

Holy Living and Holy Dying

United Methodist/Roman Catholic Dialogue

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Ethical issues linked to death and dying are explored in an agreed statement released in August by the official Methodist-Roman Catholic dialogue in the United States. Pastoral care of the dying, the ethical nature of suicide and euthanasia, the use of modern, life-sustaining technology and the withholding or withdrawal of medical interventions are among questions treated by the dialogue group. The group's co-chairmen, Methodist Bishop Benjamin Oliphint of the Houston Area, and Catholic Bishop Joseph Delaney of the Diocese of Fort Worth, explain in the document's Foreword that in 1986, when the time came to begin another round of dialogue, "several parties in both churches suggested that a topic be chosen that would challenge the participants less in the area of dogmatic theology and more in the area of ethics and moral theology." Care of the dying, says the dialogue group, "must always be guided by the principle of loving stewardship of life." The group agreed that "the direct, intentional termination of innocent human life, either of oneself or another, has been generally treated in Christian tradition as contradictory to such stewardship because it is a claim to absolute dominion over human life." Full agreement was not reached in the dialogue, however, on whether there may be exceptions to the rejection of suicide and active euthanasia. The statement urges pastoral care for health-care workers who work with the dying. It urges the acknowledgement of dying "as apart of human existence" and the creation of a context in which relief of suffering can be accepted "as a goal for care of the dying rather than focusing primarily on cure or prolongation of life." Pastoral care for the dying, it says, "means engaging in a relationship with them so that they may know the signs of God's presence." The text of the statement follows.

Forward

This present document is the fruit of the third round of a process of official dialogue between United Methodists and Roman Catholics in the United States. The first round (1971-1976) was centered on ministry and produced a document titled "Holiness and Spirituality in the Ordained Ministry." The second round (1977-1981) had as its topic the eucharist and produced a document titled "Eucharistic Celebration: Converging Theology -Divergent Practice."

In 1986 when the time came to begin another round of dialogue, several parties in both churches suggested that a topic be chosen that would challenge the participants less in the area of dogmatic theology and more in the area of ethics and moral theology. Since both United Methodists and Roman Catholics sponsor a great number and variety of health care institutions, an agreement was reached to center the next round of dialogue on a topic with real and pressing concerns to the churches and their institutions, namely ethical issues surrounding death and dying. This document will highlight the many areas, both theoretical and practical, that the dialogue covered. We would be the first to recognize that further dialogue on this topic is needed as medical science advances and new ethical dilemmas arise. Our hope is that this document will encourage many others to reflect on these important issues and to appreciate how closely our two religious traditions converge in these critical areas of moral thought.

Bishop Joseph Delaney
Bishop Benjamin R. Oliphint

Introduction

For three years, as representatives of the United Methodist Church and of the Roman Catholic Church in the United States, we have carried on a dialogue on ethical issues in the Christian care of the dying. Early in our discussions we agreed to base our conversations on four sources: Scripture, tradition, experience and reason. Foremost among these is Scripture which provides us with the primary revelation of faith and with the nature and character of holy living and holy dying in light of that faith. Tradition provides us with a history of the theological, ethical and pastoral concerns of the church that must be considered when treating the issue of care for the dying. Experience narrates the concrete human situation where persons encounter the issue of dying and the need for merciful and just care. Reason, as a source, provides us with the wisdom of the human arts and sciences which are so important in our efforts to understand and love the dying in our age. It enables us to integrate all of the other sources into a coherent whole. Having used this approach we now offer the following theological and ethical principles which we consider crucial to any consideration of the subject of our dialogue.

I. Theological and Ethical Principles

1. Affirmation of human life.

We affirm all human life as the gift of God. Distinct from other creatures, we are created male and female in God's image with intellect and free will. Thus endowed with the capacities for knowledge, freedom and personal relationships, we are called in community to realize the divine purpose of living which is to love God and one another. As Christians we believe that God reaffirms the value of all human life through the incarnation of Jesus Christ and through the empowering presence the Holy Spirit.

2. Stewardship of human life.

Life is given to us in trust: not that we "might be as gods" (Gen. 3:5) in absolute autonomy, but that we might exercise stewardship over life while seeking the purposes for which God made us. In this life we are called by God to develop and use the arts, sciences, technologies and other resources within ethical limits defined by respect for human dignity, the creation of community and the realization of love.

3. The human condition.

Humanity in its actual condition is subject to disease and the inevitability of death. This situation is exacerbated by our sins of violence, greed, exploitation and indifference, and by the moral failure engendered by stupidity and narrow-mindedness. As a result we have rendered our earthly environment unhealthy and produced unjust social structures perpetuating poverty and waste. This deprives much of the human family of health; it hastens death or robs it of dignity.

4. The healing Christ.

In the face of the ultimate mystery of why humans suffer and die, we affirm two realities. Through Jesus Christ God enters into our suffering even to the point of dying an agonizing death. In the healing ministry and sacrificial death of Jesus Christ we experience God always seeking to turn suffering and death into wholeness and life. These

realities call us to witness to God's presence in the midst of suffering by sharing compassionately in the tasks of healing the sick and comforting the dying.

5. *Caring.*

The Christian community as a whole must be engaged in promoting health, in healing suffering and in being present with the dying. Our care of the dying, however, must always be guided by the principle of loving stewardship of life. The direct intentional termination of innocent human life either of oneself or another has been generally treated in Christian tradition as contradictory to such stewardship because it is a claim to absolute dominion over human life. The application of this norm in certain cases, however, has been problematic. Sacrificing one's life for others or ending life in face of irreversible and intractable suffering, or choosing martyrdom, for example, test this principle. Among the dialogue participants there are those who hold that tradition provides a norm which must lead one to the unequivocal rejection of suicide and active euthanasia while others held that there may be exceptions. In our discussion we noted that the Roman Catholic Church reaffirmed its rejection of suicide and euthanasia in its 1980 "Declaration on Euthanasia" (Congregation for the Doctrine of the Faith).

We affirm that the obligation to employ life-sustaining treatments ceases when the burdens (physical, emotional, financial or social) for the patient and the care givers exceed the benefits to the patient. The application of excessive procedures, sometimes encouraged by the ingenuity of modern medical technology, does not reflect good stewardship because it does not serve the purpose for which God gave life. In determining what constitutes Christian care we should engage our biblical and doctrinal understanding with the wisdom of new knowledge about human life and with our own experience of the reality of disease and death. This enables us to remain fully open to the reality of God's continuing guidance and to our need to discern God's intentions for us as we minister to those who suffer and die.

6. *Resurrection.*

The ultimate purpose of our life is union with God in the community of the risen Christ. Then our bodily and spiritual healing will be complete in perfect wholeness and holiness. Only then will the mystery of suffering and death find its complete answer. Until then "holy living and holy dying" means mutual support among pilgrims on the way.

Issues for further exploration.

We have not resolved two issues which both parties to our dialogue acknowledge have elicited differing viewpoints. These are the ethical application of the norm of love and the theological view of human nature. The diversity that has emerged among us can be stated in the following way: In our ethical reflection can it be said that the supreme law of love permits, in certain situations, the direct taking of innocent life, or does it always forbid it? And in theological understanding is death to be viewed as part of finite existence, a boundary ordained by God in the ordering of creation, or is it the consequence of our fallen nature and therefore necessarily evil?

II. Pastoral Care for Holy Living and Holy Dying

1. *Description of pastoral care.*

Pastoral care implies intentional relationships that empower and engage persons in holy living and holy dying. Such care is an experience of families, the various care givers and, of course, the sick and dying themselves.

The U.S. Catholic bishops, in their pastoral letter, "Health and Health Care," emphasize that pastoral care is offered within a faith perspective: "Since the limitations of the human condition impose a degree of suffering and ultimately death for all of us, those involved in the healing mission of Christ render a unique service by bringing a faith dimension to these crucial moments."

Pastoral care to dying persons means engaging in a relationship with them so that they may know the signs of God's presence. This care may come from many sources including the church, family, friends, neighbors and the health-care team. Through the pastoral relationship common acts of service are signs of God's disclosure and presence as the basis for hope and the power for healing.

Persons offering pastoral care should manifest solidarity with suffering patients by empathizing with them, understanding the wounds of their lives and comforting them by pointing beyond their human pain to glimpses of strength and hope. Even in the face of an obviously terminal condition, pastoral care persons may join the suffering patient in prayer for a cure, but its primary focus should be on that healing which points to wholeness in the person, whether dying or not. This wholeness comes from love whose sources are relationships with God, with others and with oneself. It enables the dying person to face death realistically and "wholly." Healing implies the affirmation of the goodness of life and the realization that while life is a gift, death is not always an enemy.

We believe that, through Jesus Christ, God enters into human suffering even to the point of dying an agonizing death. In both the healing ministry and in the sacrificial death of Jesus Christ we experience God seeking always to turn suffering and death into wholeness and life. We believe this because the ultimate purpose of our life is union with God in the risen Christ. The healing ministry includes sustaining patients through illness or guiding them through the passage of sickness unto death. It may well include reconciliation whereby one assists a patient in reestablishing broken relationships with God and with others.

2. *Giving and receiving pastoral care.*

Pastoral care need to understand both givers themselves and others through the art of communication and listening. They need to experience the meaning of life and human relationships and, most of all, to experience God through their particular faith tradition.

Suffering and dying persons remain autonomous and have a right to choose the depth of their relationships with the pastoral care givers. Pastoral care should be extended to families and friends of patients. They need time and a place to share their grief and to be reminded that these feelings are normal. Families congregating at the bedside act

according to long established patterns of relationships. Caring for these families involves seeking the signs of God's presence even in this difficult time.

Pastoral care also occurs within families when members and pastoral care persons wrestle with difficult questions that have many answers, or none, or which lead to more questions. The supporting community of the church provides the family access to the proclaimed word of God, specific faith and family traditions, experiences of God, and the freedom to engage in critical thinking and decision making. The pastoral act helps to develop these relationships.

Another group of people who need pastoral care are health-care workers, themselves. Care givers are generally expected to do their work without debilitating emotional involvement. However, for those who work regularly with dying people, it is unrealistic to expect emotional detachment. Doctors, and especially nurses, have physical contact with dying people in ways experienced by few others. This interaction, while remaining intense, does demand some emotional distance. Pastoral care with care givers means helping them to take loving care of themselves as well as their patients.

3. *Specific Pastoral Concerns.*

A pressing pastoral concern is communication with the sick or dying person. Pastoral care persons are trained to help patients clarify their understanding of their illness and its prognosis. While they should normally not communicate medical information to patients, they can assist patients and families in assimilating information provided by medical personnel. Pastoral care persons are especially needed when illness is terminal and neither patients nor families will discuss this freely. Pastoral care givers can gently and lovingly facilitate discussion of treatment options including home and hospice care. Christian faith in life after death may often be at the heart of these discussions.

The complexity of treatment options and requests by physicians for patient and family involvement in life-prolonging decisions require good communication. Pastoral care persons can bring the insights of Christian values and Christian hope to discussions when decisions are being made. If advance directives for treatment ("living wills") are contemplated or are being interpreted, the pastoral care person can offer thoughtful and reflective guidance.

Some patients, in their suffering and anguish, may consider suicide as a means to hasten death. Some may even ask care givers for assistance in taking their lives. We wish to accent the importance of the teaching offices of our churches in preparing clergy and laity to give witness to Christian hope and the dignity of human life in dealing with these complex issues and tragic situations. The appropriate pastoral care response for those patients who contemplate suicide is to assist them in understanding God's gift of life, the human stewardship of life and the saving action of Christ in his suffering, death and resurrection.

Passing judgment on the guilt of persons who die by suicide, restricting pastoral services based on such judgments or stigmatizing survivors are actions that have no place in

responsible ministry. The loving presence of Christ as manifested in the church community should surround those contemplating suicide and the survivors of those patients who take their own lives.

Another specific pastoral concern is the donation of organs for transplants, or of one's body after death to medical research. The gift of life in organ donation allows survivors to experience positive meaning in the midst of their grief, and is an important expression of love in community. Our churches support these practices as long as death is not hastened and is determined by reliable criteria. Pastoral care persons should be willing to explore these options with patients and their families.

Finally, the major pastoral concern of pastors and chaplains is the spiritual growth of patients, families and health-care personnel to whom they minister. This growth can be described as a deepening unity with Christ in the church. The Bible is a primary source of spiritual growth for Christian people. Patients and their loved ones who bring their Bibles to the hospital clearly indicate its role in their lives. Pastoral care persons who offer prayers and read the Scriptures with patients witness to the word of grace, comfort and salvation.

Roman Catholic pastoral practice offers three sacraments as signs and sources of spiritual growth: reconciliation (penance), the anointing of the sick and holy communion. The fruitful and faith-filled realization of each of them is a major responsibility of those in Catholic pastoral care. The anointing of the forehead and hands can be offered to all who are seriously ill or in frail health. Ideally, the family, close friends and health-care personnel participate in the sharing of Scripture and in the prayers associated with these sacraments.

In the United Methodist tradition the process of spiritual growth is enhanced by holy communion services, the laying on of hands and by informal prayers of repentance, reconciliation, and intercession. New rituals are being developed for prayer services in the care of the sick and dying. For example, a ritual of prayer after miscarriage, or after a death in a hospital or nursing home, brings comfort and grace to the participants. Rituals developed in connection with a diagnosis of terminal illness, or of welcome to a hospice or nursing home, could also enhance spiritual growth.

Pastoral care points us to signs and glimpses of God's presence and work in the world. As the community of faith, we are called to be open to these signs, to engender hope and to enable the whole people of God to live and die in faith and in holiness.

III. Social Dimension

The social context of dying and death decisively affects individual ethical decisions to forgo treatment and to embrace death at the time of terminal illness.

Social describes the policies and practices emanating from legislative bodies, public agencies and institutions which may be presumed to reflect to some degree a societal consensus. In order

that individuals may find alternatives to long, painful, expensive dying, or to a ready, easy euthanasia/suicide, social policies and practices must protect the fundamental values of respect for persons, self-determination and patient benefit in treatment.

Concern for the social context of dying is consistent with the United Methodist focus on life in community and social activism rooted in seeking a holy life both through individual experience of conversion and sanctification, and through disciplined groups seeking to create communities which promote individual and social good. Concern for the social context of dying is likewise consistent with Roman Catholic social tradition that recognizes the inseparability of mercy and justice, and that calls for sustained efforts against unjust social structures and institutions.

1. *Respect for persons: Dying with dignity.*

Dying with dignity calls for care that puts emphasis on compassion, personal interaction between patient and care givers, respect for the patient as a whole person with social as well as medical needs, and open and honest communication. In dying, as in living, it is in accord with human dignity to participate, insofar as possible, in those activities that are distinctively human: namely, the cognitive and affective activities that enable conscious, loving relationships with others in community. Medical technology supports the preservation of human dignity to the extent that it is used to sustain, support and compensate for human functions. Indeed, medical technology is a gift of our age supported by the will and resources of a society that values life and is willing to apply the measures necessary for extending life when possible.

However, when technology becomes an end in itself, unduly prolonging the dying process, it creates a paradox in which human dignity may be undermined and where the goals of treatment are distorted to accommodate the imperatives of technology: When a person is dying and medical intervention can at best prolong a minimal level of life at great cost to human dignity, structures of care and use of medical technology should focus on maximizing the individual's capacity for awareness, feeling and relationships with family and community. Decisions that subordinate the humane dying of a terminally ill man or woman to the technological imperative, or personal or institutional self interest - legal, financial, professional, etc. - are not consistent with Christian values and traditions.

2. *Patient benefit.*

All persons, by virtue of their common humanity, deserve the opportunity for meaningful life as they die. Each person should have access to the means necessary for a dignified death, regardless of age, race, social status, lifestyle, communicability of disease or ability to pay for adequate care. The biblical witness to God's concern for justice, particularly for those most marginalized and powerless in society, demands such commitments.

Equitable allocation of resources will help to assure that the holistic needs of the patient - social, spiritual, emotional, physical - are attended to. Such allocation will also assure that the common good of society is balanced with the right of individuals to be protected in their dying as far as possible from neglect, social isolation, unnecessary pain,

unreasonable expense and from the extremes of premature or delayed termination of treatment.

3. *Self-determination.*

The right of persons to exercise autonomy and to be self determining is protected in a just society by norms and procedures that involve the patient as an active participant in medical-treatment decisions. The Christian community supports such personal rights because it views all persons as created in the image of God, endowed with freedom and called to accountability before God and their covenant community for the decisions they make.

In order to safeguard the right of self determination at a time when one may lack decision-making capacity due to dementia or unconsciousness, individuals will be encouraged: a) to designate a "proxy," or to appoint an "attorney-in-fact" under a durable power-of attorney statute, where this is authorized; and b) to stipulate, in written advance directives, guidelines for their treatment in terminal illness. Congregations and other church groups can play a particularly important role in helping persons consider such advance directives, choose between alternatives and find support for carrying them out.

Public support for the exercise of self determination in illness is enhanced through state legislation that: a) gives expression to societal consensus regarding dying and death; b) moderates between vagueness and stringency in setting parameters for forgoing treatment; and c) protects the interests of society traditionally understood as preservation of human life, prevention of suicide, protection of innocent third parties and upholding the standards of the medical profession.

4. *Pain and dying.*

The withholding or withdrawal of medical interventions of little benefit to the patient compared with the burdens they impose should not be confused with euthanasia or suicide.

Euthanasia, as commonly understood, is the deliberate taking of life, with the assistance of another, in order to end all suffering.

Suicide is the intentional and direct taking of one's own life.

Today there seems to be a growing belief that euthanasia and suicide may be the most human solution for many terminal or irreversible medical conditions. This belief is encouraged by increasing emphasis on the autonomy of the individual, the application of sophisticated medical techniques for sustaining patients who are in the final stages of life, the ethos of the medical profession that impels the use of such technology even when it is inappropriate to a patient's condition, and by physicians' fears of legal liability for failing to use available technology. These factors are exacerbated by efforts to control costs.

The proper application of medical science, as demonstrated by hospice care, can in most cases enable patients to live and die without extreme physical suffering. Provided the

intention is not to kill but to relieve pain, such methods of controlling pain, even when they risk or shorten life, can be used for terminally ill patients.

If adequate support by community, family and competent pastoral care givers is provided, the mental suffering of loneliness, fear and anguish, which is often more painful than physical suffering, can be alleviated. This support is particularly important in those patients who have very slight objective abnormalities or are without any physical pain but who suffer extreme emotional trauma in their knowledge that they are in the early states of certain diseases: e.g., dementing illness such as Alzheimer's disease, a slowly progressive but fatal central nervous disorder such as amyotrophic lateral sclerosis or Huntington's chorea, HIV infection and the early stages of certain cancers which, with present medical knowledge, are absolutely incurable,

Here the participants in the dialogue did not reach unanimity. In the situations just described, some of the participants considered that euthanasia, given certain circumstances, might be an ethically permissible action. Other participants disagreed, including the Roman Catholic team, insisting that euthanasia is objectively sinful in any and all circumstances. The Roman Catholic Church has affirmed this exceptionless norm in its "Declaration on Euthanasia."

5. *Social Constraints.*

Certain social constraints militate against the ideals of holy dying. A sense of justice and compassion that prompts us to secure for ourselves and loved ones a humane and dignified dying will alert us to the detrimental influence of these constraints.

a. *Attitudes toward dying.*

The attempt to deny death frequently results both in reluctance by individuals to plan ahead for their dying and unwillingness in professionals to "let go" even when a patient is beyond medical help or benefit. This denial is exacerbated by negative attitudes toward old age, poverty and disability which are most often the perceived circumstances of dying.

b. *Ethos of the medical profession.*

The emphasis on curing, healing and restoration contributes to uneasiness among physicians in making the transition from cure to care when the possibilities of cure are exhausted. Members of the medical profession must accept the legitimacy of medicine oriented toward relief of suffering, rather than extension of life for the dying, and they must use their skill in identifying when it is appropriate to discontinue treatment. This is not easily done. There is often a continuum of treatment for life-threatening conditions and a tendency to seek one more procedure that can legitimately prolong a patient's life.

c. *Failures in distributive justice.*

Budget allocations and reimbursement policies for health care by both private and governmental health plans give priority to funding technologically sophisticated diagnosis and treatments, while denying or minimizing payments for less-costly services that are critical for humane and dignified dying. In addition, health-care professionals are often constrained in their efforts to implement care plans that have patient benefit as their goal by payment policies of government and

insurance companies that dictate the length and modalities of treatment. A society committed to helping every person die with dignity will reverse these policies and give highest priority to such services as hospice and home care, social services and pastoral resources.

d. *Interference by courts in the decision making process.*

The courts have increasingly become the site of medical decisions in a growing number of states. The failure of society to provide effective support systems in health-care facilities, including the use of ethics committees, leaves individuals and institutions vulnerable to outside interference. Dying patients become subject to medical practices that are calculated to protect the professional against criminal or civil liability as much as they protect the patient's right to be treated with dignity in the dying process.

Consumers have sought to redress perceived injustices in medical treatment or to resolve difficult cases in the adversarial setting of the court room. The resulting practice of defensive medicine has increased the use of futile diagnostic and treatment procedures by physicians and the costs to patients and payers.

e. *Polarizing movements that seek to institutionalize in law and/or public policy particular moral perspectives on dying.*

While some advocate legislation that would require use of life-sustaining treatment in all circumstances, others promote legalization of assisted suicide under certain conditions. Open and judicious public dialogue is imperative on issues of such importance. Unfortunately, the polemical nature of the controversy impedes clear and responsible decision making among those who are sensitive to the ambiguity involved in life-death decision.

6. *Response of the churches.*

It is not enough to identify and analyze the social dimensions of holy living and holy dying. Our churches must articulate in ever more creative and relevant language the themes of the sanctity of human life, the Creator's dominion and our stewardship of human life as well as the nature and meaning of death. As communities that attach utmost significance to respect for persons, self-determination and patient benefit as norms for holy dying, we need to work together to overcome the social constraints described above.

Our intention is to create a context in which we can:

- a. Acknowledge dying as part of human existence, without romanticizing it. In dying, as in living, mercy and justice must shape our corporate response to human need and vulnerability.
- b. Accept relief of suffering as a goal for care of the dying rather than focusing primarily on cure or prolongation of life. In addition to pain control, comfort-giving measures in a setting of communal affection and support such as hospice are within our human and financial means, if we make this a priority of our society.

- c. Assure equitable access for all to the resources that will relieve the dying and their loved ones of anxieties about financial crises created by medical expenses, while providing holistic care to accompany patients through their dying.
- d. Promote effective support systems for health-care professionals who must implement difficult decisions on behalf of the dying and their families. Intrainstitutional support systems, such as ethics committees, are preferable to the courts or other forums for weighing alternatives in the sensitive balance that the circumstances of dying may require.
- e. Participate as communities of faith in public dialogue to help shape consensus on treatment of the dying. The insights drawn from the United Methodist and Roman Catholic theological traditions offer valuable contribution to this discussion.

The right of every person to die in dignity, with loving personal care and without efforts to prolong terminal illness will be defended to the extent that society reaches out in mercy and justice, touching individual persons, but also touching the social conditions that hinder the wholeness which is God's desire for humanity.

Implications for Action

In order that the principles and concerns articulated in the document on "Holy Living, Holy Dying" be translated into practical action, the following recommendations are submitted to our churches.

F. Congregations/Parishes

1. Encourage United Methodist and Roman Catholic study of this document, jointly where possible.
2. Provide for study and dialogue on issues related to decisions at the end of life, with particular attention to:
 - role of advance directives ("living will," durable power of attorney for medical decisions),
 - importance of communication with physician, family and loved ones prior to a medical crisis with emphasis on the rights and responsibilities of the patients.
 - hospice philosophy.
3. Facilitate and cooperate in the formation of support groups and systems for those dealing with terminal illness. Where this can be done on an ecumenical basis, this should be promoted.

G. Church Leadership

1. Promote ecumenical dialogue at the national and parish level and with advocacy groups and decision makers on issues such as allocation of finite health-care resources, and access to health-care resources needed for holy dying.
2. Encourage the training of pastoral personnel on the issues raised in this study.

3. Promote dialogue and exercise leadership to influence public attitudes and policy on end-of-life decisions.
4. Support public advocacy for adequate similar and care home for funding hospice, programs for all persons.

H. *Health-Care Institutions*

1. Provide multidisciplinary education for community and specialized health-care personnel on issues related to holy living and holy dying.
2. Encourage the formation of institutional ethics committees for policy advising, discussion of issues and educational leadership.
3. Encourage the establishment of policies and procedures that support alternatives in terminal care.
4. Assure the presence and availability of persons and programs to:
 - assist in the resolution of doubt and conflict associated with the use of life-sustaining technology.
 - support those who must make and implement the complex decisions that arise at the end of life.

I. *Seminaries and Other Educational Institutions*

1. Promote dialogue among church and academic communities around the issues addressed in this study.
2. Incorporate into the curriculum study and reflection on theological, ethical and pastoral issues related to dying and death.
3. Encourage the study of public policy on the use of health-care resources and the psycho-social impact of these issues on care and treatment of terminal cases.
4. Foster in all formation programs the development of caring skills toward those facing the end of life in terminal illness.