

The Church and Palliative Care

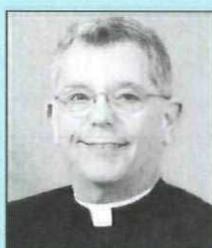
BY FR. MICHAEL D. PLACE, STD

I am writing this on a flight home from Rome, where I attended the 19th International Conference of the Pontifical Council for Health Pastoral Care. Before and after the conference, the continental delegates who constitute the board of the International Federation of Catholic Health Associations (AISAC) met. I will begin with a few observations on the AISAC meeting and then turn to the conference's subject: palliative care.

AISAC

A regular component of the AISAC agenda is a report by each delegate on the condition of Catholic health care in his or her part of the world. For me, it is always an opportunity to expand my appreciation of the rich and diverse nature of the ministry across the world. Although these reports are never short on problems, this year's reports were quite sobering. While there was great variety in the specific matters discussed, the general conclusion was that Catholic health care was experiencing a time of significant challenge to its ability to maintain its identity.

As a result of our discussion, it was agreed that two of the delegates will prepare a "basic text" (we Americans would most likely call it a "white paper") that would, first, characterize the themes common to the international experience of the health care ministry and, second, outline some initial opportunities for collaboration. Reflecting on our conversations, I would expect the "basic text" to consider health issues, such as the pandemic of HIV/AIDS; delivery issues, such as the cost of pharmaceuticals; economic issues associated with the increasing commodification of health care delivery; public policy issues resulting from the increasing cost of health care and the desire of many governments to realign existing government responsibility for supporting access to health care services; ecclesial issues, such as relations with bishops and episcopal conferences; leadership issues often associated with the changing demographics of religious life; and structural



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issues concerning the best ways to organize and manage the ministry civilly and ecclesially.

Although it will not be easy to provide coherence to the dimensions of these issues, all of which are held in common, it will be still more difficult to discern the "value added" opportunities for common or shared activities. The possibility of such activity will not be new to Catholic health care in the United States. We are aware of the activities of Catholic Relief Services and the Catholic Medical Mission Board. In addition, within the ministry, there is the Catholic Consortium for International Health Care, a U.S.-based effort to support health care in the Third World. Many institutions and systems also provide opportunities for medical "missions" to various nations. At issue now will be whether, in addition to these activities, there will be other opportunities for international solidarity within the ministry. Stay tuned!

PALLIATIVE CARE

Now to the International Conference: The attendance at this year's meeting was significantly higher than in recent years. There also were more practitioners, particularly nurses, from across the world. Clearly, the topic addressed a very real need.

As I reflect on two and a half days of talks (dialogue was not part of the conference agenda), there are three aspects, among the points of discussion, that I would like to highlight.

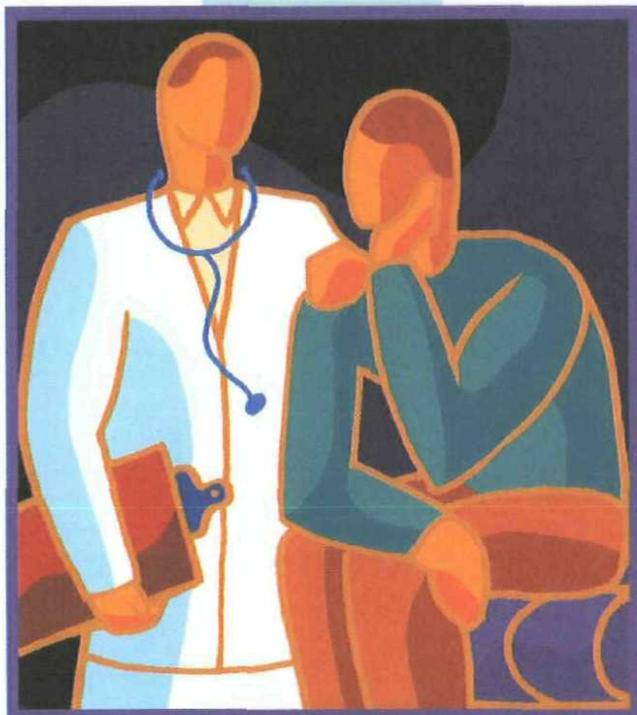
Consensus Regarding the Challenge Unlike some international meetings, in which much time can be spent debating definitions and defining the problem, this meeting got quickly down to business. One explanation for this clarity is the significant role the World Health Organization (WHO) plays in much of the world. While we Americans tend to rely on our federal health agencies for expertise and guidance, much of the world—most especially developing nations—rely on WHO. For WHO, increasing access to palliative care is an international priority.

What I found quite interesting was the holistic approach to palliative care taken by WHO and others. Palliative care is commonly understood to include the improvement of quality of life on the part of a patient and family facing life-threatening illness through the relief of suffering by addressing the physical and psychological needs of patient, family, and caregivers. Palliative care's focus also goes beyond death to include bereavement. Though this expansive definition would not include control of pain not associated with life-threatening illness, conference speakers proposed that tens of millions of persons across the globe would benefit from palliative care. In fact, one speaker argued that *few* people who need palliative care actually receive it.

As for why this is the case, the international analysis, as summed up by conference speakers, was strikingly similar to what advocates of palliative care in the United States speak of as barriers: lack of political support, social prejudices, the size of the affected population, limited health care resources, deficiencies in the training of health care professionals, and legal and regulatory barriers to providing medications—especially opioids.

In considering these barriers, a speaker proposed that the effective provision of palliative care should be viewed as a public health problem that requires a comprehensive, population-based solution. Components of such a comprehensive approach would include influencing government policies and priorities, developing and providing effective educational and training programs, making needed medications available, and providing home-based care.

In light of our Fall Member Strategy Sessions, I found the framing of the issue as a public health problem to be quite provocative. While it is not clear how your board will prioritize our strategic and transformational activities for the next three years, board members are aware that the challenges facing aging services and palliative care arose in all three sessions. Whether palliative care becomes a signature activity for us as national ministry gathered and engaged, it already is a pri-



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ority for many in the ministry. Perhaps some of the international discussions will be of help.

A Theology of Pain and Suffering Not surprisingly, the conference devoted some attention to how we, as believers, approach the reality of pain and suffering.

The intent was not to minimize the importance of palliative care, but, rather, to highlight the fact that, even if all people in need of palliative care were to receive it (and, as we know, they do not), the reality of pain and suffering would remain. This means that, for the believer, at least two fundamental faith questions will arise: Why do I experience pain and suffering if my God loves me? What is the spiritual meaning for that pain and suffering?

Although Pope John Paul II has provided a contemporary perspective on pain and suffering in his apostolic letter *Salvifici Doloris*, I would dare to suggest that we lack a coherent contemporary pastoral understanding of pain and suffering. Although the acute care clinical setting is

not the most apt environment for presenting a catechism on pain and suffering, such a setting would be enriched by an ethos that could help caregivers explain, to some patients, what medicine is *not* able to do for them, and, to other patients, why medically successful outcomes do not *always* eliminate pain or suffering. Such an ethos might be even more helpful in our continuum of care services, where caregivers tend to have contact with those they serve for longer periods of time. Pastoral care certainly has responsibilities in this area, but, I would suggest, a theological understanding of pain and suffering is central to the mission of Catholic health care itself. How we might go about gaining such a pastoral perspective is a provocative challenge.

Sacrament of the Sick and Palliative Care Another of the conference papers reflected on the Sacrament of the Sick and palliative care. Perhaps because of my personal interest in liturgy and my theological training, I was particularly impressed by the theological and pastoral dimensions of this presentation. In listening to it, I was reminded of the support CHA provided the National Association of Catholic Chaplains for a project on the Sacra-

ment of the Sick, which included dialogue with diocesan bishops. While I know that the resources developed for this initiative were quite good, I do not know what impact they have had in the acute care setting. I know even less about their impact on the continuum-of-care setting. Perhaps this is another topic we could pursue. Earlier I posed questions about the meaning or spirituality we bring as we provide palliative and other care; we also could benefit from discussing what prayer we bring as a sacramental people.

Without entering into that discussion here, I would like to share an evocative image. One of the components of the rituals associated with the Sacrament of the Sick is Viaticum. Intended for the person who has entered the final stage of the dying process, Viaticum can include the celebration of the Sacrament of the Sick, but it also includes reception of Holy Communion and the community of faith's final blessing. While I have often heard of receiving the Eucharist described as "food for the journey," at the conference I heard about an image that was new to me: "In the celebration of Viaticum, we commend the person for whom and with whom we pray from our loving embrace to the loving embrace of an 'eternal family.'" As I heard that description, I wondered how many patients in acute care or the continuum of care had that image available to them. If they did, what difference might it make?

A PAPAL ALLOCUTION

In drawing this column to a close, let me offer a relevant excerpt from John Paul II's allocution to the conference:

4. True compassion, on the contrary, encourages every reasonable effort for the patient's recovery. At the same time, it helps draw the line when it is clear that no further treatment will serve this purpose.

The refusal of *aggressive treatment* is neither a rejection of the patient nor of his or her life. Indeed, the object of the decision on whether to begin or to continue a treatment has nothing to do with the value of the patient's life, but rather with whether such medical intervention is beneficial for the patient.

The possible decision either not to start or to halt a treatment will be deemed ethically correct if the treatment is ineffective or obviously disproportionate to the aims of sustaining life or recovering health. Consequently, the decision to forgo aggressive treatment is an expression of the respect

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that is due to the patient at every moment.

It is precisely this sense of loving respect that will help support patients to the very end. Every possible act and attention should be brought into play to lessen their suffering in the last part of their earthly existence and to encourage a life as peaceful as possible, which will dispose them to prepare their souls for the encounter with the heavenly Father.

5. Particularly in the stages of illness when proportionate and effective treatment is no longer possible, while it is necessary to avoid every kind of persistent or aggressive treatment, methods of "palliative care" are required. As the Encyclical *Evangelium Vitae* affirms, they must "seek to make suffering more bearable in the final stages of illness and to ensure that the patient is supported and accompanied in his or her ordeal" (n. 65).

In fact, palliative care aims, especially in the case of patients with terminal diseases, at alleviating a vast gamut of symptoms of physical, psychological and mental suffering; hence, it requires the intervention of a team of specialists with medical, psychological and religious qualifications who will work together to support the patient in critical stages.

The Encyclical *Evangelium Vitae* in particular sums up the traditional teaching on the licit use of pain killers that are sometimes called for, with respect for the freedom of patients who should be able, as far as possible, "to satisfy their moral and family duties, and above all . . . to prepare in a fully conscious way for their definitive meeting with God" (n. 65).

Moreover, while patients in need of pain killers should not be made to forgo the relief that they can bring, the dose should be effectively proportionate to the intensity of their pain and its treatment. All forms of euthanasia that would result from the administration of massive doses of a sedative for the purpose of causing death must be avoided.

To provide this help in its different forms, it is necessary to encourage the training of specialists in palliative care at special teaching institutes where psychologists and health-care workers can also be involved.

Hopefully, the pope's reflections will be helpful to the ministry and, in particular, to those who work in palliative care. □

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