Good and Bad Deaths, or Dying as a Temporal Sequence

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Abstract: Based on pre-pandemic research conducted in Montreal among relatives who supported a child, an adult, or a senior through illness and end of life, this paper discusses the time of dying as a temporal sequence. Identified as the (long) time of illness, the time of end of life (the hours or days preceding death) and the time of death, each time in this temporal sequence had a bearing on whether a death was perceived as good or bad by the over 100 relatives we met with. The end-of-life trajectories we documented bring into question the elements that contribute to the many-sided notions of good or bad deaths as they intersect without offering unambiguous points of reference. When people refer to a bad death, are they referring to the time of illness, the time of end of life, or the time of death? The imbalance between these different times or, on the contrary, their concordance gives rise to the perceptions of a bad death or a good death that are at the heart of the "dying with dignity" discourse.

Keywords: end-of-life; dying; trajectories; good death; bad death; life cycle; culture

Résumé : À partir de recherches menées avant la pandémie à Montréal auprès de proches ayant soutenu un enfant, un adulte ou une personne âgée pendant sa maladie et en fin de vie, cet article traite du moment du décès comme une séquence temporelle. Identifiée comme la (longue) période de maladie, la période de fin de vie (les heures ou les jours précédant le décès) et le moment du décès, chaque étape de cette séquence temporelle a eu une incidence, bonne ou mauvaise, sur la perception du décès par la centaine de proches que nous avons rencontrés. Les trajectoires de fin de vie que nous avons documentées remettent en question les éléments qui contribuent aux notions multiples de bonne ou mauvaise mort, car elles se croisent sans offrir de points de référence clairs. Lorsque les gens parlent d›une mauvaise mort, font-ils référence au temps de la maladie, au temps de la fin de vie ou au temps de la mort ? Le déséquilibre entre ces différentes temporalités ou, au contraire, leur

concordance, donne lieu à des perceptions de mauvaise mort ou de bonne mort qui se situent au cœur du discours sur « mourir dans la dignité ».

Mots clés : fin de vie ; mourir ; trajectoires ; bonne mort ; mauvaise mort ; cycle de vie ; culture

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[...]
La santé dans le slow-fader, je cherche en vain une lueur
Un p'tit rayon pour m'accrocher
[...]
Mais mon corps usé à la corde
Demande sa miséricorde
[...]
Ce soir, c'est l'ombre de moi-même
Qui, sans bruit, va quitter la scène
Pour passer d'l'autre bord du rideau
[...]
J'n'aurais pris plus, c'est d'jà le terminus
Moi qui a tant aimé la vie, tout est fini
J'suis fatigué, j'peux pu chanter
J'en ai plein l'cul et le cœur n'y est plus
J'suis rendu au boutte du boutte de ma route
[...]
Qu'est-ce qu'y a après la fin du show?
[...]
Y a rien d'l'autre côté du rideau
Pas de voyage organisé dans un tunnel illuminé
[...]
Je sors par la porte d'en arrière
Pour que m'avale l'Univers[1]
(Excerpts from "La fin du show," Daniel Lacoste, Gus van Go, and Jean-François Pauzé, Les Cowboys Fringants, 2024)

Death sometimes is just a better place, you know? God planned that because he's saying, "You know what? I don't want this person to live." [...] The good people leave early and the bad people, they stay [...]. I sometimes think like that, too. [Marwa had a good death], she went

> away in her sleep. But she went away in a most calmest form. She left that smile on her face. She wasn't screaming; she wasn't bleeding.
>
> *(Hakim: age 48, a South Asian migrant, Muslim, Marwa's husband. Marwa passed away at age 47.)*

Are the elements or events that contribute to a good death intrinsic to it? And what about a bad death? Does dying "too early"—before one's hair turns grey[2]—automatically make it a bad death? In the words of Hakim and Pauzé (quoted above), does the afterlife, as imagined by the living, confer a certain quality to the upcoming death? Can dying in the prime of life ever be considered a good death? Does dying in late middle age or old age make it easier to consider the death a good one, as opposed to dying in childhood?

Each stage of life gives rise to a particular interpretation of the time of death, reflecting what it represents socially, culturally, and locally. Good or bad, a death is often assessed, paradoxically, by those who witness it, placing death in the time of the living. In the context of our study, the deaths were commented on and assessed by the relatives who shared their stories with us, giving rise to "constructions" about what constitutes a good death and its opposite, a bad death. Nevertheless, and beyond this ambiguity, there is an overlap between the time of death (the moment when it occurs in the life cycle) and the impact of its unfolding on the memories of loved ones.

The end of life is nonetheless an unknown journey, dictated by illness and the needs it entails (Jordan et al. 2015). Yet, it is also a continuation of life, both philosophically and biologically (Voléry and Schrecker 2018). As a life stage (and object of study) with imprecise, non-linear edges, and unclear delimitations (Kaufman and Morgan 2005), Carr and Luth (2019) emphasize above all its social character, beyond its clinical dimensions. The end of life and, more broadly, dying, are relational, made up of everyday practices; they are social and inclusive phenomena with a physical component (Kellehear 2022). Good or bad, many elements shape the experience. On the one hand, dying is a situation where culture makes its social mark, expressing itself in a network of relationships (social and cultural) that vary in time and space (Cottrell and Duggleby 2016; Le Gall 2025). Plural worlds (Soom Ammann et al. 2016; Zivkovic 2021) co-exist, particularly in the many localities where diversity (or "hyperdiversity" according to Hannah 2011) is part of everyday life. As a result, there are many ways of experiencing and thinking about the end of life and what constitutes a good

death. The latter evokes a wide range of meanings: it could be an individual experience or one that is part of a family, kinship, or community group, a pain-free or fully conscious end of life (which, for some, implies refusing pain relief), a death at home (in the local society or, for migrants, in their land of origin) or in an institution. It can also take on different meanings depending on the patient's position within the family (child, parent, spouse, brother, or sister), their gender, age, or social background. For some, a good death is one of control (of events, of pain), of acceptance, or one where the dying person is surrounded by loved ones (Kaufman and Morgan 2005). For others, it is inseparable from personal liberty (Vallée 2020), the freedom to make independent decisions (Zivkovic 2018), or choices negotiated between the dying person and the group to which they belong (Borgstrom et al. 2019). Furthermore, the healthcare experience (trajectory, undue care, or lack of care) has a definite impact on the way a death is appraised, whether it is considered good and dignified or bad (Fortin et al. 2025).

But what are its qualities? Without an explicit definition, the notion of a dignified death, of *dying with dignity*, has taken hold, notably in Quebec, with a special commission that produced the report *Mourir dans la dignité* (2012)[3]. This expression echoes the notion of a "good death" that, for many (according to the report), means dying surrounded by loved ones, in one's sleep. On the other hand, such a death can be slow, painful, and deteriorating in a context where life expectancy is increasing without being of high quality. Lessard (2023, 185) refers to the negotiation of *what is right and enough* in a rather paradoxical societal context where medical advances that prolong life are sometimes at odds with the notion of a dignified death and the difficulty of recognizing the end-of-life period. These notions of right and enough refer to what Kellehear (2007, 234) calls the *right time to die* and to *enough*… treatments, life, and suffering.

When people refer to good or bad deaths, what comes into play … and when? For whom? Are they referring to the time of illness, the time of end of life, or the time of death? At the core of this paper and beyond the dimensions that constitute the preconceptions of a good or a bad death, we consider these times of dying as a temporal sequence. We wonder whether a gap between the time of illness, of end of life, and of death favours a bad death. Inversely, concordance between these times may foster a memory of a good death. With this in mind, we present a number of short stories depicting trajectories of dying, as well as the elements that constitute good and bad deaths, as put forward by the loved ones we met with. These trajectories, whether involving

children, adults, or seniors, are marked by different ways of seeing the world, the family, medicine, and medical institutions, and reflect the performativity of dying as a social process. A portrait with ambiguous edges emerges, nullifying the intrinsic qualities of these deaths, beyond their given trajectories. From these threads emerge the reflections at the heart of our paper: the time of dying as a temporal sequence. These times (of illness, of end of life, and of death) and their concordance or, on the contrary, their discordance are key elements in the assessment of death, whether good or bad. But first, a few words about the study on which our observations are based.

The Study

This paper draws on semi-structured interviews conducted between 2017 and 2019 in Montreal (Quebec, Canada)[4] with over one hundred relatives of deceased children (16), adults (30), and seniors (73) and discusses dying, or rather times of dying, as a temporal sequence. We documented the end-of-life trajectories of migrants, children of migrants, and non-migrants, and the challenges their loved ones encountered along the way. Inspired by the work of sociologist Anselm Strauss and colleagues (1985), the notion of trajectory enabled us to grasp serious illness, the end of life, and death as temporal processes, but also as a social one (in addition to the biological process), at the crossroads between many potentially divergent perspectives between the ill person, his or her family, and the healthcare providers. In this regard, sudden or unexpected deaths were excluded from our study.

These were "long" interviews (between 60 and 120 minutes) led mainly by Samson and Lessard, then doctoral students much involved in the study[5] throughout its duration and by me (in particular when related to children's deaths). The themes central to our study[6] were addressed from different angles. The study was retrospective, based on end-of-life experiences that had occurred over the past year. Prospective studies in this field are rarer (for methodological and ethical reasons), with a few exceptions (Carr and Luth, 2019). As van der Geest (2021, 85) reflects, "Should we sit on a person's deathbed with a notebook or audio recorder and note his last words, observe his last gestures, record and interpret the bystanders' reactions?" And before that, "There are moments when you should close your notebook and stop your role as a spectator."

In order to capture diverse experiences, we used a variety of recruitment methods, including an invitation to participate in our study sent via the university network, a homemade advertisement posted in local businesses, and

flyers distributed outside of metro stations and at popular festivals. We also networked with health care institutions and organizations in the Montreal area.

Among the 119 deceased individuals, there were 59 women and 60 men ranging in age from newborns to 98 years old, from a range of national origins (38 countries), including Europe, the Middle East, Asia, North and East Africa, Central and South America, and North America. Of these, 63 were migrants, 13 were born in Quebec to migrant parents, and 43 were of French-Canadian descent. Only nine people spoke neither French nor English. The vast majority of the deceased had permanent residency or Canadian citizenship. Most of the seniors had immigrated a long time ago.

Cancer was the dominant disease for 69 of the deceased individuals, followed by advanced chronic illnesses (that is, respiratory, cardiovascular, neurodegenerative, circulatory, and other chronic illnesses) for 21 individuals. Another 21 individuals had multiple conditions (that is, co-morbid situations such as amyotrophic lateral sclerosis and substance abuse, or multiple concurrent health problems). Finally, eight individuals had rare or genetic diseases.

As for the relatives, they were the mothers and fathers of the (16) deceased children, and mainly the spouses of the (30) adults, some friends, siblings, but also first-generation (daughters) and second-generation descendants (nephews). The relatives of the (73) seniors were sometimes spouses (mostly women), sometimes first-generation descendants (again, mostly women), and sometimes granddaughters (third generation).[7] As with the deceased, national and religious affiliations varied.

Good and Bad Deaths

Generally speaking, across all age groups, the majority of participants in our study considered that their loved one had experienced a *good death*. Nevertheless, some of them (21 out of a total of 119 documented trajectories) were qualified as *bad deaths*. The vast majority of these bad deaths concerned seniors (16 out of 21, including 11 long-term migrants), four adults (two migrants, two non-migrants) and one child born to migrant parents. Capturing the dynamics, key elements, or turning points of the trajectories sheds light on the elements that contribute to the quality of these deaths, whether good or bad. And, as we shall see, good and bad deaths do not necessarily reflect distinct trajectories. They are, however, part of a plurality of reference systems regarding what is considered central throughout the dying process, from the sanctity of life and

a dignified death to a quality life and death in particular (Lessard 2023; Maffi and Papadaniel 2017).

But first, a few stories…

Lucas's Story

At the age of nine, Lucas developed an aggressive form of cancer. Faced with a devastating diagnosis and a grim prognosis, his mother confronted her son's illness head on. Veronica, age 45, made many attempts to achieve the improbable, using both medical and alternative approaches. The whole family (nuclear and extended) was fully involved in the long period of illness. Lucas was aware of his illness and prognosis, while his mother sought to give her son a life filled with plans and aspirations.

The end-of-life period was also a time of relative action: the boy's environment was lively and colourful, and Lucas's mother and older brother were there for him. In hospital, Lucas was cared for, supported, and accompanied throughout the end-of-life period. Days (and weeks) went by, time passed, and Lucas gradually faded away. The time of death arrived smoothly—death settled in, as expected. In Veronica's own words: (the author's translation) "I put my hand there, and at a certain point his heart stopped beating, and I felt a shiver go through me." When asked about the qualities of a good death, she replied: "Lucas's death, Lucas's death was perfect. There couldn't be a more perfect death, a death such as his, because he smiled." Yet, at the time of our encounter (18 months after Lucas' passing), Veronica shared how difficult it was for her to come to terms with her son's death, still very much in mourning. Through his illness, she also felt very strongly about sharing death issues with her son (not a generally favoured path by the healthcare team) and how it allowed them both to experience his end of life peacefully.

Lina's Story

Lina, age 34, a Central American migrant of Protestant faith, experienced two contrasting deaths. Both her children, Alexia, age 10, and Ivan, age seven, suffered from a genetic disease with a guarded prognosis. Although both children were severely disabled, they were taken care of mainly at home by extended family members, in and out of the hospital at different times as their condition worsened. And while the children's healthcare team and local professional caregivers often suggested "placing" the children, Lina repeatedly declined (the author's translation): "It's not done in our culture, you know, I

mean I grew up here, yes, but I grew up with the customs of my parents and my grandmother."

Lina recalls Ivan's peaceful death in a respite and palliative care home for children. In contrast, Alexia died in the emergency room of a local hospital where the advance do-not-resuscitate (DNR) directives were disregarded, giving way to aggressive procedures. Lina and her husband were also suspected, for a time, of having hastened Alexia's death. As Lina says: (the author's translation) "The way I experienced it, it wasn't humane."

Alexia's unfortunate (although expected) death marked the end of a long illness punctuated by many happy moments (as recounted by Lina). Despite the relative harmony of the times preceding it, the time of death cast a shadow on Lina's assessment of her daughter's death.

Shenika's Story

According to Shenika (age 29, a non-migrant who accompanied her mother Gabriella, age 65, a West Indian migrant, both Christians), a good death does not exist, as she does not wish anyone's death. She considers that a sudden, unexpected death in one's sleep characterizes a good death when compared to a death preceded by a long period of suffering, which is what happened to her mother. Shenika explains:

> For me, I had an expected death with my mom, so watching somebody you love deteriorate in front of you is one of the hardest things I can ever imagine. And I wouldn't wish that on anybody. [...] So for me, a good death is an unexpected death. An unexpected death where you didn't know it was coming, but now that it's here, you have to deal with it.

Although Shenika's idea of a good death is one that is sudden and unexpected, she appreciates that she was able to be with her mother to the very end. Gabriella was ill for more than three years, at home until the ultimate day when she was admitted to an emergency hospital ward, and where she died that same day (Shenika and her brother were by her side). She said that it was precisely because her mother's death was not sudden that she was able to enjoy the time they spent together during the end-of-life period:

> Life is so funny like that, that I spent time with her although I would have preferred it to be unexpected, you know, but there would have been so many unanswered questions I would have had, for having an

> expected death, I got those questions answered from being with my mom, so yeah.

Ava and Farhad's Story

Ava's (age 56, a Muslim West Asian migrant who has lived in Montreal for 32 years) father, Farhad (age 86, also a Muslim West Asian migrant, who lived in Montreal for 30 years), was living in a long-term care residence because his care needs were too great to be maintained at home. Ava would have liked her father to benefit from hospital expertise and care. The family did not agree with the facility's decision to move toward supportive/palliative care rather than curative care. According to Ava, Farhad was "not there yet," and the family would have preferred that everything be done to maintain his life. The alleviation of suffering advocated by supportive care, particularly during moments of respiratory distress, was perceived by Ava as having hastened her father's (bad) death:

> It was draining for me, for six and a half months, and to be finishing like that, it was just, uh… […] I find the end was something that is like, you … you have this nail and you do it slowly to go inside the wood, but at the end you do a big, big pressure and with that big pressure it goes in. So, when he died, that was like a big pressure at the end that completed all of the things that I was going [through], that was the thing that, you know, to finish it.

Following Ava's story, can a long period of illness be "stolen" by an end-of-life period "accelerated" by pain relief, for example? Is this the fear that prevails when loved ones or patients refuse pain relief or euthanasia (as made possible by medical aid in dying [MAID])? Are they afraid that the ill person will move too quickly from the time of dying and end of life to the time of death?

Many-sided Notions

These stories reveal that the elements of a good or a bad death intersect without offering clear or unambiguous points of reference. They seem conjectural and give rise to shared feelings, sometimes good, sometimes less favourable.

Many relatives said that a good death meant being surrounded by loved ones and being in a trustworthy place. A good death is also inseparable from how we envision the life cycle and the representations it inspires (Baker and McCullough 2009, Fortin et al. 2023). In this sense, a good death occurs at an advanced age. But here again, this observation needs to be qualified; while

dying before developing “grey hair” is often perceived as unfair, Hakim (quoted in the opening of this paper) sees it as a sign of the deceased person’s exemplary character.

A good death should also be pain-free (Carr and Luth 2019). Yet, some people decline all pain relief, which does not necessarily lead to a bad death, as this refusal is part of the dying person’s end-of-life philosophy. And while its main goal is to alleviate suffering and improve the quality of life now (Kellehear [2022] speaks of palliative care as a well-being science), palliative care is welcomed by some but criticized by others. This care is often seen in a dichotomous way: curative care and life versus comfort care and end of life. At the same time, you might say that a good death is an accepted death. Is it this acceptance that makes palliative care possible?

Is the availability of social (family and friends)[8], economic, and symbolic resources intrinsic to the perception of a good death? The acknowledgement (*Reconnaissance* in Ricoeur’s [2004] terms) of who the patients and their families are, by those involved in institutional or home care, is an integral part of the social and symbolic dimensions of dying. A good death is also, at least in the imagination, associated with dying at home. However, although home is often portrayed as the ideal locus, some envision the hospital as the ideal location for a good death as it is viewed as a place where everything will be done to ensure a *good death*. In other words, for some, home is the ideal location, but for others, it is the hospital. And yet, dying at home with medical care is also a question of resources. It requires both social (family and friends) and economic resources. Carr and Luth (2019) concur, citing a disparity in access to these resources, particularly with regard to group affiliation, with “Whites” having greater access to dying at home than “African Americans” or “Hispanic Americans.” In the context of our study, however, group affiliation has no direct bearing on the place of death. Nevertheless, those who died at home and were of migrant background benefited from a wider range of support (local and transnational) than non-migrant families.

Even the best public home care cannot meet all the needs of a dying person and must be supplemented by private healthcare services or by the constant presence of loved ones who are able to take turns caring for the dying person. However, the dying person may want to be placed in a more formal care setting (such as a hospital) for fear of imposing themselves on their loved ones or because they’re looking for some assurance that, when death comes, they’ll be properly attended to. So, while dying at home is associated with a good death,

the hospital remains one of the main places where a dying person can let themselves go and where loved ones can feel reassured that everything is being handled properly. The results of our study show that just over half of all deaths occurred in hospitals (all units combined), just under 20 percent at home, 13 percent in Centre d'hébergement et de soins de longue durée, and less than 10 percent in palliative care homes.

However, out of the 119 end-of-life trajectories in our study, 21 were described as *bad deaths* by relatives. A key component of these deaths lies in interpersonal dynamics, such as difficult relationships with professional caregivers as well as conflicting relationships within the family, especially those involving non-consensual decision-making (Durivage et al. 2025).

As mentioned earlier, dying at an early age is another component of a bad death. Although no distinction is made between pain and suffering, the latter is associated with a bad death. The place of death may also generate a perception of a bad death, and although home is often portrayed as the best locus, some envision the hospital as the ideal location for a good death because it is seen as a place where everything will be done to ensure a good death. In other words, while home is perceived as the best location for some, for others, it is the hospital. Yet, as discussed earlier, dying at home requires considerable resources (social and financial), which some families may lack.

Furthermore, as Lina's story reveals, intrusive medical interventions can also generate the perception of a bad death, particularly when involving children. Yet both life-prolonging care (sometimes qualified as excessive care) or, on the contrary, comfort or life-enhancing care, may be seen as contributing to bad deaths. On the other hand, in contrast to Lina's perceptions, a curative approach may foster a long-term life view, where longevity takes precedence over time now. In this way, comfort or palliative care may be perceived as abandonment. Abandonment through care, abandonment without care.

Where does culture fit into all this? Culture certainly plays a part in this assessment—but a culture thought of as alive, as interacting with its environment. The diversity of perspectives on good and bad deaths testifies to this, both in our data and in the literature (Olazabal and Fortin 2023). Plural urban environments (such as the one in which this study was conducted) reflect an interweaving of plural identities that transcend ethnic, national, religious, and linguistic origins, as well as cultural practices determined by a given tradition. These identities also encompass other social categories such as age, generation, sexual and gender orientation, etcetera. In other words, culture as

a web of meaning (or *web of significance* according to Geertz [1973]) is certainly present in the assessment of a good or a bad death. This culture is nonetheless alive and dynamic, inseparable from the social experiences (and interactions) in which it evolves.

Times of Dying as a Temporal Sequence

The times of dying as expressed in this paper are inspired by van Gennep's 1981 [1909], in Lessard 2021) three phases common to all rites of passage: rites of separation from a group or a state, rites of margins (or liminality), and rites of aggregation or incorporation into a new state or group.[9] When people refer to a bad death, are they referring to the *time of illness* (rite of separation), the *time of end of life* (rite of transition/margins), or the *time of death* (rite of aggregation/incorporation into a new social status)? Can a gap between these three times cause the death to be perceived as bad? As in the case of Ava and her father, Farhad, can a *long period of illness* be "stolen" by an *end-of-life period* "accelerated" by pain relief? The same is true of Lina and her daughter Alexia, who experienced a *long period of illness*, as well as a *period of end-of-life* with her loved ones, in a spirit of family solidarity, but the *period of death* ended abruptly, a bad death made up of doubts and excessive interventions. Does this mean that the imbalance between the different stages of dying or, on the contrary, their concordance, gives rise to a poor perception of death or, conversely, a good death at the heart of *dying with dignity*?

Is it the fear of loss (of stolen time) that prevails when loved ones or the patient refuse pain relief or euthanasia (as practised in Quebec), the latter of which alters the time of dying and end of life to that of death? Yet, let us remember that perspectives on dying may differ between the dying and the living: the experience of the one who is dying and that of loved ones is similar, but not the same (Kellehear 2022).

In the same way, as stated by the French physician and ethicist Didier Sicard (2012), the question of dignity (*dying with dignity*) does not belong to those who suffer or enjoy, but to those who see (that is, the look of the other).

That being said, the imbalance between these different times or, on the contrary, their concordance (harmony), seems to give rise to the perception of a bad death, or a good death at the heart of *dying with dignity*.

Mirroring this, we can anticipate that a good death, as evoked by loved ones, implies a relative concordance between these times, without making them

absolute conditions (a rule of thumb). Shenika evokes two of these times: a sudden, rapid death, while at the same time appreciating the long time of dying, in order to take full advantage of the time with her mother.

As Badone (2023) remarks, if this temporal sequence unfolds harmoniously, that is, not too quickly nor too slowly, it gives way to a social consensus that a good death has been achieved. Lucas's story is an example of this, even though he was a young boy when he died, well before getting the "grey hair" mentioned at the beginning of this paper.

Concluding Remarks

Grasping what constitutes a good or bad death, as related to the time of dying, brings us back to the notion of temporal and social trajectories (in addition to biological). The trajectories of the children, adults, and seniors in our study all express, in their own way, the complex relationships between the social, the biological, and the many places where illness is experienced. Home becomes a metaphor for a familiar space, where support and solidarity are expressed between loved ones (including the sick person), and between loved ones and caregivers. The relational aspect of dying becomes central to the assessment of a good or a bad death as reported by the living, whatever their origins. Illnesses and trajectories are all subject to a good death, not because of the intrinsic qualities of that death, but rather because of the conditions and rhythms involved.

Whether young or old, no one is immune to a bad death, and once again, this is linked to the times of illness, end of life, and death, all of which can be disrupted. With all the attendant nuances, a balance in these different times of dying seems a promising way to identify the components of the qualities of death as perceived by the living, while neither the place, nor the type of care, nor the support of loved ones are consistent indicators of a good or a bad death.

In other words, these nuances must be situated within contexts of interaction, throughout the trajectories of dying (or journeys and the liminal time between the announcement of illness and death [Kellehear 2022]). These paths become a window through which we can gain an awareness of good and bad deaths as times of death, end of life, and dying. These times may also be the key to a better understanding of the quality and processes of mourning that follow good and bad deaths.

Mossière and Le Gall (2025) describe the end of life as a time to (the author's translation) "welcome death and ... prepare the living." Beyond separation and mourning, it is the living who are at stake. We are confronted with this limit, while the questions shared throughout this paper remain about the living, without presuming their relevance to those who, young or old, pass on. As Levillain-Danjou (2013, 14) once wrote, (the author's translation) "death remains a matter for the living."

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Notes

1 The author's translation: "[...] With my health fading out, I'm searching in vain for a glimmer / A little ray of light to hang on to [...] But my weary body / is asking for mercy [...] Tonight, it's the shadow of myself / who will quietly leave the stage / and step to the other side of the curtain [...] I wouldn't take any more, I've reached the last station / It's all over for me who loved life so much / I'm tired, I can't sing anymore / I've had enough and my heart's no longer in it / I'm at the very end of my road [...] What happens after the show is over? [...] There's nothing on the other side of the curtain / No organized tour through an illuminated tunnel [...] I'm going out the back door / for the universe to swallow me."

2 "[...] la vie est souvent injuste, souvent injuste surtout pour ceux qui partent avant d'avoir les cheveux blancs [...]" (The author's translation: "[...] life is often unjust, often unjust especially for those who leave before their hair turns grey [...]") ("Les cheveux blancs," Marie-Annick Lépine, Les Cowboys Fringants, 2024).

3 *Dying with Dignity* (the author's translation).

4 Supported by the Social Sciences and Humanities Research Council of Canada (SSHRC), the team assembled to conduct this study included S. Fortin (principal researcher), J. Le Gall (co-principal researcher), I. Olazabal, G. Mossière, L.Rachédi, and P. Durivage, with the close collaboration of M.E. Samson (project coordinator), S. Lessard, B. Mathiot, T. Bytyqi, S. Ouadfel and, earlier, J. Fuentes Bernal, P. Gagnon, V. Kayayan, É. Develey, C. Goglio, J. Simard, and M. Cliché-Galarza (research assistants). A. Simard, M. Drolet, C. Sigouin, and J. Desrochers rounded out the team with their expertise in health care environments.

5 As mentioned earlier (prior footnote), our team was strongly supported by research assistants, all doctoral or master's students (mainly Anthropology, Université de Montréal).

6 In addition to the sociodemographic profiles of the interviewees and the deceased, the topics covered during the interview included: the interviewee's relationship with the deceased, the illness history and end of life story, the decisions that marked the end of life and the negotiations involved, knowledge and perspectives on the local (Quebec) law on medical assistance in dying, spirituality and burial practices, and in fine, an exploration of key concepts associated with the end of life and death (Fortin and Le Gall, eds. 2025 covers all of these topics).

7 See Olazabal and Samson (2025) on the role of granddaughters in supporting their grandparents during the end-of-life period.

8 Le Gall (2025) notes that migrant seniors are more likely to be supported by family caregivers than non-migrant seniors.

9 Van Gennep (1909 [1981], 193–194) further states: "It is not the rites in their detail that have interested us, but rather […] their sequence. […] in order to show how the rites of separation, margin, and aggregation […] are situated in relation to one another with a given goal. […] Their tendency is the same everywhere, and beyond the multiplicity of forms we always find […] a typical sequence: *the pattern of rites of passage*." (In italics in the text, the author's translation.)

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