

CARE OF THE DYING: A CATHOLIC PERSPECTIVE

Part IV: Theological, Moral, and Pastoral Response—The Transformation of Suffering

Because of the growing movement toward physician-assisted suicide and euthanasia, in 1990 the Catholic Health Association (CHA) convened a group of its members to clarify and extend the insights of Catholic theological teaching to address issues at the end of life. From this effort came the foundational document, *Care of the Dying, A Catholic Perspective* (CHA, St. Louis, 1993).

In the past three issues, *Health Progress* has presented excerpts of the first three parts of the document: "Cultural Context," "Social and Political Context," and "Clinical Context." Following is an excerpt of the final part.

The complete text of *Care of the Dying: A Catholic Perspective* has been sent to all CHA members. Additional copies are available from

CHA, 4455 Woodson Road, St. Louis, MO 63134-3797, 314-253-3458. The cost for one to four copies is \$9 each; five to nine copies, \$7.50 each; and ten or more copies, \$6 each.

To shine the light of faith on the experience of suffering and dying, Catholic healthcare providers aspire to give meaning to what seems meaningless and to respond in a way that expresses our faith and fills us with love and hope.

DEATH AS EVENT

Everyone can easily recognize the distressing prospect that death is the termination of earthly

Summary People struggle to find meaning in suffering and death. In a culture that cannot depend on religious insights into suffering to address the deeper questions (e.g., Why me?), all kinds of interventions, even euthanasia and assisted suicide, may seem inevitable. Catholic healthcare providers can respond by offering patients, families, and care givers a vision of how suffering can be understood. Based on the power of divine love to transform suffering and death from absolute evils to personal triumphs, the moral principles the Catholic Church upholds can provide a hopeful perspective for healthcare professionals who care for the dying.

Three principles support Roman Catholic teaching on conserving health and life: sanctity of life, God's dominion and human stewardship, and the prohibition against killing. These principles by themselves are insufficient as a moral or pastoral response to the care of the suffering and dying. Action is also required. Moral virtues must be

reflected in ethical behavior and in pastoral practice so that we may enact our Christian vision in the face of suffering and death.

Attention to our character as providers and our ethical practices is of grave importance in these days when euthanasia and assisted suicide are being promoted so aggressively. To carry on Jesus' healing mission by responding to human suffering and death, healing communities must embody virtues that bear convincing witness in both a personal and a corporate manner regarding the care of the dying. Three characteristics of a virtuous community stand out: interdependence, care, and hospitality.

By being a virtuous community, we may be able to address many of the concerns that motivate people to consider euthanasia. In addition, by offering principled, rational arguments against euthanasia and assisted suicide, we can shape public consensus toward death as an experience we need not hasten through lethal intervention.

life, but it takes a different perspective to see that death completes life. "Gaudium et Spes," a document issued by the Second Vatican Council, underscored the Catholic conviction that God has called us to an endless sharing of divine life beyond death (see Austin Flannery, ed., *Vatican Council II: The Conciliar and Post Conciliar Documents*, Daughters of St. Paul, Boston, 1988, no. 18, pp. 917-918). But even for believers, letting go of earthly existence is difficult. We rightly fear death because we lose so much in dying: people we love, our work, and all those things which have given us gladness in life as we have known it. Further, we are bothered by the prospect that our lives will be forgotten.

All our turning to technology to keep death at bay cannot calm our anxiety over death. The desire to live is inescapably lodged in our hearts. We cannot ultimately control or prevent death from happening to us. Therefore, we also fear death because it opens a door to the unknown.

Given the ambiguity and threat death poses, it is not surprising that people avoid thinking and talking about death, deny its imminence in the face of medical diagnosis, take heroic measures to prevent death at all costs, and postpone it for as long as possible.

As members of the Christian faith, we must take these fears seriously and stand with people in their anxiety to effectively share the perspective that can transform suffering and death from a mere termination to a completion of life.

TRANSFORMATION THROUGH SUFFERING AND DYING

Our first reaction to suffering and dying is to resist it. We direct all our skills, medications, and treatments against illness and against premature death.

Suffering Pain and suffering are closely related, but they are not the same. Not everyone in pain is also suffering. Suffering is a personal matter, which is as much a function of an individual's attitude as it is of physical causes.

We experience suffering as a state of distress when we sense that our physical condition may harm or destroy us. The presence and extent of suffering, though, can only be known to the sufferer. We have no objective way to measure or to verify the claims of patients that their suffering is unbearable. So, if we want to know whether someone in pain is also suffering, we have to ask him or her.

People in pain report suffering when they feel out of control. The dying person is at the mercy of the medical world, which is filled with procedures, technologies, and a language that can be confusing and oppressive. All efforts to set patients free can actually oppress and hold them

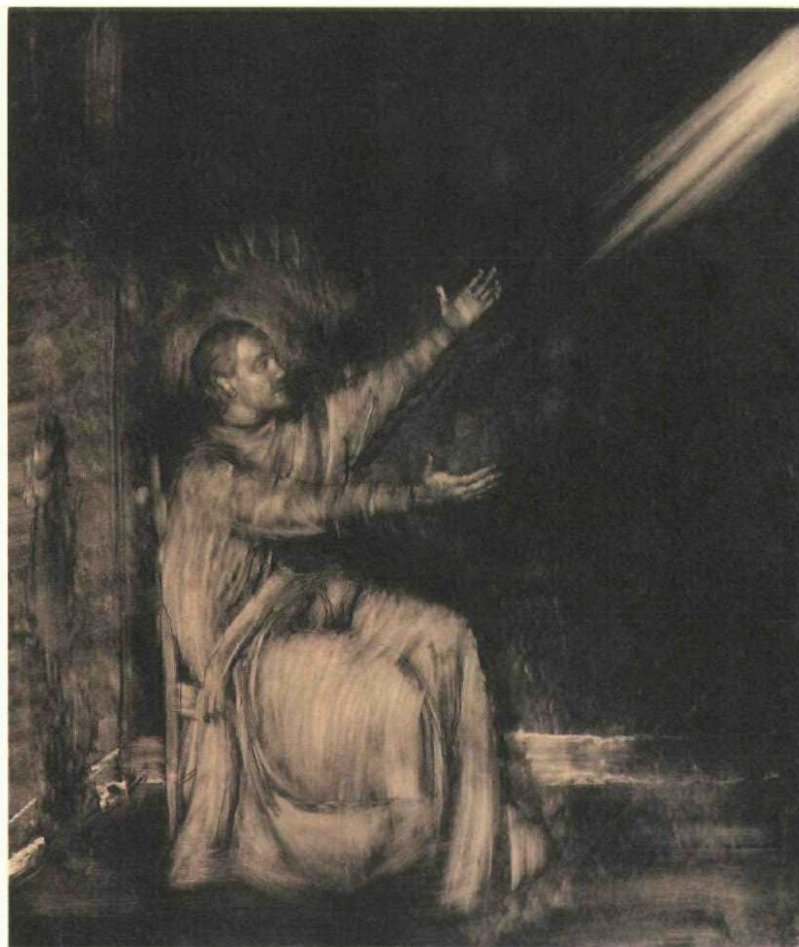
captive. When this happens, patients report they are suffering.

People in pain also suffer when pain cannot be relieved, when its source is unknown, when it becomes overwhelming or seems endless, or when they can find no meaning in it.

It is no wonder, then, that the ever-present question in the minds and hearts of those suffering from pain is, Why? Questions arise about the source of pain or cause of suffering (What have I done to deserve this? Why me?), as well as about the meaning and purpose of suffering (What's life all about?). In a culture that cannot depend on religious insights into suffering to address the deeper questions, all kinds of interventions, even euthanasia and assisted suicide, may seem inevitable.

Meaning in Suffering We turn, then, to our tradition of faith to find meaning in the mysteries of suffering and death. The Catholic tradition teaches that suffering can be transformed. The Rite for the Pastoral Care of the Sick observes: "Christians feel and experience pain as do all other people; yet their faith helps them to grasp more

When the dying patient can no longer appreciate treatments as benefit and creative living becomes impossible, then hope should focus on the eternal life after death.



© 1993 John Collier

deeply the mystery of suffering and to bear their pain with greater courage" ("Introduction," no. 1).

Suffering offers Christians the chance to identify with the suffering of Christ. If, through suffering, a person is brought nearer to the cherished goal of a closer bonding with God in Christ, then that person may have no sense of suffering because of the comfort of the spiritual experience it offers.

This conviction does not make a virtue out of pain or attribute any intrinsic value to suffering in itself. As Pope John Paul II observed, "Suffering is, in itself, an experience of evil" (Pope John Paul II, *On the Christian Meaning of Suffering*, St. Paul Editions, Daughters of St. Paul, Boston, 1984, no. 26, p. 44). Furthermore, the Rite for the Pastoral Care of the Sick points out: "Part of the plan laid out by God's providence is that we should fight strenuously against all sickness and carefully seek the blessings of good health, so that we may fulfill our role in human society and in the Church" ("Introduction," no. 3). When this is not possible, however, the power of faith permits us to find meaning in the experiences of suffering and dying and thereby transform them.

Both the terminally ill and their care givers can see through the eyes of faith that there is power in our deterioration, freedom in our dependency, hope in what appears to be defeat, and life on the other side of death. This vision does not come automatically. It often entails a struggle with periods of doubt and feelings of anger, loss, or abandonment. But with the help of compassionate care givers and the support of a community of faith, the dying are able to understand these paradoxes and draw on that capacity of their human spirit to "feel whole" in the midst of pain, frailty, and deterioration.

The Transformation of Suffering The true depth of the meaning of the incarnation and God's ultimate loving embrace of humanity is revealed in the cross. The ministry of Jesus tells us that God reaches into life to heal and to show mercy. The crucified Jesus tells us that God goes with us all the way through suffering even into death. But death does not have the last word; life does.

The resurrection of Jesus teaches us that God is stronger than death. God's love, revealed in Jesus, gives us the strength to hope for the fullness of life in God's kingdom, where we will find the dissolution of all suffering and the enjoyment of unimpeded dignity for all persons.

Suffering and death remind us that God's reign is not yet fully present. Creation, the incarnation of Jesus, his suffering, death, and resurrection all remind us, however, that we are sacred and intensely loved. Through these mysteries God

promises that we shall know a life that triumphs over death, a love that conquers death. These mysteries tell us, as well, that the terrible isolation of suffering and death is not final. The Risen One, surrounded by all the saints, goes with us, accompanies us into death, and invites us to participate in resurrection.

By seeing God's response to human suffering through Christ's love, and by sharing the mystery of his cross and resurrection, a dying person is enabled to overcome the sense of suffering's uselessness. Isolation and victimization can yield to peace and courage.

Based on the power of divine love to transform suffering and death from absolute evils to personal triumphs, the moral principles the Catholic Church upholds can provide a hopeful perspective for healthcare professionals who care for the dying.

MORAL AND PASTORAL PRINCIPLES

The Vatican "Declaration on Euthanasia" draws on the three principles that are the pillars supporting Roman Catholic teaching on conserving health and life—sanctity of life, God's dominion and human stewardship, and the prohibition against killing (Congregation for the Doctrine of Faith, "Declaration on Euthanasia," *Origins*, vol. 10, 1980, pp. 154-157).

Sanctity of Life The principle of sanctity of life states that each person is of incalculable worth and has inherent dignity because he or she is made in the image of God, redeemed by Christ, and called to share fully in the life of the triune God.

The inherent dignity of human life entitles each person to the same basic right to life regardless of age or condition. The value and dignity of human life are guaranteed because they result from God's creating and sustaining us by love, not because of our personal achievements or usefulness to others.

The proper respect for the sanctity of life lies between two extremes. One extreme is "physical vitalism," which advocates the absolute value of maintaining biological life regardless of other values, such as independence, loss of dignity, preventing pain, or saving resources. The other extreme is "utilitarian pessimism," which values life for its social usefulness and advocates ending life when it becomes frustrating, useless, or burdensome.

Between these two extremes, the Catholic principle of sanctity of life affirms that life is a basic good, but it is not an absolute one to be preserved at all costs. Physical life is a basic good because it is fundamental for achieving all other values, and furthermore it sets the limits for pro-

moting human well-being.

Two obligations flow from the sanctity of life principle: (1) the obligation to nurture and support life and (2) the obligation not to harm or destroy life. The sanctity of life principle therefore gives a strong presumption in favor of sustaining life. Anyone who would take life or fail to prevent death must have a very serious reason to warrant overriding the presumption.

Finding the balance between extremes and affirming the sanctity of life while coping with intense emotion are exceedingly difficult. A skilled care giver who shares the experience with the patient, the family, and medical experts can often offer both the perspective and the support needed to make appropriate decisions.

God's Dominion and Human Stewardship The principle of God's dominion and human stewardship acknowledges that we are creatures who owe our creation to God. Human responsibility for life is one of stewardship, not ownership. Absolute dominion is an exclusively divine prerogative. Yet our human glory is that we are not fated to be mere victims of biological forces, since we exercise responsible stewardship of our lives by going beyond our physical limitations, as well as consenting to them.

A care giver, attentive to the movement of God in a patient's life, can help the person recognize new spiritual possibilities for human well-being. By placing importance on spiritual understanding, we also encourage patients to make reasonable efforts to maintain life and to restore health. When patients avail themselves of treatments that they appreciate as a benefit, then they can live with hope that sees every moment, even moments of pain, fear, despair, or struggle, as occasions for growth.

But life and hope have reasonable limits to which each person must consent. Just as one must not sacrifice life as long as there is reasonable hope for its well-being, one also must not sacrifice hope when life has reached its reasonable limits. When the dying patient can no longer appreciate treatments as a benefit and creative living becomes impossible, then hope should focus on the eternal life after death.

No one should be expected to sustain this hope alone. Through prayer, sacraments, community presence, and physical care, the Church accompanies a seriously ill or dying person by exercising joint stewardship with that person for the life that belongs to God.

The Prohibition against Killing The prohibition against killing entails the obligation to protect life and the obligation not to destroy or injure human life directly, especially the life of the innocent and vulnerable. To clarify this principle, it is

necessary to examine the distinction between killing and allowing to die (see "Care of the Dying: A Catholic Perspective, Part II—Social and Political Context," *Health Progress*, April 1993, p. 18).

Necessary ethical considerations focus on whether the benefit to the patient from the treatment is proportionate to the burden he or she would endure.

We must avoid generalities that say *all* patients

IMPLICATIONS FOR CATHOLIC HEALTHCARE

People fear suffering and the losses that come with death. In the following ways, Catholic healthcare providers show they support people in their anxiety by helping them see death as a completion, not a termination, of life and by helping them find meaning in what seems meaningless:

- Death can be something that does not just happen to us but that arises from within to bring to fulfillment all that is valuable to us. In this spirit, Catholic healthcare providers must establish practices to help a patient transform the experience of dying from a mere ending of life to its personal completion.

- Suffering is personal and has no objective measurement. Care givers must make a special effort to pay attention to patients' claims of suffering and provide the medical, social, psychological, and spiritual resources that will help them bear their suffering.

- Suffering and death are not absolute evils to be avoided at all costs but can be transformed by identifying with Jesus' suffering, death, and resurrection. We need to include the resources of Christian faith—its stories, symbols, and rituals—in our total care of the dying.

- Catholic moral principles regarding the conservation of health and life do not promote physical life as the absolute good to be prolonged "at any cost." Catholic healthcare providers should advocate for specific policies that guide us in respecting a patient's limits as to what he or she can accept as beneficial treatment to avoid the burdens of overtreatment or undertreatment.

- The moral character of our communities gives true witness to our theological and moral convictions. Through our actions, we must give witness to being a virtuous community of interdependence, care, and hospitality.

- The ethos of individualism asserts that independence, not interdependence, is the key to human dignity. As Catholic healthcare providers, we must ensure we are committed to interdependent partnerships sustained by trust and honesty. Also, we must be catalysts for collaboration with other communities that care for the dying.

- The paradigm of curing has dominated the delivery of healthcare so that caring is reduced to the consolation prize for a cure that could not be attained. Catholic healthcare providers need to examine their overall style, plan, and goals of treatment to see whether the whole person is being treated and respected.

- Hospice care admirably embodies the virtue of hospitality. We must ensure we respect the multiple dimensions of a patient's total good, improve the conditions of dying, and reach beyond a patient to his or her network of support.

of a certain class (e.g., those in a persistent vegetative state) need not be treated, or *all* treatments of a particular sort (e.g., mechanical respiration) need not be used because they are always disproportionate. Rather, we must examine every treatment from the patient's perspective to determine whether it provides a benefit proportionate to the burden he or she will have to bear. If the reasonably foreseen benefits to that patient (e.g., cure, reduced pain, or restored consciousness and bodily functions) outweigh the burdens to the patient or to others, then the treatment is morally obligatory.

On the other hand, the treatment is not obligatory if it would be disproportionately burdensome or futile. A treatment is futile when it offers no probable hope of success to restore the patient to a state of reasonable well-being. Some guidelines suggest that treatment may be judged to be excessively burdensome if it:

- Produces excessive pain and suffering for the patient
- Is repugnant
- Impairs bodily functioning
- Suppresses consciousness
- Is too expensive for the patient, the family, or the community
- Requires an investment in technology or personnel disproportionate to the result
- Requires inequitable allocation of social resources

The burden-benefit principle makes no moral distinction between withholding or withdrawing life-sustaining treatment when its use is futile or would produce burdens disproportionate to the benefits the patient could appreciate. In these cases, there is no question of murder, suicide, or assisted suicide because the physical cause of death is ultimately the fatal disease or condition that suggested the use of such treatment in the first place.

Related to this discussion is the use of narcotics with the specific intention of relieving pain, even if it is foreseen that their use will shorten life. We can reasonably presume that most people would want to be kept free of pain, even if they do not explicitly say so. The effective use of narcotics to alleviate or to suppress pain is the prudent thing

Moral virtues

 must be reflected

 in ethical behavior

 and pastoral practice.

to do, even though these drugs may eventually cause loss of consciousness or a quicker death. In all cases, the use of pain relief should be under the patient's control as much as possible. The patient must decide what level of pain is tolerable and how much medication is beneficial.

Although these principles have served the Catholic community well in meeting our

moral responsibility to conserve life and promote health, they are not by themselves sufficient as a moral or pastoral response to the care of the suffering and dying. Moral virtues must be reflected in ethical behavior and in pastoral practice so that we may enact our Christian vision in the face of suffering and death.

MORAL VIRTUES AND PASTORAL PRACTICE

The moral character of our community embodies the truth expressed in our principles. Paying attention to our character and our ethical practices is of grave importance in these days when euthanasia and assisted suicide are being promoted so aggressively. Whether the Catholic community will be able to influence public opinion on these issues depends a great deal on the kind of community we become.

To carry on Jesus' mission by responding to human suffering and death, healing communities must embody virtues that bear convincing witness in both a personal and a corporate manner regarding the care of the dying. What kind of community should we be to help people face the end of their lives with a sense of completion rather than hastening their termination through lethal intervention? Three characteristics of a virtuous community stand out: interdependence, care, and hospitality.

A COMMUNITY OF INTERDEPENDENCE

One of the major features of our society, individualism, influences our attitudes and practices toward those who are suffering and dying. Individualism isolates people into islands of self-interest and thereby blunts their sense of social responsibility for the common good. Also, individualism asserts that independence, not interdependence, is the key to human dignity.

The challenge to the Catholic community in

the face of this cultural attitude is to care for the dying in a way that embodies the truth of interdependence. Catholic healthcare professionals must meet this challenge on two fronts, the personal and the corporate.

The Personal Front On the personal front, we must examine the character of relationships in our healthcare institutions. One value at the foundation of the Catholic healthcare mission is the belief that the healing relationship is a mutually redemptive experience. The commitment to healthcare embodies the general moral commitment to be partners with one another in an interdependent relationship sustained by *trust* and *honesty*.

Trust makes a therapeutic relationship possible. Patients trust that physicians will act in their best interests. Physicians trust that patients will accept their medical knowledge and skill as instruments that promote patients' good. Trust easily conflicts with the desire to be autonomous and to exercise absolute control over everything. The need for trust in the healing relationship is a clear reminder that we do not have control over everything and that we are interdependent partners who need one another.

Honesty comes easily when trust is secure. The healing relationship is held together by honest exchange, occurring not just once, but over and over again. The therapeutic process is often impaired because of deceptions.

Patients often put physicians in ethical binds because they fail to be honest in a number of ways. For example, patients are dishonest when they do not comply with their prescribed plan of treatment; when they fail to take preventive measures by developing unhealthy patterns of diet, work, and exercise; and when they ignore warning symptoms or hide symptoms by failing to express what they are experiencing and really want.

Physicians, too, must exhibit honesty in a number of ways, not the least of which is in seeking informed consent. Honesty requires clear and timely communication of the diagnosis, prognosis, risks, and benefits of possible treatments or nontreatments. Poor communication on the part of physicians is one of the most common causes of malpractice suits. Honest communication from physicians can enable patients to participate in making decisions about their lives and in carrying out their part in the treatment plan.

Pastoral care is governed by the same values of trust and honesty, not only between the care giver and the patient but also between the care giver and the medical staff. A pastoral care giver should not get caught between a patient and a healthcare professional or appear to take sides if

that relationship is not harmonious. On the other hand, a pastoral care giver can mediate differences and communicate information so that bonds are strengthened and better medical care is offered.

The Corporate Front Corporately, the Catholic healthcare community can give witness to the liberating and life-giving potential of interdependence by being catalysts for collaboration among other communities that have an interest in the care of the dying. Hospitals, parishes, schools, and religious organizations can be integrated into a comprehensive program of healthcare. Pastoral care departments and mission effectiveness committees could lead this outreach effort and provide an example of interdependence by doing so.

A COMMUNITY OF CARE

To be a community of care calls for a definite shift in the way we imagine the master plan for the practice of healthcare. Healthcare is governed, for the most part, by the paradigm of curing, propelled by a bias toward acute care, high-technology medicine. As the delivery of healthcare became more technologically resourceful, skilled technical intervention forced aside "human-touch" practices such as expressing concern for and keeping compassionate company with patients.

In many ways, we have adopted the standard medical model, where curing and crisis intervention are the major goals. Conscious of inappropriate moralizing in the past and relying on therapeutic techniques borrowed from psychology, even pastoral care givers often have felt they were on the outer edges of the healing process and have been embarrassed about discussing spiritual issues or praying with patients. Where this has been the case, healthcare has been delivered on almost exclusively medical terms without integrating pastoral care into the overall treatment plan. The increased public interest in euthanasia and assisted suicide draws our attention to the "curing" limits of medicine. We eventually wear out even if we do have access to a vast array of technical assistance.

The paradigm of caring allows us to realistically face the limits of our mortality and of our medical power with an attitude that does not despair. In this paradigm, "caring" is not the consolation prize for a cure that could not be attained, but it is integral to the style and plan of treatment of the whole person.

THE VIRTUES OF A COMMUNITY OF CARE

Caring Caring enables a person to enter another's life and through human empathy help make it more meaningful. In the case of the sick and dying, this might involve a cure, but more often

it means keeping company with a person during a difficult period of life.

True caring involves persistent presence, careful listening, and a willingness to enter deeply into another person's life to help carry the burden that person feels. A caring community can help a patient bear reasonable burdens that come as part of the limitations of being human. But when burdens become overwhelming, the caring community can base its actions on the Catholic tradition that maintains we are not morally obliged to bear burdens beyond our capacity.

Courage Courage is another virtue of a caring community, whose members "take heart" to stick through hard times, to take risks, to cope with tragedy. Courage empowers physicians to fulfill their covenant with society to act in the best interests of patients, even when doing nothing is the only thing left to do.

Courage also assumes proper responsibility for one's treatments. The fear of being trapped in unacceptable conditions of dependency and disability brought about by medicine's power to prolong dying encourages the movement toward euthanasia. Unfortunately, the healthcare community will continue to find itself making many more difficult choices unless patients exercise personal courage to control the way they will live and die.

If care givers could encourage patients to set limits on their own treatments and properly inform them how they might do this, through ongoing conversation with their physicians and families or even through the use of legal documents, then euthanasia would not be necessary as a means of ensuring their dignity and autonomy.

Perseverance Perseverance stretches the boundaries of courage and each person to proclaim: "I'll get through this; I'll hang in there." A persevering community stays with a person as long as necessary and does not crumble when the going gets rough, but taps into the reservoirs of trust—in God, in one another, in one's self—to draw on the strength of earlier times when confidence was high and self-esteem was secure. Perseverance makes possible doing and receiving the daily tasks of long-term care—activities such as eating, bathing, and toilet functions—without viewing

A caring community can help a patient bear reasonable burdens.

them as demeaning.

To do for others what they cannot do for themselves requires supportive emotional intimacy, commitment, time, and resources. Families sometimes pool their resources to persevere through long-term sufferings and finally the death of a loved one; and care givers are often the privileged supporters and affirmers of this grace in action.

Compassion

Compassion is the companion of courage and perseverance. It responds to the reality of suffering with supportive emotional intimacy and hope. In a world where suffering is real, compassion means to suffer with another. It pushes the boundaries of care further by allowing persons with a special kind of courage to be present even in the remotest corners of another's suffering. The Christian pastoral response to those who suffer is to keep company with them, to relieve what distress we can, but above all to assure them they do not suffer alone.

Humility Humility is necessary to deliver care without viewing any part of it as demeaning, and humility is necessary to receive care and to accept being dependent on others for those things which one cannot do for oneself.

Humility should not be confused with submissive servility, self-diffidence, self-hate, or infantile docility. Humility means being down to earth about ourselves. It is the gracious acceptance of ourselves as creatures and acceptance of God as creator.

Humility is a realistic and comforting response to our being mortal creatures, especially when shared in a community of humble people. When we have reached the limits of what we have and what we can do, humility speaks the truth: God is still there, on our side, passionately involved with us, loving each of us without end.

Patience Patience is the virtue closely allied to perseverance and humility. Yet patience is not a typical characteristic of the sick or of those who care for them. Patience demands taking control of ourselves when panic threatens to hurl us in all directions. Patience gets trivialized as a virtue when it is interpreted as pure passivity. Patience, as purposeful waiting, is based on the firm conviction that good will be victorious eventually, that suffering need not be futile, and that God

will prevail in the end.

But to be patient is not easy, especially in a culture that prizes immediate results and that accepts depression, despair, and sometimes even taking one's life as appropriate responses when things do not quickly turn in one's favor. Patience steers us on a different course. Patience invites us to remain courageous and confident in the hope that God cares, is at work righting the wrongs and healing all hurts, and will ultimately triumph.

Hope Hope, also allied to patience, is virtue tinged with defiance. Hope imagines what is possible, even in the face of limitation and death. It is rooted in the fundamental biblical truth that all possibilities for life and its future stem from the goodness of God.

Hope is the virtue that banks on the promises of Jesus Christ. One promise concerns the present: Whatever we have now on earth is not complete because it will be transformed by God. Another concerns the victory over suffering and death: Jesus conquered death and thereby gave us eternal life. Hope is a resilient virtue that enables the healing community to carry on its mission of proclaiming the nonfinality of death and the transformation of suffering.

A community of care might inspire hope by providing a framework of spirituality that gives meaning and hope to the aging so that suffering and decline have purpose in life. Unlike our culture, which supports the notion that human fulfillment is the product of relentless activity in the world, our spiritual tradition values letting go of earthly life and preparing the self for eternal life. Also, one of the foundations of the Catholic spiritual tradition is that suffering, when accepted for loving reasons, has redemptive meaning.

A COMMUNITY OF HOSPITALITY

Becoming a community of interdependence and care is activated by hospitality, offering people the warmth of a welcoming response when they are away from their homes.

One of the ways hospitality is being provided today is through hospice care. Hospice is an institutional response for relieving pain in the clinical setting. The purpose of hospice care is to create an environment in which one maintains the best quality of life possible while dying peacefully, without actively prolonging life or hastening death.

Three characteristics of hospice satisfy many of the requirements for the virtue of hospitality. It respects the multiple dimensions of the patient's total good; it improves the conditions of dying; and it reaches beyond a patient to his or her network of support.

Respect for the Patient's Total Good First, hospitality improves the quality of mercy we extend by attending to the patient's total good. We must respect the reciprocal relationship of the physical and spiritual dimensions of the patient as an "embodied spirit," or "inspired body."

If healing is to address the whole person, then pastoral care is as essential to treatment as are the interventions provided by other healthcare professionals. Pastoral care in a community of hospitality must be an integral part of the treatment plan and must be delivered with the same competence that is expected from all other healthcare professionals.

The challenge is to treat the dying person not only as a patient with physical symptoms but also as a person needing love and seeking a sense of significance. The hospitable community of faith can share stories and insights from the Christian tradition to assure the dying that their lives are not meaningless and that they are not suffering alone. Pastoral care givers especially can be the companions who enable the dying to reach into their own experiences of life and into their tradition of faith to find comfort and meaning.

Often, telling their stories becomes a way for dying persons to acknowledge that their time in this world has made a difference. By describing what they accomplished in life and what they found meaningful or fulfilling, as well as what made them (and others) happy, the dying are able to discover how they want to be remembered. In this way they are able to see concretely that their love has not been lost in the lives of those they touched.

The pastoral care giver can suggest ways to interpret these memories by sharing images of faith. Reflecting on the Scriptures, for example, can enable patients to see how their lives reenact God's saving history and what contribution they have made to God's purposes. In the same way, a pastoral care giver can help dying patients connect their suffering to that of Jesus and thus become witnesses of the transforming power of God in their lives.

Improvement of the Conditions of Dying The second characteristic of a hospitable community is that it improves the conditions of dying. Hospice care focuses on comfort rather than on cure. The importance of controlling symptoms includes managing pain, nausea, vomiting, and other reactions as effectively as possible. Preventing pain before it begins rather than administering pain relief as needed, for example, would be one of the main features that sets a community of hospitality apart from any other hospital community.

One dimension of pain is loneliness. Suffering, as life ends, is exacerbated for some if they are

unable to form and to sustain relationships of meaning and value. Care givers can support these relationships, while a community of faith can amplify them through its symbols, stories, and rituals.

Spiritual and religious support systems are extremely important to people facing death. In the Catholic tradition, the most powerful resources are prayer and ritual, especially the thoughtful celebration of the sacraments. Prayer makes explicit and personal the community's relationship to

dying persons. It brings to consciousness God's presence and allows patients to express anguish and fear, as well as hope and love.

The Catholic tradition has long affirmed that sacraments are of great importance in a life of faith; they are a privileged means of heightening our experience with God's love. The Eucharist is at the heart of the Church's life as a profound encounter with the Risen Lord. The Sacrament of Reconciliation, which restores harmony with self, others, the environment, and God, can help patients:

- Repair broken relationships
- Heal the soul
- Become reintegrated into the community of faith
- Feel a sense of forgiveness often needed to face the crisis of dying.

The Anointing of the Sick reflects God's compassion to strengthen the body and soul so that the sick will not lose faith or hope but be at peace with God, others, and themselves during their illness.

A Patient's Network of Support The third characteristic of a hospitable community is that it reaches beyond the patient to include his or her network of support—family and care givers. A lack of support for those who have to spend endless hours caring for terminally ill patients is a factor that makes euthanasia an attractive way to bring relief not only to the dying but to those who care for the dying as well.

The responsibility to be hospitable challenges care givers to look for opportunities to provide:

- Relief help for those caring for the sick so they can deal with other affairs of their lives

Hospitality

.....
improves the quality

.....
of mercy we extend

.....
by attending to the

.....
patient's total good.

- Good advice on how to access services that provide financial support

- Temporary housing, if necessary, so families can stay together and be responsible for each other's well-being while remaining close to the one who is dying

Hospitality also includes providing pastoral care staff and others to help survivors celebrate the story of their loved one by telling those parts of the story the dying person could not tell. It means listening compassionately to

the shock, anger, mistrust, and hatred survivors feel lest it overwhelm them and lead to depression and despair. Also, support groups for those who are trying to cope with the death of a loved one can be helpful, because they provide a comfortable place to clarify stories and to reconcile and heal what still needs to be mended.

When each member of the care team contributes according to his or her particular talents, he or she meets the multidimensional needs of patients and their families. In addition, adequate response to the dying will mean that the church must be linked closely with dying patients and healthcare institutions. Pastoral care services may be the important link in this network of interdependence that upholds basic values and sustains the communication necessary for everyone to work as partners along this final phase of life's journey.

A VIRTUOUS COMMUNITY

By being a virtuous community of interdependence, care, and hospitality, the Catholic community gives witness to the convictions that lie behind the arguments we use to oppose the practice of euthanasia.

By virtuous living we may enhance patients' sense of worth, meaning, and belonging while alleviating some of their fears. In this way, the Catholic community may be able to address many of the concerns that motivate people to consider euthanasia. By offering principled, rational arguments against euthanasia and assisted suicide, we can shape public consensus toward death as an experience we need not hasten through lethal intervention. □