two physicians of the need to end their life due to intolerable suffering changed their mind and continued living until their natural death. Even those who are convinced they can no longer continue living may change their minds. For this reason, assisted suicide—which means that the person can control the timing of their death without the intervention of a third party—better protects the rights of a patient who wishes to kill himself/herself. In the case of euthanasia—when a physician must intervene to end a life—a specific

type of social situation is created, in which the decision to postpone death for a few days or weeks becomes more complicated.

For or against?

Brian Mishara believes that for society to legalize assisted suicide and euthanasia, both methods must be deemed morally acceptable and the whys and wherefores fully understood; all the same, in his opinion, the legal methods currently available in Canada to shorten a life are not adequate. We must also be confident that these methods can be implemented in our socio-cultural context after having concluded that the benefits of legalization justify any possible risks. Such reflection can only be based on presumption and hypothesis.

Understanding facilitates reasoning

It is essential to clarify the concepts, list the advantages and

risks attached to each of these methods and review the impact in countries that have legalized these practices. Many people believe that legalizing euthanasia or assisted suicide would be equivalent to sanctioning practices that are already legal. Further, there is a big difference between assisted suicide and euthanasia in terms of who has the control or power to decide the timing of death: the sick person (assisted suicide) or the physician (euthanasia).

There is still relatively little understanding of the issues and different methods of shortening a life. According to Brian Mishara, the more confused people are, the more they tend to favour legalizing these methods. In the thinking and debate about the issues surrounding “dying with dignity” we must keep in mind the importance of information, so that we can make informed decisions as a society. <<

The Choice to Die

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Our society is evolving, as reflected by its inhabitants, who are seeking more and more autonomy over our lives. Only two or three generations ago, the subjects of divorce, abortion, gay marriage and suicide were still relatively taboo. Today, as revealed by a CROP/Radio-Canada survey published on November 21, 2010, a strong majority of Quebecers are in favour of legalizing euthanasia, as long as clear guidelines are applied which make it possible only under very specific circumstances.

This was the position of Dr. Marcel Boisvert and Hélène Bolduc of the Association québécoise pour le droit de mourir dans la dignité (AQDMD) in their address to the annual symposium of CREGÉS, Old people are dying too: Support practices in End of Life Care for Older Adults and their Caregivers. They reported that between 70 and 80 percent of the population believe that euthanasia is justified and acceptable under certain circumstances, when the person who is directly concerned makes the request. They discussed

and analyzed a number of concepts in their presentation, some of which were particularly striking to those in attendance.

Excessive prolongation of life

Palliative care has its limits; it is not possible to relieve all forms of suffering. Some people will suffer a long and horrible death. Sometimes

the end of life is terribly distressing with no possibility of treatment or relief. Patients die slowly, wasting away—an unbearable death.

Health professionals: blindly focussed on healing or sensitive to patients' wishes?

Most health professionals are not

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SUMMARY OF THE AQDMD'S MANIFESTO

- 1. Respect the autonomy of the individual:** A patient's autonomy and the respect of their wishes are fundamental principles of medical ethics. Any adult suffering from a terminal illness or an unbearable and untreatable condition who has been duly informed about their support options, treatments and palliative care, should have the right to request and receive medical assistance so they can determine the timing and manner of their death.
- 2. Dying in accordance with one's own values:** The concept of dignity is personal. Pain and suffering is subjective and only the patient can affirm its intolerable nature.
- 3. Importance of compassion:** Compassion for the ill requires acknowledgement of their nearly untreatable suffering; patients should be supported and their wishes and values respected.
- 4. End of life care:** Suffering can be so great that palliative care practitioners may employ continuous deep sedation or cease nourishment and hydration of the patient. If this is the patient's informed choice, these are dignified ways to die. If they have expressed the wish, however, dying patients should have the option of choosing a quicker method.
- 5. Guidelines for the practice:** The practice of assisted death essentially depends on the free, informed and repeated request of the patient, confirmation of their ability to decide and consultation with a second physician.
- 6. Respect for another's point of view:** An individual may place their life and death in God's hands and believe that any form of life is better than death, even the most extreme situation. This belief should be respected. On the other hand, no one has the right to impose this point of view on everyone else.

equipped to understand the desire of some patients to end their life because they are focussed exclusively on healing. Physicians are ethically obligated, however, to respect their patient's freedom of choice. Their obligation is not to keep a body breathing but rather to honour a patient's wishes. This is why it is important to have a living will with medical directives that reflect your wishes regarding medical treatment in the event your condition prevents you from communicating what you want to health professionals.

A good death is not utopic!

Aspiring to have a good death means insisting on the freedom to choose the timing of one's death. An individual may be ready to die, or wish to die, when they've "had enough." A good death is a conscious death, the recognition of a person's autonomy in the matter of life and death: "If I can't decide about my death, who does my body belong to?" A good death is being able to die in dignity and in the respect of one's humanity. A dignified death is not death by euthanasia; rather, it is death in accordance with the values that have driven the person's life history and not the commonly accepted religious, personal or social values.

"Voluntary euthanasia is a new form of freedom"

Boisvert and Bolduc emphasized that euthanasia is not violent, like murder; death itself can be violent. Euthanasia does not mean "killing," it is "helping someone to leave gently" in accordance with certain conditions and as a continuation of palliative care. Euthanasia in this respect is not passive, it is an informed decision a patient makes as an exercise of their freedom of choice. It is a form of taking power over the final stage of life. Dying is a question of freedom, and euthanasia in this respect is an option, a desire, a lucid decision, a personal

and individual choice.

A question of individual freedom and also one of social responsibility

It is not illegal to kill yourself, to commit suicide. Euthanasia and assisted suicide involve other individuals in our death, however, making it a social responsibility. This social responsibility consists of ensuring that the grounds for the request are properly unders-

stood before giving the patient access to these options for ending their life.

Marcel Boisvert and H el ene Bolduc concluded by reminding us that Qu ebec was the first government to recognize the right to refuse treatment. Will it be equally progressive when it comes to legalizing assisted suicide and euthanasia? There will be much more



Wolfgang Kotzhan

age : 57

born : January 19, 1947

first portrait taken : January 15, 2004

died : February 4, 2004

There are colourful tulips brightening up the night table. The nurse has prepared a tray with champagne glasses and a cake. It's Wolfgang Kotzahn's birthday today. "I'll be 57 today. I never thought of myself growing old, but nor did I ever think I'd die when I was still so young. But death strikes at any age."

Six months earlier the reclusive accountant had been stunned by the diagnosis: bronchial carcinoma, inoperable. "It came as a real shock. I had never contemplated death at all, only life," says Herr Kotzahn.

"I'm surprised that I have come to terms with it fairly easily. Now I'm lying here waiting to die. But each day that I have I savour, experiencing life to the fullest. I never paid any attention to clouds before. Now I see everything from a totally different perspective: every cloud outside my window, every flower in the vase. Suddenly, everything matters."

With the obliging collaboration of the Mus e des religions du monde (Nicolet, Qu ebec, Canada). We thank the creators of the exhibition *Life Before Death*: Walter Schels and Beate Lakotta.



Vox Pop at the Symposium

Nancy Guberman

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Participants at the symposium on end-of-life care for older persons and their caregivers, Old people are dying too: Support practices in end of life care for older adults and their caregivers, were invited to participate in workshops addressing 14 topics that were designed to come up with recommendations on how to improve the care and support of older persons at the end of their lives. Participants discussed end-of-life interdisciplinary approaches, the organization of palliative care, giving meaning to life and death, grief, spiritual support, volunteer work, close family and friends and ethical issues, among other questions. The symposium organizing committee compiled the recommendations, which are presented here.

Regardless of the workshop topic, the recommendation that comes up most is about the need for training: training for palliative care practitioners and palliative care training for gerontology practitioners. A few workshops mentioned specific aspects of this training. For instance, it was reported that there is a real need for training among long-term care practitioners and managers. Others commented that the training should cover topics such as spirituality and sexuality, two subjects that are often put aside.

The second most-frequent recommendation relates to communication problems among the actors concerned: between practitioners, especially across disciplines, and

also, with a view to providing support, between practitioners and other actors, particularly families (including during the period after death).

Many recommendations cover a variety of topics, including the attitude to be adopted by practitioners and different intervention methods to be promoted. Among these:

- put the whole person at the centre of care;
- clarify the notion of incapacity in order to be able to continue seeing and working with a dying person's potential and abilities and avoid reducing them to an illness;
- be in contact with one's own feelings about dying;
- ensure openness to diversity;
- respond to loss and grief as it occurs throughout the trajectory toward death;
- accord greater priority to rituals (secular and otherwise) as a way to offset the dominance of socio-technical interventions;
- integrate commemorative practices and rituals; and
- treat spiritual healing as an integral aspect of the practice of support.

Other recommendations are directed to health and social services institutions:

- improve continuity of services between institutions;
- reduce changes in living environment when people are approaching death;
- ensure greater staff stability;
- provide a private room in long-term care residences to a dying person and their family; and
- set up a multidisciplinary palliative care committee in all insti-

tutions to support staff (dealing with compassion fatigue) and families.

Especially in relation to families, the workshops that addressed issues regarding those close to a dying person recommended early discussion with the dying person and their family, including about the possible settings for death, and that we substantially increase the resources provided to loved ones, such as psychosocial and respite care. The main concern, however, is that the contribution of close family and friends be recognized and valued.

The workshops that considered the situation of volunteers involved in accompanying the dying recommended that they be provided with proper training at the provincial level, including professional development. They also recommended that our system value this form of volunteer work more; for example, by providing space for volunteers to meet among themselves.

Naturally, many workshops discussed the political will for developing end-of-life care and the necessary funding. The recommendations in this area, however, are limited to the need for political leadership and adequate funding to implement past recommendations.

The workshop discussions were infinitely richer than what is conveyed by this summary of the resulting recommendations. The practitioners attending the symposium made these recommendations spurred by the hope that their work provides genuine support to those who are dying and their loved ones. <

Profile of the Palliative Home Care provided by CSSSs in Québec

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The elderly want to die surrounded by their loved ones in a familiar environment.¹ In the next few years, this fact, combined with an aging population, will spark the growth of palliative home care. The health and social services centres (CSSSs) are responsible for these services, which are delivered by their affiliated local community service centres (CLSCs). However, the most recent reports and overviews on these services date back a dozen years; in other words, before the CSSSs were created.² Since then, various policies and standards have been adopted in this field, bringing changes to the offering and methods of palliative home care services.³

A CREGÉS research team decided to fill the information gap by producing a complete overview of palliative home care services provided by CLSCs associated with the 95 CSSSs in Québec. The study was conducted between 2008 and 2010. Among other metrics, the

researchers examined communications methods within and between institutions, the formation of palliative care teams, types of services and their availability, community-based services, the number of referrals, and whether the program was actually applied or simply existed on paper. The researchers paid particular attention to the services and care provided to the elderly, and the offer of psychosocial services and grief follow-up to close caregivers. The links between organizational, environmental and contextual variables were also examined.

The research was presented at the 18th International Congress on Palliative Care held October 5–8, 2010, in Montréal. <<

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OUT OF BOUNDS

Palliative Home Care Practices: Social Exclusion or Inclusion of Seniors at the End of Life

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Older people at the end of life are faced with many decisions in a context which could be harmful to those who also suffer from social exclusion. Currently, these individuals are referred to palliative home care services less frequently than younger people, and they encounter more barriers in obtaining such services. Given the impact of ageism, marginalization and an erroneous representation of death for the elderly (considered "good,



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normal and accepted"), older people's experience of the end of life is too often trivialized and ignored. Those who practise palliative home care and accompany these individuals function in this context and are confronted with the wishes of the elderly and their loved ones along with their own value system. It would appear that the "dying well" model is prevalent among professionals and that it may contribute to social exclusion.

Since there is little available literature on the different manifestations of exclusion in this area of health care, a CREGÉS research team decided to answer this question: How can palliative home care services for the elderly contribute to, or combat social exclusion?

Semi-structured individual interviews of roughly one hour were conducted

with 19 social service practitioners and nurses. They were asked to discuss specific aspects of home support work, service organization, their experience of working with the dying and the elderly, dying at home, and ethical issues. Social exclusion was addressed through questions about the participation of older people in developing their intervention plans and the maintenance of their social roles. The practitioners' representations (values, beliefs, attitudes) and intervention strategies turned out to be useful indicators of the social exclusion or inclusion of older people at the end of life.

This study was presented at the 9th edition of the *Congrès international francophone de gériatrie et gerontologie* (international francophone geriatrics and gerontology convention), held from October 19–21, 2010, in Nice, France. <<

Curtain

Jacques Boulerice

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A provincial conference addressing suicide among seniors, organized by the *Association québécoise de prévention du suicide* (AQPS), was held on September 23 in Trois-Rivières. *PluralAges* was invited and I attended, representing its editorial committee as a non-specialist, a role in which I specialize. The conference was entitled *La vie des aînés nous tient à Cœur*, a statement with which the 220 participants would certainly agree—in different ways.

My first impression: a wealth of statistics. We heard reports presenting a wide spectrum of facts firmly based on scientific studies whose findings were left open to interpretation. There were several astounding observations. Some raised a smile while others sent shivers down the spine. Considered together, the list seems unconnected but the apparent causal links are striking.

Seventy-five per cent of seniors who commit suicide had an appointment with the family doctor in the preceding month.// Women's life expectancy increases in relation to the mortality rate of men who kill themselves.// Among the factors of protection against suicide in old age are shared life experiences, social support and Alzheimer's.

A horrible yet darkly-comical fact, that last factor, at least in the final stages of the illness.

But did I understand correctly? I remember my mother, ill with the disease, who often asked me to "help her die." Could this protection factor (that we'd like to think a joke) in fact constitute the ultimate "solution"? I must reread Jean Maisondieu's disturbing essay, *Le Crépuscule de la raison*, in which he describes how it seems that the brain can make this awful "choice" to forget in order not to suffer. Let us move on, for the moment.

Everywhere else—in Canada, Europe, and the United States—the suicide rate rises with age. The opposite is true in Québec.// The rate is rising among seniors because this age group is increasingly expanding. In reality, the percentage is falling. So there's a myth circulating that reinforces the idea that large numbers of seniors suffer psychological distress, when the truth is quite the opposite: they're generally quite happy with their situation.

By the way, there are roughly 6,000 of these "happy" people now waiting to be admitted to a long-term care centre, those places where everybody knows that visitors are clamouring at the doors to come and share their life experiences with a relative. That said, perhaps our understanding of some statistics sends shivers up the spine because we can turn our backs on the calls for help from those abandoned at the end of their days. To each our own particular fantasy. But now, back to reality and a sampling of the observations.

Those who refuse treatment are not represented in the statistics. Nor does the portrait include the failed attempts. Deaths by overdose (accidental or intentional?) occurring in the home are not reported nor are the cases of people who simply let themselves appear nowhere.

Depression is a major risk factor. Eliminate depression and the suicide rate is cut by 75 percent. Among seniors, however, this illness is frequently undiagnosed. Indeed, many believe that it is difficult, even pointless to treat old people, as if this life-threatening condition were inherent to old age.

But, aside from the studies, there are the unknown names of those who are thinking about erasing themselves from the list of the living--those who want to make their faces disappear from the family photo. One is too many. Throughout the conference we heard repeated summonses to action.

In short, it was a meeting rich with statistics and powerful presentations.

In the morning the weather forecast was for a day in three stages: sunny in the morning, cloudy in the afternoon and overcast and rainy in the evening. The kind of evening that could incite someone to draw the curtains on the dreariness. The AQPS meeting was devoted to all those who believe that this scenario should not apply to any human being. <

Life Before Death (*À la vie, à la mort*)

Report by **Michèle Modin**

Based on press releases
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A fascinating exhibition had its North American premiere at the Musée des religions du monde in Nicolet-Yamaska. Between May 19 and September 6, 2010, a total of 10,604 people came to see the exhibition—the largest attendance in the museum’s history. Outside the major urban centres it is a real feat to attract so many visitors.

The exhibition consists of 54 photographs that immortalize 26 people before and after their death, accompanied by a short description of their thoughts on the approach of death. The images, at once magnificent and deeply disturbing, sparked both praises and confidences from museum visitors. Mathieu Fortin, in charge of public programming at the museum, reports: “People came to us afterward and told us their stories of loss. I have a whole host of fascinating stories. For example, the man who arrived 20 minutes before closing and who, as he was buying his ticket, told me that he didn’t have long to live and had come to prepare himself.”

The exhibition, created several years ago by photographer Walter Schels and journalist Beate Lakotta, has been to several cities in Europe, including Berlin, Hamburg, London, Lisbon and Vienna. The combination of Schels’ camera, Lakotta’s pen and the



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ingenuity of these two German artists brings us poignant images of striking quality, while the touching stories inevitably inspire deep reflection on this obligatory transition.

The editorial committee of *PluralAges* wanted to give readers a glimpse of these remarkable images that we find strangely comforting. Some of the photographs and their accompanying texts appear in the pages of this issue. *Life Before Death* was presented jointly with *Deuils*, an exhibition

about the funeral rites of the world’s five major religions. *Deuils* presents the different rites of passage as perceived by believers of these religions, including the various stages of grief, the preparation of the body and the rituals for remembering the person who has died. *Deuils* runs until March 13, 2011. <

A Social Gerontology Textbook

Vieillir au pluriel. Perspectives sociales

Véronique Billette

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It is with great pride that we announce the publication, with the Presses de l'Université du Québec (PUQ), of CSSS Cavendish's Centre de recherche et d'expertise en gérontologie sociale (CREGÉS)' anthology of writings about the social issues of aging. *Vieillir au pluriel. Perspectives sociales* presents contributions from 45 researchers and practitioners, members and partners of the CREGÉS. Together, they constitute a unique pool of expertise on the elderly and society, out of which has emerged the first French-language social gerontology textbook.

Attended by over 60 people, the launch on October 6, 2010, at the Grande Bibliothèque de Montréal was the culmination of a project that has been especially important to CREGÉS and its members.

The book is structured in four sections representing four areas of research. Some articles are theoretical in nature or present empirical data, while others are more rooted in practice, offering analysis of innovative intervention methods. The book is accessible to a broad and diverse readership: college and university students, practitioners, researchers and those who are interested in the subject.

The first section, entitled *Les multiples vieillissements et leurs repré-*

sentations (multiple forms of aging and their representations) deals with the different representations and definitions of age, women and aging, and with aging issues associated with immigrants and older gay men and lesbians. The second section, *Les inégalités des défis rencontrés* (inequalities and related challenges), addresses physical health, mental health, elder abuse, medication of people afflicted with Alzheimer's and palliative care. Social and geographical issues associated with the elderly are discussed in the third section, entitled *Vieillir où et avec qui*. These include intergenerational relationships, the experience of intimate caregivers, and aging and receiving care in residential or home settings, both in rural and urban environments. The last section, *Vieillissements, politiques et actions* (forms of aging, policies and actions), plunges us into the situation of older workers, "post-retirement" employment and retirement plans, Québec policies concerning seniors who are incapacitated, volunteer work "by" and "for" seniors and the multiple forms of community involvement engaged in by seniors.

Social exclusion and solidarity, the central focus of the theoretical framework and activities of the VIES (*Vieillissements, exclusions sociales et solidarités*) team, are cross-cutting themes throughout the book, ensuring that issues surrounding aging are addressed with a concern for representativity and diversity. The experience of aging varies, depending on multiple personal and social factors such as

gender, ethnic background, sexual orientation, socioeconomic status, civic skills, capacities and incapacities, etc. Diversity at the individual level is combined with diversity of life stories and forms of aging and the diversity of choices and possibilities available to seniors. The authors' multiple perspectives give readers an insight into the issues surrounding aging from a social and community standpoint. The book offers food for thought on aging and its multiple forms and presents the challenges of creating a society for all ages. <

VIEILLIR AU PLURIEL. PERSPECTIVES SOCIALES

Edited by Michèle Charpentier, Nancy Guberman, Véronique Billette, Jean-Pierre Lavoie, Amanda Grenier and Ignace Olazabal

Les Presses de l'Université du Québec, collection Problèmes sociaux et interventions sociales, Québec, 2010, 496 pages.

Articles by Paul Bernard, Valérie Bourgeois-Guérin, Shari Brotman, Brita Brown, Normand Carpentier, Robert Cormier, Bernadette Dallaire, Martine D'Amours, Patrick Durivage, Ilyan Ferrer, Annie Frappier, Zelda Freitas, Norma Gilbert, Danielle Groleau, Eddy Guarino, Danielle Guay, Nancy Guberman, Marijo Hébert, Sarita Israël, Marie-Jeanne Kergoat, Marie-Emmanuelle Laquerre, Josiane Le Gall, Annette Leibing, Frédéric Lesemann, Catherine Montgomery, Nona Moscovitz, Kareen Nour, Manon Parisien, Sacramento Pinazo, Anne Quéniart, Alan Regenstreif, Isabelle Rousseau, Bill Ryan, Anne-Marie Séguin, Andrée Sévigny, Maryse Soulières, Julie Thériault, Isabelle Wallach, Hélène Wavroch and Janine Wiles.

RECENT PUBLICATIONS

PROCESSUS DE CHANGEMENT DE COMPORTEMENTS CHEZ LES AÎNÉS ARTHRIQUES. ÉVALUATION D'UN PROGRAMME D'AUTOGESTION DE LA DOULEUR POUR DES AÎNÉS CONFINÉS À LA MAISON
(Changing behaviour in arthritic elderly. Evaluation of a home-based self-management program for housebound seniors)



Kareen Nour
Éditions universitaires européennes, Sarrebruck, 2010, 248 pages

Arthritis is one of the most

prevalent chronic health problems, particularly in the elderly. The symptoms of arthritis can be managed if certain behaviours are adopted and maintained. However, little information is available in the literature on changes in management behaviour among housebound adults and even less on the reasons leading them to adopt and maintain such behaviour. This thesis is an attempt to understand the processes underlying the adoption and maintenance of health-related behaviours in housebound seniors with arthritis who completed a self-management program to control their symptoms. The program is called "I'm taking charge of my arthritis!" The results showed that, by following such a self-managed program, these individuals were able to change their health-related behaviour, especially their participation in physical activities. The changes were influenced by each individual's psychological and socioeconomic status and by different elements in the program.

Author Kareen Nour, Ph.D. is a researcher with the Centre de recherche et d'expertise en

gérontologie sociale at the CSSS Cavendish and associate clinical professor in the department of social and preventive medicine at the Université de Montréal. Her field of research is the evaluation of programs related to front-line services for the elderly. <<

LES TECHNOLOGIES DE L'ESPOIR. LA FABRIQUE D'UNE HISTOIRE À ACCOMPLIR

Edited by Annette Leibing and Virginie Tournay
(Technologies of Hope. The Structure of a History to be Built)
Les Presses de l'Université Laval, "Sociétés, cultures et santé" Collection, Québec City, 2010, 320 p.



This book is a plea for erecting an analytical framework specific to the "technologies of hope", that is, the set of biotechno-

logical techniques defined by their advocates as medical tools with the potential to preserve or prolong life. These technical tools are the outcome of a history that is at once material and subjective, individual and collective. Reconstructing this history requires a simultaneous examination of the institutions, tools and techniques connected with the structure of the "technologies of hope", as well as the expectations, demands and public policies formed by and around these technologies. From this vantage point, the hypothesis developed is that hope has an organizational power that channels technological constructions in a specific direction – in a possible collectively-shared future. The performance aspect of future scenarios is challenged here. The book's aim is

to shed light on this regime of hope that is linked to the global circulation of technological knowledge and material progress.

This collection brings together contributors from different disciplines (anthropology, sociology, social work, political science, history of medicine) working to analyze a variety of cultural contexts (Brazil, France, Canada, Germany, North America, China, Great Britain). It provides an outline of different ways of understanding the technologies of hope and attempts to define the milestones for future developments.

Contributing authors: Jean-Paul Gaudillière, Céline Granjou, Liselotte Hermes da Fonseca, Lilian Krakowski Chazan, Céline Lafontaine, Annette Leibing, Mélanie Lemonnier, Ilana Löwy, Jonathan M. Metz, Francisco Ortega, Michèle Robitaille, Thomas Streitfeller, Virginie Tournay, Pascale Trompette, Fernando Vidal, Ayo Wahlberg, and Wilson Will.

Annette Leibing is an anthropologist, full professor at the Faculty of Nursing, Université de Montréal, and researcher associated with the Centre de recherche et d'expertise en gérontologie sociale at the CSSS Cavendish. Her research interests centre mostly on aging (particularly Alzheimer's and Parkinson's disease), medications and psychiatry. For several years she has been exploring the complex and contradictory culture of Brazil.

Virginie Tournay is a biologist and permanent political science researcher with the Centre national de la recherche scientifique (CNRS) at the Institut d'études politiques de Grenoble – UMR PACTE, where she teaches pragmatic approaches to public action. She researches the origin of institutions from the standpoint of a political sociology of "the infinitely small." <<

Reflections on Dying with Dignity

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Joseph Caron

MLIS, PhD, Librarian

Summaries by **Marijo Hébert**

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Montréal; Research assistant, CREGÉS*

In 2010, the National Assembly of Québec set up a special commission to study the right to die with dignity. As part of its work, public hearings were held for citizens and organizations to voice their opinions. We wrote the following summary with the assistance of the authors of the brief presented by the Maison Michel-Sarrazin and Mr. Joseph Caron.

Position of the Maison Michel-Sarrazin

When discussing the matter of dying, two basic terms must be clarified: dignity and autonomy. Human dignity is intrinsic to the status of being a human being and is not at all changed by age, illness or privation in the face of death. Accepting that a life should be cut short would confirm, paradoxically, that an individual who is ill or dying has lost his/her dignity and is therefore no longer a full-fledged human being.

Autonomy cannot be seen as a radical, absolute manifestation of

individual freedom, allowing one to claim the right to choose the time of one's death. Autonomy is seen from a collective perspective, whereby, since the earliest of human history, it is closely bound to respect for certain basic prohibitions, including that of taking another's life.

Death is a family and community event. Like old age and illness, death only has meaning if it includes the perspective and wellbeing of others. We need the help of our fellow humans to enter life and we need them to leave it. To live and assert one's freedom until the end provides memories for those who live on and who continue their journey towards their own death.

The word "euthanasia" is misunderstood. When euthanasia is presented as a form of care by care providers arguing humanitarian grounds, it is in fact a form of counterfeit compassion. Compassion should make us empathetic with the suffering of others and not mean suppressing someone whose suffering is difficult for us to bear. We must also recognize and accept our powerlessness in the face of some forms of moral suffering that are difficult to ease through medicine.

The best answer to suffering is found in total, complete accessibility to the methods of relief and accompaniment developed for palliative care in the past forty or so years. Unfortunately, some end-of-life care practices are mistakenly confused with euthanasia. Among these practices, which still need to be better understood, are refusing

or stopping treatment, the use of morphine for pain, stopping artificial hydration, and continuous palliative sedation. We must resist the temptation to do away with the final stage of dying through euthanasia. Experiencing this period, as long as the dying person is comfortable, can be extremely beneficial for loved ones as they begin to mourn, for the slow process of detachment begins long before death. This is a human phenomenon experienced for millennia.

In our brief, we expressed many reasons for our reluctance to support the legalization of medical assistance to die, be it euthanasia or assisted suicide. This runs counter to the philosophy and underlying values of palliative care. There are real risks of excesses and legitimate fears of unexpected adverse effects on palliative care; and suffering on the part of care providers who, despite themselves, are confronted with these practices. Another great danger is family, social or economic pressure to encourage vulnerable people to request euthanasia. The authors called on the Commission to exercise prudence regarding the preservation of space-time during the terminal phase. The State should not call into question the prohibition of taking another's life.

Joseph Caron's position as a citizen

I understand "dying with dignity" as an extension of "living with dignity." The reason I'm taking part in this discussion is because I want to live with dignity until I die. Compassion and the duty to help others and to ease their suffering



oblige us to do everything we can to help those who choose to die. However, compassion and the duty to help others have limits. We must acknowledge that some forms of suffering cannot be eased and that, in these circumstances, everyone has the right to obtain help to die with dignity. I want to be helped to achieve my aim in a simple, effective and compassionate manner, with no risk of legal proceedings or other problems for the people involved. For this to happen, certain ground rules are necessary.

I don't feel like committing suicide, not today or in the near future. Nor do I want to incite anyone to commit suicide. If changing laws and regulations were to result in one more person committing suicide that would be extremely sad. However, to my mind, it would not be reason enough to refrain from taking action.

I believe in individual responsibility. In a society that banks on education and on everyone achieving their dreams and ambitions, and which facilitates these goals, each individual is free to make his/her own decisions. All healthcare and social service practitioners know that citizens want to be more involved in decisions that concern them and that, because of such discussions, they are better informed today than in the past. This important development of citizens taking charge of their lives can help to shape a different world and who knows? perhaps a more compassionate one.

If a day comes when I'm in a state where I feel life is no longer worth living, I would like to be able to commit suicide gently, without upsetting my loved ones, who know my opinions and intentions in

this respect. The conditions in which helping me to commit suicide would be justifiable are as follows: I am suffering and think my situation cannot improve. My suffering could be physical, moral or psychological, accompanied by a diagnosis of certain and imminent death or not. I would then like to have the right to the help that would allow me to end my days without additional suffering, without having to inflict on my loved ones the spectacle of death by a violent deed, without running the risk of bungling my attempt and then suffering even more, without possibly being a burden to my loved ones and to society.

Suffering is a very personal business. It can be even more agonizing when it is not physical, for example, "debilitating and demoralizing symptoms" that are "accompanied by a loss of dignity, self-esteem and privacy because one is entirely dependent on others for his/her physical and mental needs, 24 hours a day." I

personally fear getting Alzheimer's and living for years in a state of dependency and lack of awareness. My father spent the last years of his life living with that disease.

I want to avoid living that way at all costs. There's no reason why I should be forced to do so and put my loved ones through the experience if I can avoid it. I wouldn't want to be a burden to the people around me or to society, nor would I want to live in a state of dependency, because, in those conditions, I believe life is not worth living.

Conclusion

Dignity is most certainly an inalienable value for every human being, but at the same time it is a subjective concept of which the individual is the sole judge.¹ It is not surprising, then, that reaching a consensus on "dying with dignity" is a difficult undertaking. <

1. M. Carvey, "Éthique et dignité : deux mots difficiles." <http://michel.cavey-lemoine.net/spip.php? Article 62, 2007>. Consulted November 18, 2010.

Marie Laberge's Letters on Dying and Grief

At the symposium organized by CREGÉS, *Les vieux meurent aussi. Pratiques d'accompagnement en fin de vie pour les personnes âgées et leurs proches*, which was held in Montréal on May 7, 2010, we were fortunate to have among us the novelist Marie Laberge, who offered us two readings. Her letters about dying and grief provide us with a complex and sensitive portrait of the diverse attitudes to death.

Madame Laberge generously offered to let us post her pieces, *Lettre d'une patiente* (letter of a patient) and *Extrait du journal de Clémence*, la psychologue (excerpt from the diary of Clémence, psychologist) on CREGÉS' website for the next six months. It is with great pleasure and pride that we invite you to read them at www.creges.ca. The letters will be available until June 2011.



Heiner Schmitz

age : 52

born : November 26, 1951

first portrait taken : November 19, 2003

died : December 14, 2003

Heiner Schmitz saw the affected area on the MRI scan of his brain. He realized immediately that he didn't have much time left.

Schmitz is a fast talker, highly articulate, quick-witted, but not without depth. He works in advertising. Everyone has to be on top form – on the ball. Normally. Heiner's friends don't want him to be sad. They try to take his mind off things. At the hospice, they watch soccer with him just like they used to do. Beers, cigarettes, a bit of party in the room. The girls from the agency bring him flowers. Many of them come in twos, because they don't want to be alone with him. What do you talk about with someone who's been sentenced to death? Some of them even say "Get well soon" as they're leaving. "Hope you're back on track soon, mate!"

"No one asks me how I feel," says Heiner Schmitz. "Because they're all scared shitless. I find it really upsetting the way they desperately avoid the subject, talking about all sorts of other things. Don't they get it? I'm going to die! That's all I think about, every second when I'm on my own."

With the obliging collaboration of the Musée des religions du monde (Nicolet, Québec, Canada).
We thank the creators of the exhibition *Life Before Death*: Walter Schels and Beate Lakotta



LES RENDEZ-VOUS DU CREGÉS – A CONFERENCE SERIES

Our conferences cover a wide variety of topics, with diverse speakers and formats. They have scientific, clinical, citizen and sometimes artistic perspectives. Furthermore, this year, our series will be enriched through the contributions from the teams of the cutting-edge services for seniors of CSSS Cavendish. These knowledge-sharing activities are opportunities for researchers, practitioners, students and seniors to reflect together on issues related to the social aspects of aging.

We hope they will be of interest to you and fit in with your schedule. With the objective of making these conferences accessible to a larger number of people, some of these are available through videoconference. If you are interested in this option, please contact us.

These conferences are free and all are welcome. We look forward to meeting you at our CREGES Rendez-vous!

DATE	THEMES	TRAINERS	PLACE
Thursday January 20, 2011 15 h – 16 h 30	La ligne provinciale Aide Abus Aînés: Un bilan après 4 mois d'opération Conférence présentée en français	Maryse Soulières Superviseure Clinique, Ligne Aide Abus Aînés Agente de recherche, CREGES Sarita Israël Coordonnatrice, Service de pointe Abus envers les aînés, CSSS Cavendish	CSSS Cavendish Site CLSC René-Cassin 5800, boul. Cavendish. 6e étage, salle 21, Montréal
Tuesday February 8, 2011 13 h à 14 h 30	Évaluation du risque suicidaire et Prévention du suicide Présentation vidéo en anglais Conférence en français Période de questions bilingue	Alan Regenstreif Coordonnateur du service de pointe Santé mentale et vieillissement du CSSS Cavendish Praticien-chercheur au CREGES	CSSS Cavendish Site CLSC NDG-Mtl-Ouest 2525, boul. Cavendish Salle Décarie, Montréal
Tuesday February 15, 2011 12 h à 14 h	La belle visite Documentaire sur l'hébergement des per- sonnes âgées en Gaspésie www.labellevisite.com Activité en français	Jean-François Caissy Réalisateur	UQÀM Local A 2830
Wednesday February 23, 2011 14 h – 15 h 30	Les sens des cris des personnes âgées vivant avec une démence en centre d'héber- gement et de soins de longue durée Conférence présentée en français	Anne Bourdonnais Professeure adjointe et chercheure, Faculté des sc. infirmières, U. de Montréal Chercheure associée, Centre de recherche de l'Institut universitaire de gériatrie de Montréal	CSSS Cavendish Site Hôpital Richardson 5425, avenue Bessborough 2e étage, Cafétéria, Montréal
Thursday March 17, 2011 13 h – 14 h	Discours public sur le vieillir: ses retombées en termes de pratiques communicationnel- les et de santé psychologique des aînés Conférence présentée en français	Martine Lagacé Professeure agrégée, Dép. de communication, Université d'Ottawa Chercheure affiliée, Institut universitaire de gériatrie de Montréal	CSSS Cavendish Site CLSC René-Cassin 5800, boul. Cavendish. 6e étage, salle 21, Côte St-Luc
Tuesday April 5, 2011 12 h – 13 h	Les ressources non institutionnelles d'héberge- ment pour personnes âgées à l'heure des PPP Conférence présentée en français Diffusée par vidéoconférence à partir du CSSS Bordeaux-Cartierville-Saint-Laurent	Michèle Charpentier Directrice scientifique, CSSS Cavendish-CAU, Centre de recherche et d'expertise en géron- tologie sociale (CREGES) Professeure, École de travail social, UQÀM	CSSS Cavendish Site CLSC René-Cassin 5800, boul. Cavendish. 6e étage, salle 31, Côte St-Luc
Thursday April 21, 2011 14 h – 15 h	Le clown thérapeutique en centre d'héber- gement: souffle de vie, souffle de rire, quels fondements? Conférence présentée en français	Florence Vinit Professeure, Département de psychologie, UQÀM Cofondatrice de Dr. Clown	CSSS Cavendish Site Hôpital Richardson 5425, avenue Bessborough 2e étage, Cafétéria, Montréal
Tuesday May 10, 2011 12 h – 13 h	Age, Ageing and Growing Old: Contested Definitions of Age Conference given in English	Amanda Grenier Professeure associée, École de travail social, Université McGill Chercheure associée, CREGES Ilyan Ferrer Candidat au doctorat, École de travail social, Université McGill Membre étudiant, CREGES	CSSS Cavendish Site CLSC René-Cassin 5800, boul. Cavendish. 6ème étage, salle 31, Côte St-Luc
Thursday May 26, 2011 13 h – 14 h	Technologies of Hope – The Example of Stem Cells for Older Cardiac Patients Conference given in English	Annette Leibing Anthropologue et professeure titulaire, Faculté des sciences infirmières, Université de Montréal Chercheure associées, CREGES	CSSS Cavendish Site CLSC René-Cassin 5800, boul. Cavendish. 6ème étage, salle 21, Côte St-Luc
Tuesday June 14, 2011 14 h – 15 h	Promouvoir la santé cognitive et prévenir les déficits cognitifs chez les aînés: Quels rôles pour les intervenants des CSSS Conférence présentée en français	Manon Parisien Agente de planification, Service de pointe Prévention-Promotion, santé et vieillisse- ment, CSSS Cavendish	CSSS Cavendish Site CLSC René-Cassin 5800, boul. Cavendish. 6ème étage, salle 11, Côte St-Luc



COLLECTION
& PROBLÈMES SOCIAUX
INTERVENTIONS SOCIALES



VIEILLIR au PLURIEL

Perspectives sociales

Sous la direction de
MICHÈLE CHARPENTIER
NANCY GUBERMAN
VÉRONIQUE BILLETTE
JEAN-PIERRE LAVOIE
AMANDA GRENIER
IGNACE OLAZABAL



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