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Peter J. Cataldo
Dan O'Brien *Editors*

Palliative Care and Catholic Health Care

Two Millennia of Caring for the Whole Person

Foreword by Ira Byock

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***In Memoriam**:*

Pope St. John Paul II and Joseph Cardinal Bernardin, beloved and appreciated for teaching us all how to die well.

Foreword

The Catholicity of Caring

This anthology is a worthy contribution to the literatures of both palliative care and Catholic health care. Editors Peter Cataldo and Dan O'Brien, scholars of Catholic theology and clinical ethics, have recruited recognized experts to address key issues of caring for people through the end of life. While the editors' and contributors' perspectives are anchored in the history and principles of ethics and therapeutics, their reasoned insights illuminate today's headlines. As a result, this collection will advance the ongoing debates related to health-care ethics, policy, and systems reform.

I come to this book as a palliative care physician who has long been interested in the origins and evolution of communal responses to illness and dying. It was, therefore, no surprise that I was enthralled by its content and agree, as this volume effectively shows, that palliative care and Catholic health care are highly aligned. They share values of service, clinical excellence, compassion, and respect for vulnerable people's dignity and worth. Admirable, but hardly unique. Are not these same values held by countless health-care professionals across every specialty and organization? I firmly believe they are.

The relation of palliative care and Catholic health care is well worth examining; yet, time and again, while reading the analyses and arguments within this book, I found myself thinking that what was being discussed was just good care.

I've had similar reveries before. Sometimes, while poring through a published report of a health-care innovation or quality improvement initiative, the categorical distinctions between the professions, delivery systems, and specialties of health care dissolve before my mind's eye like smoke, and what remains, starkly apparent, are the basic elements of human caring. In those moments, I reflect on what we know of our early forbearers. Millennia before there were religions and professions, priests or doctors, human beings were caring for one another.

Of course, caring is an impulse shared by many species. Most animals, and all mammals, care for their young. However, human babies and toddlers are utterly

dependent and vulnerable for far longer than youth of other species. Other mammals also tend to their injured and ill. But here again, *Homo sapiens* are unique in being able to devote so much effort, over prolonged periods of time, tending to their most frail and dying members. It is part of what makes us human.

Earliest humans lived in tribes and rudimentary communities. Communal bonds were most evident in times of danger. When hurricanes or blizzards threatened people's lives, they turned to one another to weather the storm. Primitive people instinctively knew that the safest way to get through the most difficult and dangerous situations was *together*. It felt natural and right to do so; it would have felt unnatural, unwise, and wrong not to look after each other.

The biologist in me would say that primates evolved to look after one another; it was a survival trait. Caring was written in our genetic code before being etched in Biblical commandments and covenants. As a Jew, I came to understand the Abrahamic covenant to mean that we belong not only to God but also to one another. Whether one considers it the result of evolutionary pressures or God's will, it is indisputable that we humans matter to one another.

Two corollaries to this basic fact of life are foundational to the ethics and practice of caring. First, it is natural for people to live *in community* with one another, rather than merely in proximity to one another. Second, within human communities, social responsibilities and self-interests are intertwined. In a healthy human society, your well-being matters to me – and my well-being matters to you. I cannot be entirely well if you are suffering. Humans come to each other's aid in times of need, not merely because they were taught that it is the right thing to do but also because it would feel unnatural and unhealthy to do otherwise.

Love Has a Lot to Do with It

To this point, I've described human behavior in objective terms, as observed reality. In understanding the origins of caring, it is also important to understand the subjective reality of what people *feel* at times of their own or another's need. Emotionally, the primal human drive to come to the aid of others is love. This statement is not an assertion, nor a romantic, philosophical notion. It is, instead, a description of the synthesis of findings from the sciences of anthropology, ethology (animal behavior), neuroanatomy, functional brain physiology, and brain chemistry. Within the physiological substrate of *Homo sapiens*, the instinct of "mattering to one another" is subjectively experienced as a deep filial affinity. In plain speak, love.

In contemporary ethics and health care, love is infrequently discussed as a motivation for human caring. I suspect this reflects an unspoken assumption among clinicians and ethicists that basing academic discussions on emotional drivers of behavior, particularly love, risks appearing nonscientific. It is, however, an inarguable fact of human life that people have an intrinsic need to love and feel loved (Lewis et al. 2001).

Love May Not Be All We Need; But It Is Essential to Human Well-Being

Experienced clinicians recognize that even in the context of significant physical discomfort or social deprivation, subjective fulfillment of love can engender a profound sense of well-being. Conversely, even in the context of physical health and social privilege, feeling unloved can engender profound suffering – as can being frustrated by one's inability to express love. In early life, a paucity of love gives rise to failure to thrive, which can be lethal in spite of fully adequate nutrition and hygiene (Spitz 1945; Harlow and Mears 1979). So too, during the normal dependency that often accompanies late life, an absence of love can make life not worth living (Byock 2004; Thomas 1996).

Recognizing love as essential to human well-being and as the motivation of service integrates biological, philosophical, and theological lines of thought and underlies the catholicity, or universality, of caring ethics and practice. The story of Abraham in the Old Testament emphasizes the covenant with God that binds people in community. In the New Testament, Jesus went further in emphasizing love as the most authentic emotion and response to human suffering and service as the healthiest manner of expressing love to one another within community.

In antiquity, love and service gave rise to the caring professions of medicine and ministry. Thankfully, these highest of impulses remain driving forces within health care in contemporary times.

The Basics of Human Caring

The basics of human caring are not confined to any profession. The rudimentary elements of service to a person who is seriously ill, injured, or aged are held collectively. Providing shelter from the elements, offering of food and drink, helping with elimination, and keeping company need not be delegated. Instead, in a healthy community, people say to an ill person in fellowship, "We will keep you warm and dry. We will help you to eat and drink. We will help you with your bowels and bladder. We will keep you clean. And we will accompany you in your time of need."

Contemporary health care complements these basics by providing treatments to counter the effects of trauma and disease, curing and preserving life and function when possible, and comforting always. Although excellent health care is obviously important for providing the benefits of medical science and technology to a person who is seriously ill, it is not sufficient. Essential components of human caring are more important still. In fact, they define fundamental social responsibilities, responding to our instinctual obligations, as well as the core teachings of our faith traditions. Yet, these elemental components represent the minimum obligations rather than the full potential of human caring.

Beyond the Basics

While by no means exclusive to Judaism or Christianity, nor any health-care discipline, to my mind, palliative care and Catholic health care are distinguished in contemporary Western society by the emphases they place on inherent human dignity and worth and by the extent to which they consciously embrace values of love, service, and community. While mainstream health care is largely defined by the transactional diagnostic and therapeutic services it brings to patients' medical problems, Catholic health care and palliative care advance relation-based models of service. They stand out in contemporary health care by seeing each patient as a whole person, who deserves not only competent diagnostic and therapeutic care but also comprehensive attention to his or her bodily comfort and functional capacities as well as his or her emotional, interpersonal, social, and spiritual well-being.

Ethicist Laurie Dorfman observed the remarkable potential of this relational mode of caring, "The blessings of friendship in the human endeavor, the responsibility for the bearing of collective burden of the ill and the vulnerable, must be borne by the theology and purpose of the faith communities. That each of us will die is inevitable; what must come to be understood as miraculous is our ability to love and bear the weight of the dying in fellowship" (Zoloth 1993).

In meeting each seriously ill patient as a whole person, our basic responsibility to keep company expands to encompass the *response-ability* to bear witness. Beyond providing for the biological necessities of life and competent medical care, in fellowship we say to each person whose life is threatened, "We will bear witness to your pain and sorrows, your disappointments, as well as your accomplishments. We will listen to the stories of your life and will remember the story of your passing."

This perspective enables clinicians to recognize the potential for human development persists during illness, debility, dependence, and dying. Beyond the basic obligations we have to our fellow beings, our *response-abilities* extend to preserving opportunities for people to grow – individually and together – through the end of life. Death is inevitable; however, forgiveness, reconciliation, and healing all continue to be possible. Years ago in my palliative care practice, before concluding a review of a patient's symptoms and concerns, I learned to ask, "And how are you within yourself?" In listening to the responses to my questions, I discovered that people can remain or become well in their dying. This fuller understanding of the human condition engenders a more complete concept of beneficence which aspires to preserve opportunities for people to flourish within their families and communities through the very end of life (Byock 1997).

Non-killing

It is sadly ironic that within contemporary debates of health-care ethics and policies, Catholic health care and palliative care are most commonly recognized for honoring the core principle of non-killing. To my mind, here again, these ethics seem catholic

in the sense of being universal. Non-maleficence and non-killing were among the first principles of medicine and, even where it is legal, the proscription against killing applies to all of health care today (Miles 2005). It is worth recalling that Dame Cicely Saunders and the other founders of hospice and palliative care specifically reaffirmed non-killing was a core principle of the specialty (Saunders 1984; Twycross 1996; Byock 2009). The World Health Organization explicitly stated within its first definition of palliative care that the specialty neither hastens nor prolongs dying (WHO 1990).

It is true that articulate voices within health care, including even some within Catholic and palliative care, advocate for "medical aid in dying"; however, the intentional ending of human life remains beyond the scope of legitimate health care practice (Byock 2016). Even in jurisdictions in which physician-assisted suicide or euthanasia have become legal, the vast majority of professionals within Catholic health-care and palliative care programs respectfully and lawfully decline to participate.

Conclusion

Although it may be a shared opposition to physician-hastened death that makes us exceptional in the eyes of proponents of such practices, it is *what we are for* that truly sets both Catholic health care and palliative care apart. What makes us exemplary within contemporary health care is our intention to go beyond the basics, to meet each patient as a whole person, within their family and community, accepting each as inherently worthy and dignified, deserving of our knowledge and technical skill, but also our love.

These attributes of Catholic health care and palliative care affirm the healthiest of human drives and core tenets of our faith traditions. In our commitment to care for others expertly, as well as tenderly and lovingly, we evince the fullness of human life, the highest therapeutic principles, and, in so doing, we complete the covenant inscribed within our genetic code and Biblical commandments.

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Acknowledgments

We dedicate this book to the memory of Pope St. John Paul II (*d. April 2, 2005*) and Joseph Cardinal Bernardin (*d. November 14, 1996*) who, each in his own way, taught us much about how to live and how to die. Pope John Paul died at home of sepsis, after several years of struggling with Parkinson's disease and after a long and profound pontificate. Cardinal Bernardin died at home as well, of pancreatic cancer, spending his last days writing to the United States Supreme Court against assisted suicide. Each man died consistent with how he lived: confident in God's grace and mercy. Both, in their own unique ways, died exactly how they lived and preached: deeply dedicated to the truth that life was worth living, and worthy of our deepest respect. One can also make the case that these leaders profoundly influenced each other's teachings and writings. Both were deeply committed to the sacredness and inherent dignity of every human life. They taught that human dignity is the common thread of our existence, which connects all life issues and places a moral burden on all society to promote and protect its members – especially its most vulnerable – and to address the structures of injustice that stand in the way of peace, reconciliation, and human flourishing.

Pope John Paul is particularly known for his encyclical *The Gospel of Life* (published on March 25, 1995) and Cardinal Bernardin for his *Consistent Ethic of Life* thesis (first introduced at Fordham University in the Gannon Lecture on December 6, 1983). Some people held these two men and their teaching in opposition, as though they represented competing ideologies. Nothing can be further from the truth. In fact, both pointed to the Second Vatican Council, in its *Pastoral Constitution on the Church in the Modern World*, as providing the foundation and the key hermeneutic for understanding the common source of their teaching:

> Whatever is opposed to life itself, such as any type of murder, genocide, abortion, euthanasia, or willful self-destruction, whatever violates the integrity of the human person, such as mutilation, torments inflicted on body or mind, attempts to coerce the will itself; whatever insults human dignity, such as subhuman living conditions, arbitrary imprisonment, deportation, slavery, prostitution, the selling of women and children; as well as disgraceful working conditions, where people are treated as mere instruments of gain rather than as free and responsible persons; all these things and others like them are infamies indeed. They poison

> human society, and they do more harm to those who practice them than to those who suffer from the injury. Moreover, they are a supreme dishonor to the Creator. (*Pastoral Constitution on the Church in the Modern World*, *Gaudium et Spes*, 27, December 7, 1965)

These various offenses against human dignity identified by the Second Vatican Council demonstrate that the dignity of the person is a seamless garment, and, therefore, so is our respect for human life.

How we treat our most vulnerable members of society, our brothers and sisters, is a testament to or an indictment against our humanity. And so each of us here, in this volume, has, in our own words, shown why the work of palliative care is not only consistent with the Church's long history of care for the most vulnerable and poor among us, but is an essential characteristic of the care we ought to provide in response to suffering persons if we are truly committed to a consistent ethic of life.

This volume had its origins a number of years ago from two distinct but interrelated lectures that we delivered. We were convinced that the eight domains of palliative care, so widely recognized, were also consistent with the Church's understanding of compassionate care for the seriously ill and dying and with the inherent dignity of the human person. We began sharing an idea for a book with this thesis, with our friends and colleagues in Catholic health care, and in the larger medical community. We are deeply grateful for the contributions to this book made by our colleagues. The pages of this volume are graced with their wisdom which will be of great benefit to its readers.

This volume tells a story. It is the story of love, care, and compassion that connects us to each other, that lifts up our spirits, gives hope to the hopeless, and restores and reconciles people with each other's humanity. It is the story of palliative care and Catholic health care.

Renton, WA, USA — Peter J. Cataldo
St. Louis, MO, USA — Dan O'Brien
February 2, 2019

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Chapter 1
Introduction

Peter J. Cataldo and Dan O'Brien

Christianity is aptly described as a religion of healing. Healing the human person permeates every aspect of the Christian faith: in its sacramental life and in its moral and social vision of the human person and society. The healing essence of Christianity is grounded in its understanding of and faith in Jesus Christ as the one who brings total healing– in an integrated way – to individuals and societies, and to the world. Throughout its history, Christianity has adopted the model of Jesus' healing ministry by extending that ministry to all dimensions of the human person: physical, spiritual, emotional, moral, and social. Even with a cursory reading of the healing accounts in the Gospels, one can readily see that Jesus healed *whole* persons. Whether touching the body or the spirit of a person, he ministered to every aspect of their brokenness. The holistic character of the healing ministry of the Christian faith is paralleled in modern concepts of palliative care. For example, the Institute of Medicine defines palliative care as

> Care that provides relief from pain and other symptoms, supports quality of life, and is focused on patients with serious advanced illness and their families. Palliative care may begin early in the course of treatment for a serious illness and may be delivered in a number of ways across the continuum of health care settings, including in the home, nursing homes, long-term acute care facilities, acute care hospitals, and outpatient clinics. Palliative care encompasses hospice and specialty palliative care, as well as basic palliative care. (2015, p. 27)

The Institute of Medicine explains that this definition of palliative care incorporates the essential elements of other well-known definitions, all of which explicitly or

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implicitly recognize the multiple needs of persons and their families that are addressed by palliative care, including physical, spiritual, psychological, emotional, and social needs (2015, pp. 58–59).

The healing mission of the Christian faith may also be described in terms of serving human dignity. For the Christian faith, human dignity is derived from the fact that the human person is created in the image and likeness of God, which, as the *Catechism of the Catholic Church* explains, makes each and every human life sacred, "because from its beginning it involves the creative action of God and it remains forever in a special relationship with the Creator, who is its sole end" (n. 2258). According to the Christian tradition, the locus of human dignity in a person is the spiritual and immortal soul from which are derived the powers of intellect and free will. With these powers, the human person, in and through the body-soul unity (*corpore et anima unus*), is able to know truth, choose wisely, and direct her or his physical, spiritual, emotional and social well-being. In this understanding, human dignity is not something that can be bestowed on a person by others, nor is it simply an instrumental value that can be manipulated by the individual or by society. Rather, human dignity is an intrinsic reality that is fully present in every human being by the simple fact of being human. Human dignity therefore is not reducible to the particular circumstances of a person's life. Even though a person can be neglected and harmed or esteemed and valued by others, his or her inherent dignity—in the sense understood here—cannot be lost, diminished, or eliminated as a result of such circumstances. Recall John Merrick's famous line from the 1980 film, *The Elephant Man*, "I am not an elephant! I am not an animal! I am a *human being*! I am a man!" From the perspective of Christian faith, the physical, spiritual, emotional, and social aspects of human dignity are integrally bound together within the human person. This fundamental unity of the body and the spiritual, immortal soul is what makes the individual person a human being (*Gaudium et Spes*, n. 14).

It is this view of human dignity and the unity of the human person that has informed the Catholic tradition in healing—and so palliative care—for two millennia. The unity and intrinsic dignity of the patient as a human person is at the core of both the Catholic approach to palliative care and of palliative care in general. Recent papal teaching has reaffirmed this truth about palliative care. Reflecting on the meaning of the word, "health," St. John Paul II captured its integral nature when he wrote that: "the word is intended to refer to all the dimensions of the person, in their harmony and reciprocal unity: the *physical, the psychological,* and *the spiritual and moral* dimensions" (St. John Paul II 2005). Pope Benedict XVI often cited the social obligation to provide palliative care and recognized its integral nature: "It is necessary to maintain the development of palliative care that offers an integral assistance and furnishes the incurably ill with that human support and spiritual guide they greatly need" (Pope Benedict XVI 2007). Pope Francis, likewise, speaking in the context of palliative care for the elderly, describes palliative care as "truly human assistance," as meeting the needs of patients, as "appropriate human accompaniment," and as valuing the person (Pope Francis 2015). In all these accounts of palliative care, the popes have recognized that the holistic, unified approach to care in palliative care corresponds to the unity and dignity of the human person.

This holistic view of human dignity and whole-person care in the Catholic tradition is also paralleled in the historical development of modern hospice care. Dame Cicely Saunders, the founder of the modern hospice movement, developed the notion of "total pain experience." In 1963, Saunders asked a patient to describe her pain. Through her answer, Saunders recognized that a sufficient understanding of the experience of pain must be inclusive of multiple elements. She recounted that within one answer the patient had identified, "physical, emotional and social pain and the spiritual need for security, meaning and self-worth" (Saunders 2000). The multidimensional nature of total pain reflects the integral unity of the human person, which is at the center of the Catholic understanding of palliative care.

Since the opening of St. Christopher's Hospice by Cicely Saunders in 1967, and later the opening of the first U.S. hospice in Connecticut in 1974 by Florence Wald, there has been a steady growth and acceptance of palliative care in the United States. The Institute of Medicine reports in its *Dying in America* that by 2011, 67% of hospitals with at least 50 beds had palliative care programs. Among hospitals with more than 300 beds, 85% had palliative care programs (2015, pp. 63–64). As of 2011, 45% of individuals who died in the United States were under the care of hospice at the time of death, and in 2012, there were 5500 hospice programs (some with multiple programs per entity) in the U.S. with a (mean) average daily census of 149 patients (2015, pp. 60–61). As of 2013, 90% of Catholic hospitals with 50 or more beds reported that they had palliative care programs, and among Catholic hospitals with 300 or more beds, 95% reported having palliative care programs (Dumanovsky et al. 2016, pp. 6–7). Such statistics indicate in a concrete way Catholic health care's commitment to palliative care and the fundamental compatibility between the Catholic vision of the human person and palliative care.

The aim of this volume is to show how the integral and holistic character of palliative care parallels Catholic moral teaching and tradition on health care and the Catholic vision of the dignity and unity of the human person. To this end, the book brings together experts in medicine, (including palliative medicine), moral theology, bioethics, spiritual care, palliative care services, and church history to explore under three central themes the compatibility of palliative care with Catholic teaching on human dignity and health care. These themes are: Catholic theological and moral tradition and teaching on palliative care; the treatment of body, mind, and spirit in palliative care; and institutional and societal issues relating to palliative care as considered within the context of Catholic social teaching. As a supplement to these topics, the book provides magisterial and pastoral episcopal texts on palliative care and advance care planning.

This collection of essays begins by explaining the theological and ethical foundation for the Catholic tradition in palliative care. In Chap. 2, Dan O'Brien explores the bases for the Catholic approach to palliative care in the Gospels and in Catholic theology. He accomplishes this by focusing on some key scriptural passages from the New Testament regarding Jesus' miracles and teaching, on the history of the response of the early Christians to victims of plagues, and by demonstrating how the constitutive features of the Catholic healing ministry can be discovered in this history and in these Scriptures. Peter Cataldo provides an over-

view in Chap. 3 of the central concepts and principles pertaining to the Catholic moral tradition in health care as they correspond to the standard eight major domains of palliative care. Among the moral principles explained is the principle of proportionate and disproportionate means of sustaining life and its history.

In Chap. 4, Charles Bouchard shows parallels between the essential concepts in the Christian *ars moriendi* (art of dying) tradition regarding the experience of a good death and modern Catholic palliative care. His analysis includes an adaptation of various virtues espoused in the *ars moriendi* tradition to the contemporary approach to suffering in palliative care. As a result, Bouchard makes a helpful contribution to the spirituality of palliative care. One obstacle to the acceptance of palliative care for some individuals is the perception that palliative care is a form of "stealth euthanasia." Ron Hamel examines the arguments for this claim in Chap. 5 and shows how they are both incorrect on their merits and are inconsistent with Catholic moral teaching and tradition. Hamel rightly points out that palliative care is the only practical alternative to and defense against physician assisted suicide, and as such, even accounting for the potential for abuse, it is important that palliative care as a whole not be mischaracterized as stealth euthanasia.

The particular issue of whether palliative care is really stealth euthanasia points to the reality of a spectrum of understanding, interpretation, and application of Catholic teaching and tradition on end of life ethical issues that has developed since the 1960s across all the populated continents of the globe.[1] This field of theological and ethical opinion has both influenced and responded to a growing body of Catholic teaching and to advances in palliative care. A range of interpretation and application is evident, for example, with issues such as advance care planning and medically administered nutrition and hydration. An exploration of the convergence and divergence of views along a spectrum regarding these kinds of issues was recently undertaken in the Pathways to Convergence project (The Center for Practical Bioethics 2017). This endeavor brought together experts in palliative medicine, theology, bioethics, and administration within Catholic health care to identify points of agreement and disagreement and to indicate a pathway toward greater clarity and a common understanding of Catholic teaching and tradition on palliative care and end of life issues. One of the outcomes of this project was the realization that while there exists a difference of interpretation and application of teaching and tradition in some aspects of the issues examined, there is concurrence with respect to key principles and many areas of application.

One way in which this volume demonstrates how the essence of palliative care and the tenets of Catholic health care are coherent despite some differences in interpretation and application of Catholic teaching is with respect to specific issues pertaining to the triad of body, mind and spirit in palliative care, which several chapters

[1] For example, on the topic of medically administered nutrition and hydration, see the work of Germain Grisez, John Finnis, Joseph Boyle, William E. May, John Keown, Luke Gormally, Nicholas Tonti-Filippini, Kevin O'Rourke, O.P., Benedict Ashley, O.P., Albert S. Moraczewski, O.P., Richard A. McCormick, S.J., Thomas A. Shannon, and James J. Walter. For a diversity of European opinion on the role of palliative care in euthanasia see Jones et al. (2017).

address. In Chap. 6, Kevin Donovan applies Catholic moral teaching and tradition to the medical data regarding the use of analgesics and sedatives in palliative care. He also analyzes the issue of palliative sedation and generally considers the compatibility of the goal of pain and symptom management with human dignity. David Lichter, in Chap. 7, presents the role of spiritual care in palliative care. He provides an overview of the work of Catholic pastoral care in palliative care and explains how spiritual needs are assessed and what sorts of spiritual care services are provided within palliative care. Lichter also explains national standards in palliative care spirituality and weaves helpful patient narratives into his presentation.

In Chap. 8, Daniel Dwyer explores the psychological dimension of palliative care and its compatibility with the Catholic view of the human person. In particular, he examines the reality of depression and hopelessness in dying patients, how these can often be correlated with the request for hastened death, and how hopelessness and depression may be effectively treated within the context of palliative care. Sarah Hetue Hill examines the role of the family in palliative care in Chap. 9. Drawing especially on data and experiences in perinatal palliative care, she presents the assessment of family and social needs in palliative care and explores how to respond to those needs in the context of Catholic teaching on the family. In Chap. 10, Diane Meier and Christopher Lawton provide an explanation of the core elements of palliative care and its significant benefits. They also examine the various challenges faced by the attempt to integrate palliative care into how we approach care of the seriously ill. These barriers include an inadequate understanding of mortality within our health care system, insufficient education, emotional barriers and lack of access. Meier and Lawton emphasize how Catholic health care can play a critical role in overcoming these barriers and in the advancement of palliative care.

The remaining set of chapters cover Catholic social teaching and institutional and societal issues relating to palliative care. In Chap. 11, James Bailey explores issues affecting the relationship between the common good and palliative care. To this end, he applies Catholic social teaching to examine issues such as the provision of palliative care as part of the common good, social responsibilities and palliative care, and ensuring access to palliative care within society. Tina Picchi, in Chap. 12, provides an overview of palliative care excellence across Catholic health care, which includes a consideration of models of Catholic palliative care programs employed by several institutional members of the Supportive Care Coalition. She shows that the palliative care movement has much to learn from Catholic health care models of palliative care delivery because these are some of the best palliative care programs in the United States.

In Chap. 13, MC Sullivan addresses the need to educate the public and Catholics in particular about palliative care. She shows how this education effort is critically important for patients, families, and for the work of health professionals. In particular, she examines the issue of palliative care education for laypersons within a Catholic setting, and the need for collaboration with others in this effort. In Chap. 14, Mark Repenshek and Leslie Schmidt consider the compatibility between Catholic moral teaching and tradition and advance care planning (ACP), both from a general perspective and with respect to planning for palliative care. This is another area full

of misconceptions both inside and outside the Catholic Church. Repenshek and Schmidt provide a historical overview of advance care planning, an analysis of Catholic teaching on this subject, and the influence that palliative care can have on a proper utilization of advance care planning. Elliott Bedford, in Chap. 15, closes the book's examination of palliative care within the Catholic tradition by exploring and contrasting the goals and actions of palliative care and physician-assisted suicide. Despite attempts by many medical and advocacy groups to depict palliative care and physician-assisted suicide as being within the same ethical and medical spectrum of care for persons with serious progressive or terminal illnesses, Bedford shows how these two approaches to illness are radically different. He also demonstrates how palliative care—not assisted suicide—is the quintessential example of medical mercy.

The volume ends with an appendix that provides selected magisterial and pastoral episcopal texts on palliative care, hospice, and advance care planning. These texts serve to strengthen the chapters of the volume and reinforce the message that Catholic teaching fully supports both advance care planning and palliative care for the seriously ill.

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Part I
Catholic Theological and Moral Tradition and Teaching on Palliative Care

Chapter 2
Palliative Care and the Catholic Healing Ministry: Biblical and Historical Roots

Dan O'Brien

You are likely already familiar with the iceberg metaphor. It's a great way of initially framing the question of "what is that something else" that the Catholic healing ministry brings to care for those who are most vulnerable, especially at the end of life. The medical and nursing skills and knowledge that it takes to do effective general care, end of life care – including *hospice* and *palliative care* – are all above the surface; they can be learned and replicated. However, the *competencies* needed to apply that knowledge and those skills *well* – in an interdisciplinary, coordinated and collaborative manner – are below the surface: they require experience, ongoing training and continuous professional development. We have superb examples of people and programs both inside and outside of Catholic health care that demonstrate those competencies. But there is nothing necessarily "Catholic" about those competencies.

We need to go deeper still into the *culture* of the Catholic healing ministry – into the depths of Scripture and the Church's history and teaching, to uncover the vision, meaning and purpose of what Catholic health care does, and how that distinguishes it from other forms of care. There we will discover what created and sustained the rise of the healing ministry within the Catholic Christian tradition, history and culture. Seen in this context, the Catholic healing ministry is not just another set of technical skills to which Catholic health care aspires; nor is it simply a great way to improve quality and patient satisfaction or to lower out-of-control spending. All these things are good, and there are many other goods that we could name; but these would not get us to the heart of the matter for the Catholic healing ministry. That is what I want to explore in this chapter.

In the *Introduction* to Part Five of the *Ethical and Religious Directives for Catholic Health Care Services, Sixth Edition* ("Ethical and Religious Directives")

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produced by the United States Conference of Catholic Bishops (USCCB 2018), we find three critically important statements. First, it states that:

> Above all, as a witness to its faith, a Catholic health care institution will be a community of respect, love, and support to patients or residents and their families as they face the reality of death. What is hardest to face is the process of dying itself, especially the dependency, the helplessness, and the pain that so often accompany terminal illness. *One of the primary purposes of medicine* in caring for the dying is the **relief of pain and the suffering** *caused by it*. Effective management of pain in all its forms is critical in the appropriate care of the dying.

Secondly,

> 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. We have a duty to preserve our life and to use it for the glory of God, but the duty to preserve life is not absolute, for we may reject life-prolonging procedures that are insufficiently beneficial or excessively burdensome. Suicide and euthanasia are never morally acceptable options.

And Thirdly,

> The task of medicine is **to care even when it cannot cure**. Physicians must 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 and, on the other hand, the withdrawal of technology with the intention of *causing* death. (USCCB 2018; emphasis added)

These are three distinguishing characteristics of Catholic health care in that *what* we emphasize in this approach to care represents the best of what the Catholic faith has consistently believed and emphasized throughout the centuries: about who we are as human beings; about our relationship to God and to each other; about our destiny; and about the meaning and purpose of carrying on this healing ministry.

In this chapter, I will explore how these three key characteristics of care – especially end of life care – represent what Catholic Christians have been *inspired* to do for 2000 years. They reached out and cared for the sick, the poor, the marginalized, the vulnerable and the dying, because they recognized in them their sisters and brothers in Christ. So too, Catholics believe today, as a matter of that same *faith* that has been handed down to us, that when we heal and care for the sick, the marginalized, the vulnerable and the dying, we are touching and caring for not only our sisters and brothers, but we are touching the face of *God*.

2.1 The Faith That Has Been Handed Down to Us

Where did this belief come from? I would propose that the Church's fundamental commitment to the healing ministry – characterized especially by its commitment to care for poor and vulnerable persons – springs first from its belief in the *Incarnation*. The Incarnation is the belief that God took on our human nature in the historical man Jesus of Nazareth, and in so doing, has forever changed not only the relationship between humanity and God, but has forever changed our relationship with each other. This change entails a new order of creation – a new union between God and creation in the person of Jesus Christ. This new union inserts itself into the old order of creation, and continually *calls the old order* into a new way of being with God and of being with each other.

Sin, suffering, injustice, war, sickness and death are not done away with by the Incarnation – we are not making such a fantastic claim. Rather, the claim is that through the Incarnation, God takes on our sin and suffering, our sickness and death – and transforms them in and through the man Jesus, who is crucified and risen. Because of Christ, we believe that God suffers in and through our humanity, in and through our injustices and neglect, in and through his own divine-human unity – *which is our transformed humanity*, destined for eternal union with God.

There is another way to express this. The Catholic faith teaches that not only does God suffer in and through our suffering humanity and through our injustices, neglect and foul treatment of each other; but we also believe that God loves through our love; forgives through our mercy; heals through our touch; and comforts through our compassion.[1] The account of St. Paul's conversion drives the point home. In Acts 22, Paul recalls,

> On that journey as I drew near to Damascus, about noon a great light from the sky suddenly shone around me. I fell to the ground and heard a voice saying to me, 'Saul, Saul, why are you persecuting me?' I replied, 'Who are you, sir?' And he said to me, 'I am Jesus the Nazorean whom you are persecuting.' (NAB 1991)

Paul had never met the earthly Jesus, and yet there Jesus was, telling him how he was persecuting him. Christians believe that Jesus was not merely speaking figuratively in this liminal encounter. What Paul was doing to the followers of Jesus, he was doing to Jesus himself – on account of the Incarnation.

It is also driven home by Jesus' account of the Last Judgment as described in Matthew's Gospel, chapter 25, where he depicts the Son of Man saying,

> Come, you who are blessed by my Father, inherit the kingdom prepared for you from the foundation of the world. For I was hungry and you gave me food, I was thirsty and you gave me drink, I was a stranger and you welcomed me, I was naked and you clothed me, I was

[1] I do not mean to imply that Christ suffers in his divine nature, but only in and through the hypostatic union of his two natures. Christ, according to ancient Christian teaching, is one divine person with two natures – one human and one divine – in one hypostasis, or one individual concrete existence. In and through this hypostatic union, Christ – on account of his human nature – has truly suffered and died. In a certain analogical sense, we can also say that through his union with humanity, Christ continues to suffer here on earth.

> sick and you visited me, I was in prison and you came to me.' Then the righteous will answer him, saying, 'Lord, when did we see you hungry and feed you, or thirsty and give you drink? And when did we see you a stranger and welcome you, or naked and clothe you? When did we see you ill or in prison, and visit you?' And the king will say to them in reply, 'Amen, I say to you, whatever you did for one of these least brothers [and sisters] of mine, you did it for me.' (NAB 1991)

The words of St. Paul and of the account of Christ's parable of the Last Judgment are more than a poetic metaphor for the body of Christ. They refer to the *divinization of humanity* – the drawing of our humanity into the inner life of God[2] (Schaff 2017). If we truly believe that God so loved the world – including you and me, here, now, in our time, in our place – then the healing ministry that Jesus set out to do 2000 years ago is *our* work today. This belief has inspired Christians, individually and collectively, for *centuries*, to reach out to the sick, the hungry, the lame, the imprisoned, in order to heal, to comfort, to care, to console – and so touch the face of God.

I am reminded of the founders of our Catholic health ministries. Those women and men who began our healing ministries centuries ago were quite conscious of the fact that the work they were doing, that they were carrying on, was the healing ministry of Jesus and his Apostles. Whether the Alexian Brothers, founded in the twelfth century; the Sisters of St. Joseph or the Daughters of Charity, founded in the seventeenth century; or the Sisters of the Sorrowful Mother, founded in the nineteenth century – they were all driven by the same motto: "The love of Christ compels us" (2 Corinthians 5:14). They took seriously the command of Christ "to proclaim the reign of God and heal the afflicted" (Luke 9:2), "to expel unclean spirits and to cure sickness and disease of every kind" (Matthew 10:1), "to raise the dead and heal the leprous…" (Matthew 10:8). They took to heart Jesus' teaching that whatsoever we do to the least, we do to him (Matthew 25: 40). And so they believed and taught that if we truly love *him*, then we *must* feed the hungry, welcome the stranger, clothe the naked, comfort the sick, and visit the imprisoned.

This is the primacy of love of neighbor – of a faith that leads into action, just as they and we are taught in the letter of James (2: 14–17):

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[2] "Divinization" is an ancient concept. It refers to the mystery of humans becoming divine through the action of Divine grace. During every Liturgy of Eucharist celebrated today, Catholics pray with the priest during the preparation of the gifts: "May we come to share in the divinity of Christ who humbled himself to share in our humanity." This same concept is found in the earliest writings of the Church Fathers, for example, in Ireneus of Lyon (c. 130–200), who wrote, "The Word of God, our Lord Jesus Christ, through His transcendent love, became what we are, that He might bring us to be even what He is Himself." (Book Five, Preface, in *Against the Heresies*, in Philip Schaff, Ante-Nicene Fathers, Vol. 1). Also: "For it was necessary … that what was mortal should be conquered and swallowed up by immortality, and the corruptible by incorruptibility, and that man should be made after the image and likeness of God" (Book 4, Chapter 38, in *Against the Heresies*). Likewise, Clement of Alexandria (c. 150–215) wrote, "The Word of God became man, that you may learn from man how man may become God" (Chapter I, *Exhortation to the Heathen*), and, "For if one knows himself, he will know God; and knowing God, he will be made like God" (Book III, Chapter I, *The Instructor*).

> My brothers and sisters, what good is it to profess faith without practicing it? Such faith has no power to save one, has it? If a brother or sister has nothing to wear and no food for the day, and you say to them, "Good-bye and good luck! Keep warm and well fed," but do not meet their bodily needs, what good is that? So it is with the faith that does nothing in practice. It is thoroughly lifeless. (NAB 1991)

So, let's turn now to the healing ministry of Jesus, to examine the ways that he responded to the sick and the vulnerable. If we are to make a claim that we are the *body of Christ*, and that the work we do in caring for the sick, the dying, the poor and vulnerable is the heart and soul of Catholic health care, then we need to know and understand how Jesus healed and what Jesus teaches us about the primacy of love of neighbor.

2.2 The Healing Ministry of Jesus

In Jesus' own day and culture, illness was generally understood to be related to and even caused in some way by sin – a manifestation of spiritual ailment. This is why in John's Gospel (9:2), upon seeing a blind man, the disciples of Jesus asked him, "Rabbi, was it his sin or that of his parents that caused him to be born blind?" The spiritual, the physical and the social are intertwined, inseparable. And so it is with Jesus' healing ministry. The seventeenth century Cartesian dualism and dichotomy between body and spirit, which still influences the way we tend to think of our bodies today, especially in modern medicine, doesn't exist in the biblical stories we are going to examine. The healing stories of Jesus in the Gospels still form the foundation for our understanding of care in the Catholic healing tradition. A closer look at just one of those stories will suffice for illustrating the point.

2.2.1 The Woman with the Hemorrhage: How Did Jesus Heal?

The story of the woman with the hemorrhage is recounted in the Gospel according to Mark (also in Matthew 9:18–26 and Luke 8:41–56). In Mark's account, Jesus meets this woman while he is on his way to see a synagogue official's daughter. It is actually two healing stories wrapped into one:

> One of the synagogue officials named Jairus came up, and on seeing Jesus, fell at his feet and implored him earnestly, saying, "My little daughter is at the point of death; please come and lay your hands on her, so that she will get well and live." And [Jesus] went off with him; and a large crowd was following him and pressing in on him.
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> A woman who had had a hemorrhage for twelve years, and had endured much at the hands of many physicians, and had spent all that she had and was not helped at all, but rather had grown worse—after hearing about Jesus, she came up in the crowd behind him and touched his cloak. For she thought, "If I just touch his garments, I will get well." Immediately the flow of her blood was dried up; and she felt in her body that she was healed of her affliction. Immediately Jesus, perceiving in himself that power had gone out from

> him, turned around in the crowd and said, "Who touched my garments?" His disciples said to him, "You see the crowd pressing in on you, and yet you say, 'Who touched me?'" And he looked around to see the woman who had done this. But the woman fearing and trembling, aware of what had happened to her, came and fell down before him and told him the whole truth. And he said to her, "Daughter, your faith has made you well; go in peace and be healed of your affliction."
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> While he was still speaking, they came from the house of the synagogue official, saying, "Your daughter has died; why trouble the Teacher anymore?" But Jesus, overhearing what was being spoken, said to the synagogue official, "Do not be afraid any longer, only believe." And he allowed no one to accompany him, except Peter and James, and John the brother of James.
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> They came to the house of the synagogue official; and he saw a commotion, and people loudly weeping and wailing. And entering in, he said to them, "Why make a commotion and weep? The child has not died, but is asleep." They began laughing at him. But putting them all out, Jesus took along the child's father and mother and his own companions, and entered the room where the child was. Taking the child by the hand, he said to her, "Talitha kum!" (which translated means, "Little girl, get up!"). Immediately the girl got up and began to walk, for she was twelve years old. And immediately they were completely astounded. And he gave them strict orders that no one should know about this, and he said that something should be given her to eat. (NAB 1991, Mark 5:22–43)

Scripture scholars tell us that the recounting of these two healing stories, as with other such healing stories, serves another purpose besides the simple recollection of miracles: the story demonstrates Christ's power over evil, over the world, over suffering, over life and death. It also demonstrates that he is greater than just another prophet. Notice, for example, that Jesus did not implore God to heal the woman (as the prophet Elijah did); and he did not implore God to raise the child from the dead (as the prophet Elisha did). Rather, *power goes out from him*, the story says, where there is *faith* placed *in him*; and the dead are brought back to life by the power of Jesus' *own* word, not in answer to a prayer of supplication. The difference is accentuated by Jairus' request to Jesus to *lay his hands on her*. Healing through the imposition of hands is not mentioned in the Old Testament or in rabbinical writings (Mally 1968).

Now, we need to be very careful here to avoid any claim that Jesus was simply healing people in order to *display* his power, his divine nature, or his authority. That would suggest that Jesus was *using* people for other purposes – something that does not suggest authentic love or compassion. We also need to be careful to distinguish between what Jesus did and taught, and the particular meaning that the author of the Gospel may have been trying to convey through the recounting of the story, as well as the deeper meaning that we discover and may bring to the story through our own study, culture, experience and inspired insight. The Scripture text must be approached as a *living Word* – one that brings new insights with every new encounter.

That being said, assuming this is an actual event which took place as described by Mark, Mark uses this passage – and all healing miracles – to establish Jesus' authoritative credentials among the members of the community for whom he writes. This would in turn give Mark's Jesus the power and authority to be creative concerning rules of ritual impurity, healing on the Sabbath, touching the dead, etc. Jesus is the Lord of the Sabbath; he is Lord over the Law itself – referring to his divine