Covenant Health
Compassionate care led by Catholic values

Theological Reflection in Support of:

Covenant Health's Palliative and End-of-Life Strategy

Rejoice in hope, be patient in suffering, persevere in prayer.

Romans 12:12

Our distinctive vocation in Christian health care is not so much to heal better or more efficiently than anyone else; it is to bring comfort to people by giving them an experience that will strengthen their confidence in life. The ultimate goal of our care is to give those who are ill, through our care, a reason to hope.

Joseph Cardinal Bernadin

Introduction

The following theological reflection is intended to supplement Covenant Health's *Palliative and End-of-Life Strategy,* drawing on the Catholic moral and social tradition in which our organization is steeped.

The words from St. Paul and Cardinal Bernadin express this tradition, and the unique stamp of Catholic health care. While there are other organizations that also provide quality, compassionate health care, including palliative and end-of-life services, Covenant Health brings a particular intentionality to our work rooted within a faith tradition that we call the healing ministry of Jesus. There is a shared, conscious awareness of the reason *why* we serve, and in *whose* name we act that permeates our organization. It is articulated formally in our mission statement, but demonstrated in our behaviour. Through practical words and action, we witness the covenantal love of God made visible in Jesus Christ to all human beings without discrimination, by providing the people in our care a felt *experience* of respect, understanding and compassion.

Our tradition reminds us that we are utterly privileged to touch others at their deepest core and in moments of profound vulnerability. Like Moses, we are called to take off our shoes, for the ground upon which we stand before the one we serve is "holy ground" (*Exodus 3:5*).

The Call to Hope

Among the most vulnerable in society are persons at the end-of-life. Even though the goals of care in this context typically shift from aggressive treatment and curative

measures, to palliation, pain management and comfort care, we are nevertheless morally obligated to give those facing their mortality a reason to hope.

Such hope does not romanticize death or pretend to exercise control over it. We cannot deny death its sting by avoiding talking about our mortality. Nor can we render it more palatable through euphemisms and superficial gestures. Jesus tells the people to take away the stone from the tomb where Lazarus has lain for four days, but the people resist for fear of the stench (*John 11:39*). There can be no whitewashing the reality of death. We must be prepared to roll back the stone of our own denial, opening all our senses to the truth of human experience.

Offering aggressive therapies that provide no proportionate benefit is not a substitute for compassionate presence, either. Doing so is to be complicit in a lie and a form of abandonment. There are times, rather, when we need to sit down with our patients, residents and their families to prepare them for the prognosis of death, together setting realistic goals of care that address pain and symptom management, create space to facilitate closure with family and friends, and ensure opportunities for celebrating rituals, prayers and sacraments of the person's faith. Far from "doing nothing," quality palliative and end-of-life care intentionally focuses client and team efforts towards achieving a mutually shared goal.

Culturally, however, we live in a society that tends to view death as an enemy to be resisted and defied. When the reality of death is inescapable, we find new ways of abandoning people to their fate with the false promises of "self-chosen death" as purported by the assisted suicide lobby group. Or we throw more trial therapies at the person to hold off the inevitable. Both stances reveal a lack of capacity to be fully present to another at the end of life.

Indeed, quality palliative care is more than managing symptoms and providing pain relief, as essential this care is. We are also called to *accompany* another in their suffering even if this risks exposing our own vulnerability where no technological fixes avail themselves. The paschal mystery of the suffering, death and resurrection of Jesus demonstrates Christ's selfless love to enter into the fullness of human experience, including the mystery of suffering. Michelangelo's Pietà powerfully captures this depth of presence when we are called to hold in our arms a loved one's limp body, as well as our own broken heart.

Simeon's prophetic warning to Mary that "a sword will pierce your own soul too" (*Luke 2:35*) is a reminder of the great vulnerability that comes when we freely choose to accompany another. It is such love that allows us to be truly present to another in their dying moments. This quality of presence is not tempted to hasten the person's dying to selfishly end our own suffering. Nor does presence mean projecting our inability to let go and confronting helplessness or a sense of failure by prolonging our loved one's dying with useless, burdensome therapies.

In our willingness to suffer with, and be present to another, we express the great hope of humanity that love does not end with death. Our faithful accompaniment of another in their dying mirrors faintly the love of God that binds us in sacred, eternal relationship. We cling to the hope that we still matter – both our living and our dying are not some random, casual act. We rejoice in hope that we are "the result of a thought of God. Each of us is willed, each of us is loved, each of us is necessary."[1] It is this awareness of how precious we are in the eyes of God that gives lasting hope to the pilgrim at the end-of-life.

The Call to Compassion

From a Catholic theological perspective, all persons possess an intrinsic dignity and incalculable worth. Human life is an immeasurable treasure that must be celebrated and nurtured. Our tradition has consistently upheld the dignity of human life, from conception to natural death. But while bodily existence is a good, it is not, in the Catholic tradition, an *ultimate* good. Our ultimate goal in life is friendship with God – "to know, love, and to serve God." We must take *reasonable* care of our lives, as stewards of creation, weighing any burdens associated with treatment with the proportionate benefits such treatments offer.

So while life is a penultimate good, requiring us to take reasonable care of our lives, we are not morally obligated to seek or undergo burdensome therapies "at all costs" that provide no benefit. Nor at the same time are clinicians morally obligated to "do everything possible" if life has reached its naturally conclusion and it is no longer medically appropriate.[2] Such stance is known as vitalism and is rejected by the Catholic moral tradition.

While there are undeniable burdens and losses associated with the dying process, including the demands caring for the dying, no person *is* a burden. Promoting and defending this vision of the human person defines the ultimate measure of success for every strategic initiative of Covenant Health, including our *Palliative and End-of-Life Strategy*. This lens extends to all we serve, in keeping with the nonjudgmental and universal regard demonstrated by the religious congregations who founded our institutions.

But at the same time, having been made in God's image and likeness, and accepting our role as stewards of creation – not owners – we must never hasten death either by an action or omission. It is because of this bedrock ethical and moral foundation that Covenant Health can never support legalization of euthanasia and assisted suicide in Canada, which the Catholic tradition views as an assault on the dignity of human life and a perversion of compassion.

Indeed, attempts that seek to hasten the death of others are a failure of what it truly means to be a compassionate society. The etymological root of "compassion" comes from the

[1] Pope Benedict XVI, Inaugural Homily, April 24, 2005.

[2] *Health Ethics Guide* (Ottawa: Catholic Health Association of Canada: Ottawa, 2000). See Articles # 92-101.

Latin *cum* (with or together), and *passiō* (suffering, submission) a derivative of *passus* (to suffer, submit). At its root, compassion means to be "together in suffering." Compassion calls us to stay *with* one another, and to be present despite our helplessness in altering the disease trajectory. Palliative and end-of-life care is the epitome of this compassionate presence, in providing quality pain and symptom relief, attending to complex psychological and spiritual needs, and ultimately, being truly *with* a patient, resident and their family even when cure is not possible.

In the Roman Catholic tradition, euthanasia and assisted suicide represents the ultimate failure of compassion and expression of solidarity, revealing the seeming incapacity of being truly present to one another's suffering. For the person confronting their mortality and the spiritual, psychological and existential questions often triggered during this process, having someone to accompany them and to listen to their experience is as important as the appropriate pain and symptom management that is provided.

Suffering requires the mobilization of a community of interdisciplinary health care professionals trained in the practical skills to support those who suffer deeply. These skills include an ability to help the person explore the depths of their being and the source of the existential suffering. Legalization of euthanasia and assisted suicide is not a substitute for such support. As bearers of authentic hope, Covenant Health must be relentless in its advocacy on the local, provincial and national scene in challenging such proposed legislation.

This reflection is thus both theological and practical, offering a critical perspective regarding the growing paradox of our time. On one hand, the persistent attempts to legalize euthanasia and assisted suicide in Canada that would seem to indicate society's acceptance of the reality of death, so long as the means and timing of a person's end remain a free, autonomous choice.

On the other hand, we are confronted by the exceedingly great expectations of patients, residents and families for therapies that are not in keeping with medically appropriate goals of care. As our society ages we will no doubt be continually challenged by both, seemingly incompatible agendas. Both relate to a need for control in the face of an inescapable truth – all of us will die. Neither stance adequately addresses the deeper question of how we are called to be a community of hope that *accompanies* another in their living, and dying. Rather, these paradoxical stances are elaborate ways in which we abandon our fellow human being. It is imperative therefore that we are sufficiently grounded in our theological tradition to helps us navigate these challenges within a consistent ethic of life, and to advance a palliative and end-of-life strategy that offers authentic hope to those we serve.

The Call to Support

One practical way we accompany persons at the end of life is providing for their physical, emotional, psychological, social and spiritual needs. This should begin right from the point of diagnosis, working together with the person, family and health care team to

develop a comprehensive Advanced Care Plan that clearly sets out the goals of care. Sometimes this will require patience and perseverance, as St. Paul also reminds, especially if there is disagreement about what those goals of care should be. As a publicly funded health care system, serving people of all faiths, traditions and cultures, invariably we will be confronted by the same public misperceptions and attitudes as reflective of the broader culture.

For example, the enduring myth of inadequate pain management and comfort measures in palliative programming, or the mistaken belief that palliation amounts to "doing nothing" no doubt will only fuel more calls for assisted suicide and euthanasia if left unchecked. Covenant Health's values of *collaboration, compassion* and *respect* requires clinicians to listen to those we serve in an attempt to understand where these fears may be coming from, and to help educate and reassure the person and their families about what we *can* do to alleviate suffering. Research and public education must remain an integral part of our strategy.

Implementation of End-of-Life Pathways, too, reinforces the standards of practice to better anticipate and respond effectively to changing client needs as their disease progresses. Advanced Care Planning and End-of-Life Pathways are meant to be fluid tools, adapted to the unique circumstances of the person including those informed by particular religious and cultural beliefs. At a time of great vulnerability when one comes to terms with their impending death, such beliefs provide meaning and great solace that must be honoured.

Indeed, the experience of vulnerability at the end-of-life has many faces. Certainly, pain management issues and the myriad other manifestations triggered by the evolving disease pathology can make a person extremely anxious, agitated or depressed. Loss of immunity to ward off common viruses, or strength to carry on activities of daily living, or further still being able to tolerate food or fluids are other examples. Often associated with these physical, psychological and emotional changes is grief in coping with loss. A person may experience or anticipate the loss of dignity, self-esteem, or control. Many persons report a fear of being a burden, and becoming dependent on others. For some, the diagnosis of a terminal illness may be the first time one's sense of immortality is shattered, representing yet another loss.

It is not uncommon that these losses evoke deeper level questioning about meaning, spiritual beliefs, one's legacy in life, and the need for closure. Chaplains and other spiritual care community providers and volunteers are able to provide supportive presence and pastoral counseling to listen to, and validate, the deeper level questions raised.

For many persons at the end-of-life, concern for family's welfare after their passing takes on increasing importance. Along with the financial and legal supports, knowing that one's family will be supported throughout their bereavement with ongoing faith community presence and other social supports can bring tremendous consolation to

person's at the end-of-life, perhaps for some providing a sense of permission and freedom to let go.

Together, all these supports tangibly express what compassion and "being there" for another means. A society that abandons its citizens by either prolonging or hastening death cannot be said to be compassionate, but rather expedient. Covenant Health's *Palliative and End-of-Life Strategy* provides counter-cultural witness that human life must be treasured, in all its imperfections and finitude, even when it is inexpedient to do so. Palliative and end-of-life care epitomizes the deeper meaning of presence and the giving of authentic hope. For indeed every person is a thought of God, deserving of our compassionate support.

This gives us all a reason to hope.