

CONTEMPLATING MY DYING...AFTER THE SUPREME COURT RULING AND BEFORE PARLIAMENT LEGISLATES

Men's Groups, 18 February and 15 March 2016

A week today, the 25th I understand, Don Valley West Liberal Rob Oliphant, a United Church minister incidentally, will present to Parliament and Justice Minister Jody Wilson-Raybould a framework for a federal law governing physician-assisted suicide or physician-assisted dying. He along with his Conservative co-chair Senator Ken Ogilvie and 13 other Parliamentariansⁱ have heard 62 witnesses and received over 120 submissions. They are under the gun because of a deadline imposed by the Supreme Court. What are you hoping for?

An unknown Japanese author wrote: "I have always known that at last I would take this road, but yesterday I did not know it would be today."ⁱⁱ Welcome to the task of contemplating the end of my life, the end of your life, a road we all know we will take but impossible to visualize or imagine. And let's be honest, it's terrifying to contemplate. How many of us have said or heard others say, "If I don't know who I am or unable to recognize people just take me behind the barn and shoot me!" Let's be truthful, how many of us have exclaimed in emotionally charged circumstances, "I don't want to talk about it" when we fear we might 'flood.' The emotions flood up and we cannot get a word out; men more than women are prone to flooding. At one level it doesn't matter what Parliament decides. We have to do our own dying and we have to do our own talking.

On the day I gave the talk in February 2015 for Third Age Learning an article in the paper began, "Doctors say that when patients are seriously ill, the main obstacles to discussing what the goals of care should be are family disagreement and patient denial."ⁱⁱⁱ And Dr. Brian Goldman on CBC Radio 1 reported on a very careful study where terminally ill patients were shown two videos, one of a doctor hedging the truth to make it more palatable and a second doctor being more clear and forthright. The terminally ill patients trusted, trusted the doctor fudging the truth over the more honest and straight-forward outline of the truth.^{iv}

We humans love change but we hate loss. The process of my retiring was hell, for instance, a potentially huge loss in identity and relationships. Anything that smacks of loss we don't want to even talk about because to talk about something makes it real. One of my mentors, the Rev. Bob McLean, shared with me a life truth that I have found profoundly helpful: "I know what I know only when I say it." One of my colleagues, years ago, asked me, "Why do homosexuals have to talk about their sexual identity?" They talk about it to hear themselves into speech, to hear themselves into 'the real' of their sexual orientation.

So, let's talk. We probably recognize "right to die" as a euphemism referring to physician-assisted dying, physician-assisted suicide, physician-aid in dying. There is quite a variety of terms and I have been puzzling what to call it just for myself in order to understand as exactly as possible what we are talking about. For instance, "dying with dignity" describes a quality which I, for one, would want to support, but the term doesn't give help in and of itself to describe what is actually being promoted in terms of process. I finally landed on an awkward term, "legally permitted assisted dying by suicide." I have three reasons for this attempt in describing as accurately as possible the issue. First, I dislike euphemisms because I fear people might be trying to hide something: Is this a good secret or a bad secret? Euphemisms camouflage truth, like supporters in Quebec arguing that "medical aid in dying" is really

health care.^v That's not how it felt when we put our dog down; health care was going to the vet and bringing him home alive. Second, I think we could take a leaf from educators in the field of sexuality who use anatomically correct language. If it is a penis or a vagina, call it that. Third, a supporter of Dying with Dignity, Barbara Coombs Lee,^{vi} convinced me that being accurate was just being responsible and that it was important to take responsibility for our actions, our personal actions and our corporate actions as a society. This really spoke to me because of the death of my sister. I used to say that she died in a car accident. Gradually I changed my language to, "She was killed in a car crash." I understand accidents as unavoidable chance events. But the truth is, as long as we call them car accidents we never face the public health issue that we have had for 100 years, people getting maimed and killed because of engineering design, because of distractions, alcohol and drugs, because of speeding, because of a whole host of actual preventable causes. Clarity in description paints truer pictures.

So what do I mean by "legally permitted assisted dying by suicide?" It is not dying by drowning, by cardiac arrest, by car crash. It is what the word means in the dictionary, "the intentional killing of oneself." Suicide is not euthanasia. The difference between euthanasia and assisted suicide has to do with who does the very last act and it is not a description of the state of mind and heart of the person. Literally, it describes an action. Is it the person picking up and swallowing the pills or pushing the button on the mechanized injection? Then it is suicide. Is it a third party who does the last act? Then it is euthanasia.^{vii} And it is assisted because, first, society has decided through Parliament and the courts that there will be a system by which individuals can exercise their autonomy and choice to end their lives under certain specified circumstances and second there is someone who prescribes and delivers a drug that will cause the death. You will notice that I do not have the word "physician" in my term because, as one doctor said, anyone can do the assisting and other people can write prescriptions so Parliament could name a designated person or persons to do that part of the process although, presumably, the system would have medical assessments to determine whether a patient qualified.

I do want to acknowledge that using the word "suicide" is very tough because in society there is shame attached to suicide. For all of you who have had a suicide in your family or with friends, you will know it is a death like no other. I know that personally because of the death by suicide of one of my partner's uncles when he was in his 80's. Family and friends sometimes feel guilt, as if they have failed. I do wonder if there has been any research in the Netherlands, Oregon or elsewhere on this issue of survivor guilt or shame. Suicide is not against the law in Canada but in every instance that I have been involved with a suicidal person my instinctive reaction has been to prevent the suicide and get the person medical help. If you go back to the Bible, King Saul is not condemned for dying by suicide (I Samuel 31: 4) after his armour bearer refused to dispatch him. St. Augustine argued that the commandment, "Thou shall not kill" applied to any act that hastened death and St. Thomas Aquinas reinforced that by extending it to one's own death. The Catholic Church allowed exceptions to this absolute prohibition by making intention supreme and developing the idea of "double effect." "Double effect" absolves a person from responsibility for a death if the primary intent is an acceptable outcome. Thus, if the accepted outcome is relief from pain and suffering then the act is accepted as in giving medication that puts a person into a coma that results in no more eating or drinking. In addition, it has been argued that the commandment "not to kill" is really a commandment "not to murder," that is not to kill another human being illegally, wickedly or inhumanly.^{viii}

From suicide, let's jump to palliative care which is "aimed at alleviating suffering – physical, emotional, psychosocial, or spiritual – rather than curing."^{ix} The goal of palliative and hospice care (palliative care

within an institution or in a stand-alone institution), is to improve the quality of a patient's last years, months, days, hours by offering comfort and dignity while addressing all symptoms of the illness. Neither palliative or hospice care hastens or postpones death.^x In the book *Physician-Assisted Dying*, the editors, writing in favour of this practice, state that their position "...is seen not as an alternative to excellent palliative care but as a last resort for those relatively infrequent cases in which palliative care becomes ineffective or unacceptable to dying patients whose conception of dying well includes some measure of control over the circumstances of death."^{xi}

Of course, we are having this conversation in Canada not just because of the question upon which the Supreme Court has ruled but more significantly because of the recognition of a conflict. On the one side is technological medicine which is geared to fight the enemies of illness and death with no built in limits. This is absolutely key: There are no built in limits to technological medicine. It is becoming increasingly clear that many patients at the end of their lives receive treatments they don't want and which unfortunately make their lives more miserable.^{xii} On the other side of technological medicine with no built-in limits is death that always, without fail, wins. We are caught, as Atul Gawande notes, between two polarities neither of which we want to cause or experience – prolonging suffering or shortening valued life.^{xiii} We need to learn how to drive between those two polarities.

Some days after my sister was killed in that car crash when I was in my last year of theological studies I was sitting in our apartment in Kingston and this blackness swept over me, a cold chill rising up my spine, a black void, nothing, a pure terrifying atheism. It is an experience that every once and a while still visits me and it chills my soul as nothing else. I know viscerally I don't want to die. I know how I don't want to die. Please God, not drowning whether in a lake or by pneumonia, not in a fire, not slowly like a stroke, particularly if I lose the ability to communicate with intelligible words. And yet we all get clues of how we might succumb. One person approaching 100 said to me, "I always knew my adrenal gland would get me in the end." And I know because of family history my respiratory and circulatory systems are vulnerable and because of my mom there is always Alzheimer's out there beckoning.

So we need to plan for the inevitable. We all know of our need for wills and powers of attorney for property and personal care but if I were to name a few resources that I would encourage all of you to consider looking at it would be the website, "Advance Care Planning" and the two books by Shirley Roberts and Atul Gawande. At a minimum, they would help prepare us for the role of being an advocate either for ourselves or for another. The medical system is a system, a complex bewildering system, and once you have a diagnosis you get fed into unfamiliar territory. Do you have a sense of a patient's rights and how you might function as an advocate who can play that role without falling into, on the one hand, passivity and defeat or at the opposite extreme, anger, cynicism or bitterness? In preparation, I talked to a number of people including Lynda and Keith Marsland and Rosalind and Keith Slater, both men on what the system calls "life support," both living at home and finding meaning, purpose, even joy in their limiting circumstances. Both families talked of the significance of being an advocate or having an advocate. For Lynda it was easier being a nurse but Ros has learned the role too. It is no easy task to stand up to doctors, nurses and anonymous administrators and demand attention, demand that they relook at tests already done, demand that no more tests be done until this question or that issue be resolved. Technological medicine has a built-in momentum with busy people caring for a multitude of patients. It is not geared necessarily for taking the time to just be with people and provide the time for the issues to surface and be worked through. And technological medicine is actually an art based on probabilities and statistical averages. I have seen that strange art/science dance as I go to my

endocrinologist who discusses my bone health based on statistics of post-menopausal women, a category I don't quite fit.

But at some point we have to listen to the request of people like Sue Rodriguez, Gloria Taylor and Dr. Donald Low who have found themselves in the spotlight as they challenged Canadian society to seriously debate these issues. Those who support assisted death by suicide do so for three principal reasons: Mercy, non-abandonment, and autonomy and choice. I would like to try to explore each of these.

Mercy for those in pain and suffering: First, there are some in the palliative and hospice care communities who argue that all pain and suffering can be mitigated. The assisted suicide community argues some pain and suffering is simply pointless. If you have watched Dr. Donald Low's video recorded just before his death there is a poignant moment where he asks us to imagine ourselves in his ravaged body. One article that I read suggests that 95 to 98% of pain among those terminally ill can be adequately relieved. That is amazing unless you are one of the 2 to 5%.^{xiv} And there are statistics elsewhere that indicate that the proportion of pain that cannot be managed is actually higher.

I think there is something to be learned here from some of the spiritual traditions where pain and suffering are distinguished, pain being what we experience in our bodies and suffering what our minds do with pain. You hear of athletes competing with torn muscles, illnesses and broken bones. We call it mind over matter but there you have it, the distinction between pain in our bodies, suffering what our mind does with the pain. On a June day my 43 year old sister-in-law finally had in her hospital room her birth mother who had given her up at age 13, her adoptive mother and her mother-in-law as well as her children and some other family members. After everyone had gone she said to her husband that the pain was too much, more morphine was given to her and she died the next day. It would seem by having all those strands of her life tied together she had completed her life. I wonder whether her mental/emotional suffering overwhelmed her, not her body pain per se. I have had the same sense with people who, in their depression, die by suicide. The pain of depression has been dealt with for years and for those who have experienced depression you know it is felt in the body but sometimes the mental and spiritual energy to battle against the suffering is overwhelmed. I have no need to think badly of the person who dies by suicide but only grieve the loss. And, I think it must be said, if it is true that suffering is what the mind does with the bodily pain then there is no drug that can deal with that. It has to be the mind, the spirit, what I personally deal with all the time as a spiritual companion/director. I for one am not going to fault anyone who finds that they have run out of resources to battle the suffering. I mean, the end of our mortal life is always death and mercy, compassion and deep caring can be our only response.

In using those words, however ("mercy, compassion and deep caring"), I am raising up the significance of life-giving relationships. Years ago, I was called in the evening to a home where a person, in their 50's, was dying of cancer. The caller told me that their spouse was in unbearable pain and that the nurse said she could do nothing else. Could I come over? Ministers, priests, elders, chaplains, padres, rabbis, imams all have experiences of being called in when no one else can think of what to do. So I went and not able to think of anything else myself I read from parts of John's Gospel, slowly, quietly, meditatively and after 20 or 30 minutes the patient was no longer agitated. I recognize that was in the days when pain medications were measured out of fear a person would become addicted, a concern that is no longer felt in the same way. But I went to that home not as a stranger. I had a deep relationship with

every member of the family, including the dying person. That is so different from so many relationships in our present medical system which are often with strangers, fragmentary and short. This is not to fault those who work within the health care system for my experience is they provide excellent, even superlative care, but it is humanly impossible to have deep sustaining relationships with a host of people. I did learn that night with my parishioner that just being with someone with whom you have a deep relationship can speak to the mind and heart and change the course of physical pain.

But, if mercy is paramount, under what circumstances would we allow assisted death by suicide? How do you define “terminal”? How do you interpret categories like “unbearable suffering whether physical or mental,” “incurable debilitating illness,” “severe and enduring distress,” “hopelessly ill,” “poor quality of life?” And how would you define “end of life?” The spouse of Dr. Donald Low, in an interview on the CBC, said that she believed her husband would have taken a lethal drug 8 days before he actually died. However, the Royal Society Expert Report on *End of Life Decision Making*^{xv} defined end of life beginning with any serious diagnosis or injury. How many of you have now, today, a serious diagnosis or experienced an injury and as such do you consider yourself in the “end of life” stage? That is very broad as some people live years meaningfully after terrible injuries or with a life-threatening disease. Just think of HIV/AIDS or cancer. In my own family experience my mother would fit into all of those categories with her Alzheimer’s Disease and yet when she had the disease but still had intellectual competence she would never have chosen assisted dying by suicide and when she was totally dependent on others her assisted death could only have been done by a third party and euthanasia I cannot bear. The Right Rev. Gary Paterson, former Moderator of the United Church, has written in favour of assisted suicide, although never as a first choice but he recognizes there is great moral ambiguity with situations like dementia.^{xvi} The medical writer in *The Globe and Mail*, Andre Picard, wrote this past Tuesday about the extreme ambiguity around assisted dying and dementia. He for one would not support an Advance Care Directive be turned into a legal document that results in an assisted death after the person is deep in dementia, euthanasia in other words, a position I support.^{xvii}

Non-abandonment, the second defense for physician-assisted death, refers to medical personnel staying with a patient to the end. The argument is that if a patient is overwhelmed by their pain and suffering they should not be left to endure it without help. Jill Kannegiesser of Toronto wrote in *The Globe and Mail*, in response to a letter from Dr. I. M. Wilm of Guelph, “...the elderly don’t necessarily want unnecessary medical intervention when the quality of life is gone. I just watched for 11 days as my aged mother starved herself so she could die. It was undignified and cruel. How archaic that she couldn’t be offered the compassionate option of medical intervention for assisted passing.”^{xviii} This could be understood as an example of abandonment, a woman determined to die. We can well ask, “What was gained or learned by this 90 year old woman living 11 more days?”

Which brings us to autonomy and choice: Autonomy refers to personal freedom and freedom of the will and choice refers to being able to do what we select. So for the last 30 years or so, I have been one of the people who cooks in our family. When I am in the kitchen Barbara has given me autonomy by generally staying out. Sure, I make a bigger mess, use more utensils but I am in charge and being autonomous I get to live with the consequences of my choices. Keith Slater has written a book called *The Joys of ALS: finding happiness in a dark place*. He writes, “...about seven years after the symptoms first began to be evident, I have reached the stage where I can’t breathe, speak, eat, or move any part of my body without considerable help from machines and other people. I have chosen, in a phrase coined by Rosalind, to **embrace** the illness. That is, I accept it as a normal part of life, to be tolerated and dealt

with in the same way as any other inconvenience.”^{xix} I cannot think of a more striking example of the significance of being autonomous and choosing a way forward. “I have chosen...to **embrace** the illness.” Interestingly, my own doctor reported to me “that when people are given the choice and the means to end their lives...they often do not choose to do so which says that autonomy to choose is very important and that pain is complex and often complicated and exacerbated by fear and loss of control.”^{xx}

Atul Gawande argues in *Being Mortal* that everyone needs to be “the author of their own lives.”^{xxi} In particular he provides five questions that he learned from Susan Block, a palliative care specialist.^{xxii}

- What do you understand the prognosis to be? Or what is your understanding of your situation and potential outcomes?
- What are the concerns you have about what lies ahead? Or what are your fears and hopes?
- What kinds of trade-offs are you willing to make and not make?
- How do you want to spend your time if your health worsens? Or what is the course of action that best serves your present understanding?
- Who do you want to make decisions if you can’t?

To deal with these questions is to exercise autonomy and to make wiser choices, be the author of your own life. Those questions become essential when we need oxygen at home, when the chemo fails, when we face high-risk surgery, when liver failure keeps progressing, when we cannot dress ourselves, when there are falls, when...? When would you have conversations using these questions?

The tricky thing is how to balance autonomy and choice with society’s obligation to protect the vulnerable. We have a long tradition in our society of empowering physicians, for instance, to intervene with a person with mental health issues and obtain a time-limited hospitalization. Humans have an almost unlimited ability to dehumanize each other and to prey upon the weak and vulnerable. Think Nazis in Germany, fundamentalists in Syria or Nigeria or France. The McGill ethicist, Margaret Somerville, is reported to have said at the Centre for Clinical Ethics meeting in Toronto that an Australian politician declared to her that when you are past your “best before” date you should be disposed quickly and cheaply.^{xxiii} I, for one, quite reject such a utilitarian view of life. It assumes that being no longer productive means that we are no longer of service. Although I never got used to feeding my mother the last year of her life, at the very same time, it was an opportunity to meet her needs and to thank her for the price she paid in bringing me into the world and helping to raise me. Who among us has not felt blessed by simply helping another person? Being non-productive gives other people the opportunity to exercise their humanity. We must maintain the sanctity of human life or if you don’t like the word “sanctity” because of its religious connotations then profound respect for human life. For me, it is not either personal autonomy with the individual being supreme with choices or the need for society to respect human life. It is both/and, both we honour individual autonomy and personal choice, even the autonomy of the helpless and vulnerable, and society’s need for respect of all humans but those two can potentially be in deep conflict.

If you become a patient at Wellington Hospice you are there not to die but to live your dying in order to have a good death. In this death-defying death-denying society I don’t trust our ability to define a good death with so many of us unwilling or unable to talk straight about it. Life is difficult and death can be

distressing and ugly. And we live in a society that is youth-focused and tends to 'prettify' things. Consider the day you were born. It was not a peaceful affair. There was blood, sweat and tears that brought you into this world. Since our births, we have all struggled. Our bodies are wired for survival and will not give up easily. The goal of autonomy is to live a life as meaningful as possible as close to the end as possible. From Atal Gawande: "...as our time winds down, we all seek comfort in simple pleasures—companionship, everyday routines, the taste of good food, the warmth of sunlight on our faces. We become less interested in the rewards of achieving and accumulating, and more interested in the rewards of simply being. Yet while we may feel less ambitious, we also become concerned for our legacy. And we have a deep need to identify purposes outside ourselves that make living feel meaningful and worthwhile."^{xxiv}

Our legacy depends on the choices we make including the choices we make in the living of our dying. I find myself, on the one hand, leaning in support of assisted dying by suicide but the issue is the guidelines. Although Gloria Taylor died of an infection and did not act on her right to assisted death granted by the Court, it was her case that was before the Supreme Court. In an interview she said, "I have to see my doctors, I have to see a psychiatrist, I have to ask twice with two witnesses each time...I have to be of sound mind. I have to be of age..."^{xxv} The restrictions are critical. For instance, I would not want Parliament to allow the physician who assisted my death to be the physician who signed my death certificate, a potential conflict of interest, and the suggestion that a coroner do the signing makes eminent sense to me. The reality is that bringing together legal processes and medical decision-making makes for a complex environment.^{xxvi} The reasons need clarity: This choice of assisted dying by suicide cannot be a response to fear, for instance. Nor can it be a response to a utilitarian view of human life or an attempt to avoid the unpleasant and ugly. But choice, as I have indicated, is so important to us.

Having said I am leaning towards support for assisted dying by suicide I cannot imagine at this point in my life exercising that choice. I cannot imagine me in bed at home, for instance, asking my wife or my daughters to bring a lethal drug from the pharmacy; they become accessories assisting my decision and I cannot imagine leaving that potential burden. I find it difficult even to imagine asking my family physician of the past almost 40 years to write such a prescription although I can imagine having a conversation with every member of my family and my physician on choosing to die in this way. But, of course, I am not in intractable pain. I have not been given a terminal diagnosis. But the point I want to make is that the choices we make in the living of our dying, even the choices we make today, will be part of the legacy we leave our loved ones and the larger community. If we don't talk about it with our family we are making a choice. A year ago or more, I gave my daughters each a copy of the book *doris, inc.* I wished I had had such a book 25 years ago when my parents were starting to deal with serious health crises. Just in that act, hopefully years before I die, I am facing reality and asking them to face the reality of my aging, a small example of living my dying today.

Three final comments: First, researching this project has caused me to think about our Canadian health care system. Just what kind of system do we want? Besides having the best hospital and physician care as possible what about education and prevention, pharmaceuticals, end-of-life, palliative and hospice care, dental care? We are proud of it but read Jeffrey Simpson's *Critical Condition*^{xxvii} and you realize that we do not have the best medical system in the world, just better than the American one. We need a healthy debate, adult discussions about our health care system, not just turning money over to the provinces for them to sort it out. Second, I want to acknowledge that the faith traditions find themselves all over the map on this debate. Third, when you read the obituary page in the papers you

notice here and there, “no funeral at the request of the deceased.” I actually take strong exception to that and not because I am a minister or support traditional funerals. First, I am glad we rarely have funerals like I used to conduct when I became a minister 46 years ago. Second, I was delighted when other people began to share their memories or families got increasingly creative about how to honour their loved ones. The point I want to make is that I am responsible for deciding how I wish my body to be disposed – cremation, burial or donation. It is my body. But I have no right to inflict my choice on those who will be left behind regarding how they grieve and honour my life. I have no prior knowledge of the impact my death will have on anyone and it is they who need the freedom to decide how to both honour and grieve me. They need the freedom to make choices that make sense to them. I may have some ideas to offer but I am hoping my family and friends will treat them lightly and not as obligations.

Finally, back to the significance of choice and the choice to have conversations. You will notice that I have quoted Atul Gawande a number of times from his quite marvelous book, *Being Mortal*. He notes that in La Crosse, Wisconsin, all entering the local hospital are required to complete a form asking the following questions:^{xxviii} “Do you want to be resuscitated if your heart stops? Do you want aggressive treatments such as intubation and mechanical ventilation? Do you want antibiotics? Do you want tube or intravenous feeding if you can’t eat on your own?” Significantly, it is not the written answers that have been crucial but the conversations that have been generated, such that their end-of-life costs have been lowered to half the American national average. In other words, even at a minimum, if we want to lower health care costs we need to start having significant conversations. So best wishes and blessings on your conversations.

ⁱ <http://www.thestar.com/news/canada/2016/02/12/dealing-with-life-and-death-at-breakneck-speed-tim-harper.html>.

ⁱⁱ Quoted in Klug, Lyn, ed., *All Will Be Well: A Gathering of Healing Prayers*, Augsburg, 1998, pg. 142.

ⁱⁱⁱ Doyle, Kathryn, “Patients’ families a hurdle in care planning, doctors say,” *The Globe and Mail*, February 4, 2015, L5.

^{iv} CBC Radio, Ontario noon show, Monday, 23 March 2015.

^v Lysiane Gagnon, “Time for a clear debate,” *The Globe and Mail*, 9 December 2015, pg. A17.

^{vi} Lee, Barbara Cooms, “A Progressive View of Decision-Making at Life’s End,” *Tikkun*, undated article.

^{vii} Marker, Rita L., Hamlon, K., “Euthanasia and Assisted Suicide, Frequently Asked Questions,” *Patients Rights Council*, www.patientsrightscouncil.org/site/frequently-asked-questions/, pg. 1. Lee, Barbara Cooms, *Tikkun*, undated article.

^{viii} Lee, Barbara Cooms, undated article.

^{ix} “Quality End-of-Life Care: The Right of Every Canadian,” Final Report of the Senate Subcommittee to update “Of Life and Death,” June 2000, pg. 7.

^x With thanks to Erin McInnis in a phone conversation November 2014.

^{xi} Quill, Timothy E., Battin, Margaret P., ed., *Physician-Assisted Dying: The Case for Palliative Care and Patient Choice*, The John Hopkins University Press, 2004, pg. 8.

^{xii} Leung, Wendy, “End-of-life patients aren’t being heard,” *The Globe and Mail*, 7 November 2014, pg. L7.

^{xiii} Gawande, Atul, *Being Mortal: Medicine and What Matters in the End*, Metropolitan Books, 2014, pg. 244.

^{xiv} Quill, Timothy E., Battin, Margaret P., “Excellent palliative Care as the Standard Physician-Assisted Dying as a Last Resort,” *Physician-Assisted Dying*, pg. 323.

^{xv} Royal Society Expert Report, *End of Life Decision-Making*,

^{xvi} Paterson, Gary, “Going into that Good Night,” www.garypaterson.ca/2014/10/13going-into-that-good-night/.

^{xvii} Andre Picard, “A dignified end for dementia patients: Who makes the Call?” *The Globe and Mail*, 16 February 2016, pg. A11.

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- ^{xviii} “On Reflection Letters to the Editor,” *The Globe and Mail*, January 3, 2015, pg. F8.
- ^{xix} Slater, Keith, *The Joys of ALS: finding happiness in a dark place*, pg. 78 and 79.
- ^{xx} Dr. Carl Mackie, email, January 2014.
- ^{xxi} Gawande, pg. 140.
- ^{xxii} Gawande, pp 182-183, 259.
- ^{xxiii} Speaking at the Centre for Clinical Ethics Annual Conference, Toronto, 12 October 2012.
- ^{xxiv} Gawande, pg. 127.
- ^{xxv} Jones, Chelsea Temple, “Gloria’s Choice,” *The United Church Observer*, September 2012, pg. 24.
- ^{xxvi} Harvey Schipper, Trudo Lemmens, “Why we must move cautiously on doctor-assisted dying,” *The Globe and Mail*, 11 January 2016.
- ^{xxvii} Simpson, Jeffrey, *Critical Condition: why Canada’s health-care system needs to be dragged into the 21st century*, Allen Lane, 2012. Also see, “Canada’s crisis-in waiting,” *The Globe and Mail*, January 17, 2015, F9.
- ^{xxviii} Gawande, pp 178-180.