BCHPCA FORUM | 2014

FRIDAY MORNING SESSION MAY 9, 2014 11:00-12:00

Opening Conversations to engage, inform and educate the public on death and dying, and to initiate discussion on future care for themselves and their loved ones.

ROUNDTABLE ❸

Cultural Conversations: Judeo-Christian

MODERATOR: REV. SHELLEY STICKEL-MILES, BCHPCA President-Elect [Incoming]; Minister, Trinity United Church, Creston BC

INVITED EXPERTS

- REV. DR. RICHARD TOPPING, Principal and Professor of Studies in the Reformed Tradition, Vancouver School of Theology
- DR. EDWIN HUI, Professor, Bioethics and Christianity & Chinese Culture, Dean of Chinese Studies Program, Regent College
- RABBI CANTOR MICHAEL NADATA, Schara Tzedeck Synagogue, for Rabbinical Association of Vancouver

QUESTIONS

BCHPCA invites you to share your perspectives on the following questions. BCHPCA welcomes your personal experience in this discussion.

- the nature of conversations in your religion about death, dying and planning for care and the paths to opening these conversations
- the current and potential role of religious communities in public education about death and dying, and advance care planning
- the role of hospice palliative care organizations to support your religious communities in death, dying and advance care planning
- the potential for your religious communities and organizations to partner with hospice palliative care organizations to advocate for hospice palliative care in British Columbia

SHELLEY STICKEL-MILES: So welcome. I think we'll begin just because we have such a short time. My name is Shelley Stickel-Miles and I'm [BCHPCA] President-Elect. It always seems a bit of a surprise still. [laughter] So welcome to this conversation. And this is recorded and that's why we're going to pass the microphone around when we do questions just so that's recorded. And your voice is not going to go immediately onto radio. We're just taping this for information, so it can be typed out information and put on the website for peoples' use as information.

So I want to introduce our conversation which is to engage, inform and educate the public on death and dying, and to initiate a discussion on future care for ourselves and our loved ones. And we are very honored to have Dr. Edwin Hui, Professor of Bioethics and Christianity and Chinese Culture, Dean of Chinese Studies Program at Regent College. So welcome. And we have Rabbi Cantor Michael Nadata, Schara Tzedek Synagogue, for Rabbinical Association of Vancouver. So welcome Michael. And Reverend Dr. Richard Topping, Principal and Professor of Studies in the Reformed Tradition, Vancouver School of Theology. So welcome.

And so we will begin. And I/we have a little five minute question to begin with. But if we end up in a conversation that's okay too. So I will begin with you Dr Hui, and if you need me to repeat the question, just ask me. So what is the nature of conversations in your religion about death, dying and planning for care, and what might be the paths that you take to open up conversations?

EDWIN HUI: Okay. Let me say a couple of words about my background. I happen to have some experience in practicing either dealing with dying patients in the hospital. I spent several years as a consultant ethicist in a major hospital, not in Vancouver – in Hong Kong. I just found the jacket of the faculty that I belonged to when I was in Hong Kong. And I learned one thing very important. Of course, in Hong Kong I do not have the opportunity to use religious language all the time. But nonetheless, everyone at the time of their end of life, whatever religion they may have forgotten, they all emerge. So I can reassure you that religious language occupied a preeminent position in the … I use the word "end of life" because I want to make a specific … [phone rings] Well that's the best time to call you [laughter].

SHELLEY STICKEL-MILES: God speaking. [laughter]

EDWIN HUI: But I think it's very important … I come from the Protestant tradition, actually very much reform, so we do not need to go into details about all the Reformed doctrines. But I think it's important to distinguish between the language we use at end of life as …. End of life has two phases, I think. One is that when you are told that you have a serious illness, life-threatening illness, whether it is curable or not curable is not certain yet. So that's the phase that we tend to start, or we ought to start this [inaudible] advance care planning. But then there's a second phase clinically we call hospice care or palliative care. The patient then has entered into the dying phase. So there's a very important distinction between a person who has a serious life threatening illness as opposed to a dying person. And the languages that we use, particularly religious language entirely different for these two phases.

And the whole idea of end of life care is, when the patient is actually in the dying phase, but still consider themself a patient with a life-threatening illness. And so that's at the point where miscommunication or the wrong language can be used. And the whole project of end of life care is to convince the patient which category they're in. The patient may be still a patient with a life threatening illness and probably incurable but nonetheless still is fighting for their life as opposed to a dying person. I personally do not categorize that as a patient anymore. Because "patient" has a very specific historical definition: endure suffering and take on whatever treatment may or may not add suffering. But a dying person need not suffer, should not suffer. And palliative care is primarily to remove suffering.

So there are distinct, Reform and otherwise, religious language for these two distinct phases. And I find there's always a mismatch. First, from patients that confuse themselves which category they are in. "Am I still a patient seriously struggling to live? Or am I just a dying person?" So once we get that language straightened out, then we can apply the appropriate religious language or otherwise.

SHELLEY STICKEL-MILES: Michael Nadata.

MICHAEL NADATA: Do I have something to add? Sure. There is a sea of information which could easily overcomplicate the question and to answer that I think might be encumbering. So as opposed to doing that, I'd rather point out a narrative from one of our tracts which is known as the Babylonian Talmud. As often in Judaism, we take narratives in order to elucidate a point. So the narrative goes as follows:

There's a rabbi who is, what they call, whether one might distinguish between dying or at his end of life phase. And all of the town were praying for him to stay alive. They knew he wouldn't recover to a fully functioning state. There was no turning around; however from a spiritual plane, because they believed and needed his existence to continue, because he was their morale, they continued to pray. But one of his workers, a woman, saw that he was in agony, he was in pain. There was no quality of life, absolute pain, and she took a flowerpot from atop of the roof and threw it down to the streets. And for the moment that the flowerpot shattered, all of the psalms, the prayers that were being recited halted because they wondered, what was the commotion? And the moment that it halted was when his soul left him. His soul departed. So what point would I like to elucidate, to follow?

That in Judaism, we also firmly try and make a distinction between what is this end of life that a person goes through and when does it get to a point where there is no longer quality of life but also what steps are we allowed to take to both alleviate suffering but also to not hasten it. These are major distinctions. And one of the reasons why is because if we would do something which would by definition hasten death, that would be considered as if we brought the death upon that person. So it's a very, very delicate process all the way to moving the patient in a way that could hasten the death. So it's incredibly, incredibly delicate.

Now in terms of understanding the concept of end of life, we pray and make blessings for healing up until the point that the soul will depart. And just to conclude with another narrative which hopefully will continue to explain my point. I was in a, right outside a palliative care room, and there was a man, 33 years old, dying of cancer, and his father was outside the room. And I said, "Let's make a blessing for healing." He said, "What's the point." And I said, "Listen. I can't guarantee that this going to bring him back to life, that this is going to promote longevity if the doctor said what the doctor said. What I can say is that we are asking for divine assistance to make the process of his life that he is in right now as qualitatively sustainable for the family" so the family could be with him in the best way possible. So the purpose of prayer sometimes is to promote that longevity. The purpose of being there with the patient is to revitalize them and then there is that point, that end of life situation where we say we still have to make the most of every single moment.

SHELLEY STICKEL-MILES: Dr. Richard.

RICHARD TOPPING: Yes. So let me begin with a little bit about myself. I'm now the Principal of the [Vancouver] Theological College. But for about fifteen, seventeen years, I was also a Presbyterian pastor of a congregation in downtown Montreal with about a thousand people and probably performed in a year, maybe 60-65 funerals, accompanying people when they're dying. And it's really that experience that I'm drawing on for today, not so much as an intellectual issue but as something … You begin as a pastor in a congregation and you're visiting and doing funeral services for people who are at first strangers. But the longer you're there, the more they're your family and your grief is born of love. Because they're very often the people in your congregation who you end up seeing the most because of their condition.

I think the nature of our conversation in Christianity about death and dying, it's narrative. The rabbi has spoken of this, for us it's the narrative of the Genesis to Revelation story. That we see ourselves situated in that big story of Creation, of the coming of Jesus Christ who takes on human flesh, and of our hope for life forever with God. And so given that sort of big picture, there's great value in creation, incarnation and hope for the body. I'm always surprised at the degree to which Christianity, I think well understood is a religion that values the body. One of our central creeds, like the Apostles Creed, says nothing about the immortality of the soul. It says "I believe in the resurrection of the body, the life everlasting." Somehow the immortality of the soul has become part of Christian conversation, when our earliest creeds don't talk about it that much. It's very Greek and Platonic where the body is very valued, so …

EDWIN HUI: The rabbi is talking about the soul.

RICHARD TOPPING: So it's that big picture, that life is a gift, that bodily existence is good, that human individuals have value because they are created in the image of God and they're actively loved by God. So the bodily life is a good thing and to be treasured. And one wants to accompany people in that bodily life from its beginning to its end for its own sake. Because we would even use rights language about that. They have entitlements that belong to them as creatures made in the image of God. They are not assignments we make to them but they're entitlements they have because they are God's creature.

I think in Christian theology too, we also think that human life is finite. Nobody lives forever. As far as I know, the death rate is holding steady at a hundred percent. [laughter] And we bring that before us often. It's embedded in our liturgical experience in church. We've just come through the season of Lent and Easter where we reckon with our mortality and what we can hope for over the longer term. So I think that rather than explicit instruction all the time, participating in worship services, taking the liturgy … The fact that it's on Sunday which is always a little resurrection, the fact that you follow through reading the Bible in which the topic of death comes out again and again. It's part of the conversation of the community.

As a theological educator, we're very concerned that our students be prepared for this part of their ministry and we do clinical pastoral education which maybe some of you have worked with our students in hospitals where they're placed with health care professionals to learn to navigate that world in a way that's sensitive to the realities that are a part of it.

Past conversation about death and dying and end of life care in the context of Christian congregations very often follow funeral services where someone's friend has died. Within a week, I usually get about six appointments there. And people want to meet with me to talk about their funeral service, to talk about their will, to talk about mandates or powers of attorney. And what does Christian theology have to say about when does life end? How long should it be artificially kept alive? At Bible study groups, we say the creed in all of our services at least in my confession, belief in the resurrection of the body and the life everlasting. Creation, redemption, what we can hope for, are very much a part of the conversation.

I think practically speaking, empathy for issues having to do with death, dying and the care of those who are dying … very often in congregations there are pastoral care committees. In my church in Montreal, I had seven retired nurses on that committee. A lot of congregations are moving to congregational nurses, partly because of the demographic of most churches are older people. And so having retired nurses on staff – they're called deacons which is a particular office in the church. And I would visit people and I can do certain things but health care professionals would look for other things when they would visit to make sure that people can live with dignity at home for as long as is possible. So a little bit about conversations and paths to discussion.

SHELLEY STICKEL-MILES: That's great. And you've moved into the next part so I'll go back this way. The role of your tradition in that public education around death and dying and advance care planning.

MICHAEL NADATA: Okay. So in terms of education, so I find that up until the point where the discussion of death and dying is a part of the reality of the family, they know very little. There might be stories that they have seen inside of the Bible, and narratives that we've engaged in, but I think that we run away from the concept of death and we run as fast as we can. In fact our mode of law, in Hebrew it's called *Halakhah* which means movement, dynamism. And one of our well known authorities on contemporary Jewish law is known as Rava Joseph Soloveitchik and he wrote a book which created the dichotomy or conflict or paradox between the Halakhic Man, the lawful individual, and the next man, who kind of longs for what goes

beyond the cosmos. What's the next world, the soul? He says while we're here and we're alive, we should engage in everything which is lively. So we engage in those parameters and try not to contemplate on death. And that's often what I see with congregants, what I see with Jewish community members, that until we get close to that conversation, there is no conversation about death. And then it dawns upon them and it's a very scary reality. So what do you do?

So there are different types of discussions. As I already conveyed prior to one of the discussions is what type of care, what type of ways to alleviate pain, what can we do to promote quality of life, when is quality of life no longer according to the patients or according to the family, quality of life. These are difficult things to gauge their case by case scenario and really engage in that technical nitty gritty discussion in accordance to our law.

And I do find that yes, people are interested in engaging in the philosophical context of what is the meaning of life, what is the meaning of the next world. But they also want to know the "how to". They want to know the directions. "What do I do next?" if they feel at loose with their directions of when to turn right and when to turn left. And philosophy doesn't really matter in terms of engaging in this conversation. So we first discuss what the doctors can and cannot do and enable and empower the patients to get into that discussion with the doctors. And also have the doctors call us, call the rabbis, call the clergy and make sure that we're constantly engaged up until the very end. That's one point.

Another point which is important is moving towards that philosophical context that … I'll mention an experience that I had with someone who was in palliative [care] and not so old. And he was talking about how he was angry at God. And this is something which often comes up, especially if a person feels their life's been cut short. Who am I, the 30 something year old to engage in that conversation with him.

But there are certain discussions inside of our law book, inside of our Torah, inside what the rabbis have to say that really connect to the other side, the soul. Because we do say although the body comes and goes and it's ephemeral, what we do express and contemplate is legacy. We contemplate the values which are imparted through the centuries.

One of the reasons why religions exist throughout the centuries is because we're speaking words of sages and sagely advice which exceed their point of living. And we bring them up because that renews and revitalizes their values that they've imparted to us, that promotes longevity of life in a very deep way even if their bodies are no longer here. So a lot of the discussions we have besides the how to and what's next and quality of life and end of life care is really about the values that that person wants to impart and the longevity of who they are – their existence – what they can impart to the children to their friends, to their peers, to their family, and how we can promote that person even after they're gone.

SHELLEY STICKEL-MILES: Dr. Hui, about the role of your religious community in public education around death and dying.

EDWIN HUI: I think public education about end of life patients is a tough one because not only in the West, but even in the East Asian cultural context, dying is very much a personal thing. Only the person himself or herself can die, nobody can die with and for [them]. And so there's a tradition that dying and death are very personal issues, or in contrast, before the patient is actually dying, the whole topic of dying and death belong to the medical professionals. Many, many studies have [been] done that when they interview a patient, the patient will say that, well religious issue does not come into play in end of life care. There are many studies that indicate that. But in reality this is very untrue. Because at a certain point of a patient's dying, all the existential and transcendental questions arise such as "What is the meaning of life? Why am I here?" All of a sudden after working for eighty years, "What am I doing? Where do I come from? Where am I going?" Expectations and hopes and despair and so all these things come up at some point in a particular end of life patient.

And so I think the church or religious communities and palliative care have the obligation to go to the public square and announce or proclaim that actually in this particular, first of all in this particular area or particular part of one's journey, it is not that private. It is very relational, it is very familial, and very public in that sense. On the other hand, it should be announced and made know to the public that this is no longer a medical issue at all. Because in, as I said, the reason why it is important to distinguish between a patient who has a serious illness as opposed to a patient who is in palliative care is precisely that. See when the patient moves, makes the transition from the patient to a dying person, then religion is no longer a simple medical issue. It is no longer entirely of the medical profession. Other people have to come in. And in that regard, it's the palliative care people as well as the religious people. Because the other dimension of the human person is involved.

When the patient is a patient, a seriously ill patient, we can focus on the biomedical issues. But once the patient makes the transition to become a dying person, then other dimensions – psychological dimensions, social dimensions, relational dimensions, existential dimensions and transcendental dimensions – all come in. And these go beyond the so-called medical paradigm.

Beyond what the medical people themselves … many medical people, speaking, having ten years experience when I was a young man like you [Michael Nadata], was a physician. I had a problem with death in my early 30s, late 20s. I don't know what death is all about, and even less with dying. And that is very foreign to me. So all I know is how to cure the patient and I cure the patient. It's all medical. And when you want to talk about patient dying or not, talk to me and nobody else. Very protective, the medical profession are very protective of their turf.

But if the patient is truly a dying person, then it goes beyond that paradigm because doctors, young or old, well I'm much older now and I'm no longer practicing medicine, so I realize the other dimension is much bigger. And the palliative care team and the religious communities have a lot to play in all the other and probably more important dimensions at that part of one's journey. And so the cooperation and partnership is all related to public education. Unless we educate the public on this transition and this team, interdisciplinary and multi-dimensional approach, the public will always think,"Oh, this is all about medical things."

MICHAEL NADATA: I wanted to just add to your point in terms of it being not private but public just in terms of a Jewish ritualistic perspective. So when a person is dying as opposed to the question of whether or not they're on the cusp, so one thing that we do is we make sure that even after a person dies, there are things that the family does after they die. Well for example, they close the eyes, the mouth is closed, the windows are closed. There's also certain scriptural phrases that are recited that directly connect to God. But in addition to that, prior to, we have a committee that's called the *hevra kadisha* which purify the body. Prior to them arriving, someone will be sitting there. I've sat there for hours with a body and recite psalms or prayers. Because it is a transitional phase and we don't want the body or that soul to be alone at all as they go through that transition. That's one of our fears, so we … I think that there is a certain assurance for the family as well, when somebody is there providing that comfort, even after the soul has departed. And I've seen it. They've felt the comfort that we don't want to leave them alone. So I agree with you with that, it's not private.

EDWIN HUI: Not privately. But yet there is a small sect of Protestants in southern Alberta. I can't remember the sect. It's very conservative. But they have a tradition that when a person in a family is actually dying, they immediately announce it to all his friends and they will come and spend the last weeks, coming visiting. Because one of the big things about a dying person is that they need to have a completion, sort of a closure in their life. And they need to reconcile with all the family members, reconcile if there's any differences or conflicts with all their friends. And that sect of Protestants, they set aside the remaining

few weeks for people to come and visit and reconcile and celebrate. And so this is a very … even though a person can, only that person can face death, but the dying is a very public thing, and very relational. And so this is when the public need to be involved. I think we have a lot to contribute.

SHELLEY STICKEL-MILES: I'll go back to you because you're segueing so quickly …

RICHARD TOPPING: Yes. No, I was just thinking that part of the point you're making here is that that is one of the practices this sect has to offer to the general public, as a particular public, a kind of new option, develop our repertoire of possible responses to death and dying by looking at how religious communities deal with these things. When you asked the question here about the role of religious communities in public education, I'm thinking religious communities are publics. There is no Esperanto for dealing with death and dying. There's only the language of particular communities.

Before I came here I was sitting out in the lounge waiting and two people were talking to me about the importance of providing palliative care – verbal care – in the language of the person to whom they were dealing. Someone from Quebec and they were talking … and I was thinking, one philosopher says it's as possible to be religious in general as it is to speak language in general. And the analogy is an important one. To treat all faith groups as just varieties of the same thing is not always helpful to the person experiencing palliative care, or even care when they're sick. That there is a tendency …

I used to be a speaker to doctors who were about to graduate when I was in Montreal at one of the medical schools there. And one of the points I was always trying to make is that religious language is not avoidance. This is what people believe most profoundly and deeply. And part of it is we all operate out of a certain idiom when we're dealing with sickness and dying. And one of the, the predominant one in our culture is therapeutic and medical. And so if people bring a theological way or a faith based way about talking about their experience, there is a tendency at times to view this as avoidance or to reduce it to a kind of epiphenomenon or of some sort. And I think respecting the integrity of that language, partly because of what if offers to the larger culture is really a service to the general public about that there are a multiplicity of ways of dealing with death and dying.

SHELLEY STICKEL-MILES: Can you maybe connect to now how you have seen tradition, your tradition, people in your tradition use hospice or connect with hospice and is that a supportive role?

RICHARD TOPPING: Yes. Certainly. We had a group at our church who were trained in hospice care. More and more congregations … I was in downtown …

SHELLEY STICKEL-MILES: By hospice?

RICHARD TOPPING: By hospice, yes. And I was in a congregation where 65% of the people are single adults living alone which means that in a downtown situation they're living away from their family very often. So their faith community is their family. I said to one woman, "I guess the church is like your family." She said, "No it <u>is</u> my family." And so paying close attention to the kind of care that congregations offer, making hospice training available to them so that they serve their friends and neighbours in ways that are in public institutions but related to the deep and meaningful aspect of this person's life. Their faith commitments, it seems to me to be incredibly important.

We did this at the Jewish General [Hospital, Montreal] together with the palliative services of Montreal and it worked very well. We made an agreement between us as clergy that if someone from our particular tradition, wasn't from our tradition,

who needed care, that we would contact the faith tradition of that particular person to see that the appropriate care from that person's faith tradition was brought to them.

SHELLEY STICKEL-MILES: And in that same connection, how does hospice fit in or how do you connect to hospice? Is there a role?

EDWIN HUI: Well I think there's a lot of synergies between the Judeo-Christian religious convictions and commitments and palliative care. And the basis of that synergism is that both take the human person much more holistically than just a biomedical specimen. And so that basis provides a lot of good basis for partnership between palliative care because the success of palliative care is a function of being able to treat the person in this multidimensional perspective, both physical, emotional, social and transcendental, spiritual. And that is what a dying person is dealing with. All the dimensions are being impacted. And that's where the failure of a pure biomedical model, i.e. the health care professions would fail. But religious communities, pastors, counsellors, and this multi-interdisciplinary palliative team would complement each other. In criticism, my experience is that hospice palliative care teams are still somewhat heavy on the biomedical side. And so the religious community would act as a supplement and complement to enrich the other dimensions.

SHELLEY STICKEL-MILES: Is that experience from hospice in a hospital, like a hospice team in a hospital, or hospice in a community?

EDWIN HUI: Well I do not know how to classify. I used to be a board member of the pediatric hospice care in Shaughnessy [Canuck Place]. That type of community effort. And nowadays of course in the larger hospital, they have a segment. Those of course, needless to say, operate a lot more on the biomedical model. And that's where I think the organizations like yours and the religious community ought to be more active, and proactive.

SHELLEY STICKEL-MILES: If we can give you a minute and open it up to conversation, then we'll get a little further.

MICHAEL NADATA: Absolutely. I would agree on the point that there is a strong emphasis on biomedical care and therefore, what tends to happen is people are, since they're looking for the what's next in that strict sense, sometimes they miss the important conversations. And I think that when the religious services come in, what we try and do is navigate those waters and enable them to redirect to those important connections and as you said, foreclosure as well. You can miss the closure if you're only harping on the medical.

SHELLEY STICKEL-MILES: Thank you. And thank you very much for taking time, having thought about this to present. And I'll ask for questions and I'm going to give you the mic again for that recording purpose, not any other reason. Introduce yourself to these people here.

COMMENTOR 1 [Kay Johnson, BCHPCA Regional Director – Fraser, Outgoing]: So, Kay Johnson. I'm on the Board and I've also worked in hospice for a number of years. One of the things that I've observed over the years is the number of people who weren't affiliated with any religious, organized religious group and at end of life, or even when they were before end of life but knew they had a life-limiting illness, it seemed to me that there was a huge benefit and importance for things like rituals. And I always felt like that it was a reaching out for their spirituality when they got comfort from rituals. Can you make any comments about that?

MICHAEL NADATA: Sure. Well one of our beliefs in Judaism is that when a person is … well I'll explain a rule then I'll connect it to this concept. There's a rule when we have our silent devotion which is considered the climax of our prayers each day, that no one is supposed to be within a several foot proximity because they're kind of breaking the spiritual bubble. That being said, when someone is sick they say that the divine presence is with them when they're considerably sick. So therefore, somebody could pass to and fro, when that person is in the midst of prayer because you can't break the spiritual bubble.

And what I'm trying to explain is that someone who is at that stage I think the spirituality isn't there. And it's a question of what they're reaching for. But I think it's almost automatic that no matter what religious affiliation – who they are – the feeling and the need to connect to something and do something about what they're experiencing is necessity. And we find whether it's Jewish or not of our faith, that there's that tendency to latch onto something meaningful and figure out what that is.

SHELLEY STICKEL-MILES: Either of you want to comment?

RICHARD TOPPING: I'm going to say my experience as a visitor in hospitals. Very often I would go to visit one person and there's four beds and I would end up visiting everyone. Because they would call me over for some kind of reading or prayer or a conversation. And I think a lot of it has to do with a willingness just to be attentive to peoples' needs. To be present to people. I can remember one time praying in a room for a woman who had her hearing aid, she didn't have it in. So I prayed very loudly so she could hear. And when I finished everybody in the room said "Amen." [laughter]

So it's being attentive to … Not everyone has folks coming to see them or support them and they're feeling pretty alone in the world and if they hear or see someone who they think they can trust, and you're open to an encounter with another human being, that's amazing where that can take you in that kind of context. I think of palliative care and the hospital experience as a kind of thin place where people are open to kinds of comfort that they don't, haven't always had comfort with and they're discovering that, at that moment.

COMMENTOR 2 [Ruth Edwards, BCHPCA Regional Director – Interior, Incoming]: My name is Ruth Edwards. I'm the Executive Director of a twelve bed hospice in Vernon in the Okanagan. Over the past eighteen months in Vernon, we've had a very interesting program happening in our community called the Interfaith Café. And every couple of months there would be a meeting of the Bahai, of the Sikh, of the Hindu, the Jewish, the Protestant, Catholic – all faiths imaginable in as not a diverse community as Vernon is, they would meet. And they would discuss topics from birth, coming of age, marriage, death … all of the various phases of life would have a place during the discussion.

And it was quite interesting first of all to see how many faiths took part in those discussions, how many commonalities there were between the different faiths, and the removal of the mystique of some of the faiths that were represented in the group. But as a hospice, we were invited to those conversations and it was quite an educational experience for us to be taking part in those conversations and very educational for those other participants to get to know us a little better as well. So when it came to public education, we found that as a very worthwhile and quite an interesting initiative that took place in our community.

SHELLEY STICKEL-MILES: Very interesting. One other question? Any comments on that or anything?

MICHAEL NADATA: I have a brief remark. Since we've discussed more of the end of life but we really didn't discuss mourning so much, that state of mourning. So I was sitting with a family not so long ago who lost someone to a tragic death. And it was

sudden. There was no chance to process. And we were discussing really the chance to have that process, so how do you engage with the family that didn't have that opportunity to process and they feel like the life was ripped from them? So I sat with them and I said to them the following, and I'm sure there are far wiser words, but this is what came to me. And I said, "You can't allow the circumstance to encumber you and forget who the person was to you. Because if the circumstance is what you're focusing on, then you'll lose the memory, you'll lose the richness of the life." And I think that's one of the things that we try and do.

RICHARD TOPPING: Yes. There's a prayer in the … I'm not an Anglican but in the Book of Common Prayer by Cranmer which says, it's a funeral prayer, it says "Lord, let not what has been taken from us cause us to forget what we have received." A very similar kind of sentiment.

MICHAEL NADATA: That's right.

SHELLEY STICKEL-MILES: I should have said I'm a United Church minister and I'm now remembering bringing back together the life is the work of that learning rather than the circumstances taking that away.

COMMENTOR 3: I think as a microphone it's going to be loud and then all of a sudden it's not.

SHELLEY STICKEL-MILES: It's a recording mic.

COMMENTOR 3: I know. Hopefully that's all transcribed too for the records. That would be great. My questions is just about, we were talking earlier about medications and the things for pain. And the difference between that and the growing discussion about euthanasia. Because as people's bodies are failing, morphine and things do in a way hasten death, whereas euthanasia really hastens death. What are your guys' thoughts on the euthanasia debate?

MICHAEL NADATA: It's going to centre on me isn't it? So there's a … I'll tell you what's on the table. So most of it's off the table. I think you'll get the implication. Where in terms of hastening death as opposed to not hastening death, we say that for example applying morphine to alleviate pain, if it's going to reduce the oxygen to a certain amount and therefore that will critically hasten death, that is an active role of making the death come quicker which can certainly be an issue. It's a case by case basis.

One of the things that we really promote is nutrition. That the person gets their basic nutrients, food, water. There is the critical issue and I won't get into it now, the NG [nasogastric] tube and exactly can you take a person off it considering how uncomfortable it could get. And as I said case by case. It's very hard to discuss the nuanced details here. But we do promote nutrition until the very end because one of the considerations in our concept of Judaism is *azkar* which is cruelty. And they say it's cruel to make a person starve to death. That's considered one of the cruelest forms. So we do as much as we can to promote life.

That being said, I will cite a case that's really not euthanasia but can discuss the question of quality of life. So there's a case, someone who, this was a long time ago, but someone who was I don't think any older than their 70s that was going through … he started a procedure or certain medication that was making him extremely uncomfortable to the point where they say "I no longer have any quality of life." And it was brought to a very well known rabbi in New York. I'm not going to cite names. I might get into trouble. Very well known rabbi. And the question he asked bigger shoulders than himself and in the end he had no choice but to say, "You can relinquish this medication, this procedure because you feel that in every which way you no

longer have quality of life." And that meant certain death, that he was relinquishing it. So we do try and figure out what does it mean that a person no longer has quality of life and that's when we point out the distinction of not taking a heroic act to continue life.

RICHARD TOPPING: Yes.

EDWIN HUI: Well I think, to open to open the discussion of euthanasia is a bit late. [laughter] Seven minutes before 12:00 [noon]. But I think just a couple of remarks as, that's where the intention is very important. It is a tradition even in British Columbia, to, in a dying patient and particularly a patient dying with some discomfort … I'm a great believer that technically a person would never need to suffer pain.

Twenty years ago in the Sue Rodriguez case, I testified to the Parliament that pharmacologically, the medical people actually know how to stop all pain if they only attend to it. But nonetheless we accept that in practical reality, some patients will experience a level of comfort that is uncomfortable, unpleasant. So that giving sedation is a medically acceptable approach to, as part of palliation. But when you start giving morphine for discomfort, you recognize that the morphine first of all will require increasing doses over a period of time in order to secure the same level of comfort. But at the same time, the patient's respiration will be depressed as a result of that increasing dose. But as long as their physician's intention is still to provide pain relief, and knowing that that increasing dose will actually cause respiratory depression and therefore hasten death. But that is not his intention.

So in other words, that particular procedure relies on what we technically call the double effect. That one, the negative effect is foreseen but unintended. That is still an acceptable practice. And if you call that euthanasia, I don't know, but it definitely will lead to death. But the intention is not to depress the patient's respiration. But there are certain patients that with increasing morphine dosage, they have relief from pain and their respiration is practically, is still pretty good. But that is so much the better for the physician as opposed to euthanasia.

And actually euthanasia, the intention is the death of the patient. In fact if the patient does not die, that person who practices that will be frustrated or disappointed. So that's it. And the second thing, take home for a thought, sort of like a professor, you always take [inaudible – laughter], there is a difference between agreeing to euthanasia as opposed to agreeing to legalize euthanasia. In my practice, a very brief ten years of medical practice in internal medicine, I had a lot of patients, I could count at least a half dozen that I personally would think that if there's a way, I would do it, to stop the suffering. But that doesn't mean that I would agree to legalization of euthanasia. Because any particular patient, any one particular patient may deserve to have a better death. And if it could be fostered by medication, I would do it, but on only that particular patient. But legalizing something like that is a horse of a different colour. A lot of this would go out of control. And that's what I feel. That's all I want to say.

SHELLEY STICKEL-MILES: Thank you very much. And thanks to all of you for putting this into your minds and hearts and machinating a lot, a lot. So thank you for being here. And I have an interesting little gift that appeared to me as a little coffin, however it's not so … [laughter] A curious little … So thank you to our speakers and you're welcome to talk with them and we'll be moving towards lunch and our gathering at lunchtime. So thanks very much.