Three reflections upon the Catholic medical tradition and hospice and palliative care

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I am often struck at the similarities of caring for older, chronically ill patients, and the long Christian tradition caring for the needy, the poor, and the sick. Particularly when challenged by the scope and size of the task of ministering to this truly underserved population, I find that a spiritual re-focusing provides meaning and comfort. Viewed from the perspective of eternity, end-of-life care occurs in that space between the present and the afterlife. What is the place of spirituality in the care of patients receiving hospice and palliative care? How do Catholic healthcare personnel respond to their patients' needs? I propose three reflections addressing (1) The Church and human suffering, (2) Catholic framing of goals of care, and (3) Christian stewardship of the cycle of life.

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REFLECTION #1. THE CHURCH AND HUMAN SUFFERING HAVE AN INTIMATE AND HISTORIC RELATIONSHIP

From the earliest times of Christianity, caring religious and lay persons felt it their duty to open their homes and communities to the care of the sick and suffering (Stack 1996). The origin of hospitals and hospice dates back to these early times and was further advanced by such champions as Saints Francis and Clare of Assisi, who founded the first orders of the religious in the thirteenth century to care for the poor and sick, following an over 1000-year tradition (Crislip 2005). In the seventeenth century, St. Vincent de Paul's communities founded hospitals and hospices to provide nursing care. In the nineteenth century, St. Jeanne Jugan of France began

an order dedicated to serving the indigent sick and later developed nursing homes. Cicely Saunders, a twentieth-century nurse, social worker, and physician, trained at a Sisters of Charity Hospital in London, and founded the modern hospice movement. In more recent times, Blessed Mother Theresa of Calcutta was famed for her community's care for India's dispossessed and dying people. And in the new millennium, Blessed Pope John Paul II, in his words and by his personal example, taught the world to love the elderly, to embrace redemptive suffering, and to approach death from the perspective of eternity (John Paul II 1999).

This sensitivity to the needs of the chronically ill and dying is rooted in Catholic moral teaching that holds at its foundation the human person's inherent

dignity. The life of the human person is fundamentally sacred because it involves God's special creative action in the infusion of the soul. Circumstances of aging or of illness do not diminish human dignity. Catholic healthcare professionals should recognize the critical role they play in serving the chronically ill and dying. They are witnesses to all of society concerning the divine origin of each human life.

REFLECTION #2. GOALS OF CARE FOR TERMINALLY ILL SHOULD BE FRAMED IN A CHRISTIAN CONTEXT

Palliative care seeks to provide comfort to patients in terminal phases of illness. The term is derived from the Latin "to cloak" or mask symptoms. Hospice refers to terminal care often delivered at the patient's residence, and it can also refer to a specialized unit devoted to care of the dying. Sometimes palliative care is considered the type of care used when "there is nothing more to do." But nothing could be further from the truth. It consists of active treatment for the individual and their loved ones, seeking relief of symptoms and to improve quality of life, including collaborative models of care, support for decision making and the search for meaning as well as bereavement and caregiver support. The Church calls us to address end-of-life care with great consideration for the patient's full personhood, both body and soul (Congregation for the Doctrine of the Faith 1987). For Catholic patients, the Catholic physician has a unique opportunity to share the life of the Church with one who is suffering. Very often illness provokes a search for God and a return to him (*Catechism of the Catholic Church*, n. 1501; 1994). It is appropriate to encourage expression of emotions, and acknowledge them as death

approaches. In this way we assist the dying person to make sense of his life and to accept one's approaching death.

The *Catechism of the Catholic Church* reminds us that the dying should be given attention and care to help them live their last moments in dignity and peace (*Catechism of the Catholic Church*, n. 2279; 1994). Addressing existential suffering, the search for meaning while experiencing pain and death, and addressing spiritual concerns enhances care. Facilitating the dying person's reflection on what is most important can produce profound relief.

We read in the Ethical and Religious Directives: "Patients experiencing suffering that cannot be alleviated should be helped to appreciate the Christian understanding of redemptive suffering" (US Conference of Catholic Bishops, dir. 31; 2009). The Catholic healthcare professional may assist a Christian patient in understanding Christ's passion more deeply and personally, and how we are individually called to unite ourselves with him in our own sufferings. In the Old Testament, too, Isaiah describes the suffering servant of the Lord, and, as the *Catechism* says, "intuits that suffering can also have a redemptive meaning for others" (*Catechism of the Catholic Church*, n. 1502; 1994). It is most appropriate, therefore, for the Catholic physician to discuss care preferences with patients before it is time to make critical decisions. A physician who has a long-term relationship with a patient is in a special position to help the patient express goals of care, honor the patient's dignity, and support decisions with the family.

Discontinuing medical procedures that are burdensome, dangerous, extraordinary, or disproportionate to the expected outcome is a legitimate acceptance of our inability to impede death, and not a wish to cause death. The decision should be made by a competent patient or, if not, by

those legally entitled to act for the patient, whose reasonable will and legitimate interests must always be respected (*Catechism of the Catholic Church*, n. 2278; 1994). The task of medicine is to care even when we cannot cure. Physicians and their patients must always evaluate the use of the technology at their disposal. Reflection on the innate dignity of human life in all its dimensions and on the purpose of medical care is indispensable for formulating a true moral judgment about the use of technology to maintain life. The use of life-sustaining technology is judged in light of the Christian meaning of life, suffering, and death. In this way two extremes are avoided: on the one hand, an insistence on useless or burdensome technology even when a patient may legitimately wish to forgo it (disproportionate care), and on the other hand, the withdrawal of technology with the intention of causing death (US Conference of Catholic Bishops, dir. 61; 2009).

REFLECTION #3. HEALING GRACE IS THE KEY TO CHRISTIAN STEWARDSHIP OF THE CYCLE OF LIFE

The way a person understands life has much to do with how he or she thinks about death. For the Catholic, physical death marks the end of life on earth, but also marks the passage into eternity. While death is, in and of itself, an evil—insofar as the separation of body and soul disrupts that substantial unity that is the human person—our care for the dying can be a grace-filled time for patient, family, and caregivers alike. The Catholic healthcare professional, who has a sense of eternity as the ultimate end of human life, will always strive to see patients in this light.

Talking with the patient and family members about death allows them the

opportunity to engage their religious community in appropriate ways. Dying should be understood in a social, cultural, and spiritual context. Even if the patient and family are not Catholic, the physician can suggest to them that they involve a chaplain or their pastor, rabbi, iman, or other religious leader in their care.

The Catholic healthcare professional should be attentive to the call to be an intercessor for others, not only in prayer, but also in advocating for the Catholic patient by recommending the sacraments of healing (Stafford 2006). The Sacrament of Reconciliation and the Sacrament of the Anointing of the Sick are not limited to those with terminal illness, but they do take on a distinctive role in the Catholic patient's last days. As physicians, we recall Jesus as the Divine Physician of both bodies and souls. He used material means to heal others. The *Catechism* elaborates:

He makes use of signs to heal: spittle and the laying on of hands, mud and washing. The sick try to touch him, "for power came forth from him and healed them all." And so in the sacraments Christ continues to "touch" us in order to heal us (*Catechism of the Catholic Church*, n. 1504; 1994).

So as one of the seven Sacraments, the Church recognizes one specifically for the sick. The Anointing, said Pope Paul IV, is not a sacrament for those only who are at the point of death. As soon as anyone of the faithful begins to be in danger of death from sickness or old age, the appropriate time for him to receive this sacrament has certainly already arrived (Vatican Council II 1963). The sacramental grace helps to focus on the dignity of the dying person and to the moral obligation of accepting death and allowing it at last to take its course. Death is an inevitable fact of human life. Clinicians, patients, and their family members are all

called upon to recognize humbly their limitations in the face of life and of death. We are all asked to participate with God as the Creator of human life. The *Directives* explain this further:

The truth that life is a precious gift from God has profound implications for the question of stewardship over human life. We are not the owners of our lives and, hence, do not have absolute power over life (US Conference of Catholic Bishops, part 5; 2009).

Care of the dying includes also care for the patient's family and loved ones. The physician and care team can facilitate ways to finalize and enhance relationships, promote emotional healing and reaffirm family bonds. Each experience of death will be unique because of the distinctive nature of each family member's relationship to the dying patient. In Byock's book, *The Things That Matter Most* (Byock 2004), he suggests helping the dying patient to say, in their final moments, "Please forgive me," "I forgive you," "Thank you," and "I love you."

Dying can be a grace-filled moment for all involved. It is a privilege and honor for Catholic healthcare professionals to witness and to be involved. This is part of the cycle of life and represents a celebration of creation, demonstrating our universal search for meaning.

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