

Caring for life

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PASTORAL LETTER FROM THE NORDIC BISHOPS' CONFERENCE ON MEDICAL CARE AT THE FINAL STAGES OF LIFE

Life is a precious gift. Throughout the centuries this conviction has been the inspiration for many to defend and protect the weakest members of society. This is especially the case in the field of healthcare where Christians have found a meaningful way to assist their neighbour and to bear witness to the love God has for all his people.

In the Nordic countries we have an advanced medical care system that meets our requirements for medical treatment. However the expectations of society for even better care and quality of life, as well as the astounding achievements made in the field of medical science, present us with new challenges. This is especially the case regarding medical care at the final stages of life and also regarding the issue of euthanasia. These questions are and will continue to become increasingly topical. We, the catholic bishops of the Nordic countries, would like to shed light upon these issues based on the message of the Gospel and the tradition of the Catholic Church.

In this letter we will first of all unfold and analyse the situation today in society and in healthcare. Subsequently the answers given by Revelation to “the eternal questions” will be presented. We will go on to develop a theological analysis of the situation by expounding the teaching of the Church on these questions. Finally a number of suggestions will be presented, which hopefully can promote respect for the sick and the dying in our Nordic countries.

1. Social background

1.1 Demographic development

During the last hundred years great advances have been made in improving and prolonging human life. As a result of this scientific and technical revolution, the advances made in medical science, the mastering and control of many dangerous illnesses, better hygiene and food, the average life expectancy has increased. Towards the end of the 19th century a citizen of our countries had an expected lifespan of 50 years. Today we have an average life expectancy of about 78 years, statistically among the highest in the world.

Higher standards of living have also lead to lower birth rates. While fewer children are being born and individuals live longer, the populations of our societies are becoming older. The percentage of the population of the Nordic countries over the age of 65 is now 15 percent and is expected to rise continually. In fifty years as much as 45 percent of the Nordic population could be older than 65 years. Certainly, developments in medical science, especially in preventive medicine, genetics, surgery and cancer research will lead to even longer life. But since death is an inevitable fact in human life, questions regarding medical care at the final stages of life will increase in importance and topicality.

1.2 The changed attitude within society towards death

During the course of history the attitude of our Nordic societies towards death has changed. In the past death was seen as a natural part of life and always close at hand due to the risk of dying while giving birth, infant mortality, accidents at work and many epidemic illnesses. In most cases the sick were taken care of at home. They were a part of a social network that generally was responsible for human care and dignity. When people died there were rites, symbols and actions, especially funerals, which belonged to the culture. Death was a part of life and the dead were honoured.

With the advances and improvements in modern medicine the moment of death is no longer seen to coincide with the moment the heart ceases to beat. Modern intensive care has made it possible to prolong life in a way that in the past was seen as insurmountable. The process of dying has thus been prolonged and can to a great extent be controlled. In the past illnesses and diseases which led to death within a short period of time can now many times be treated. Moreover, today with the help of heart and lung machines or artificial organs life can be sustained in a mechanical way. These possibilities bring the following questions to a head: What is life? What is the meaning of suffering? What is death and when exactly does one die? Even other difficult questions are brought to the fore: Are we always obliged to sustain life as long as possible? Or is it sometimes allowed to discontinue medical treatment to allow a patient to die? Are we allowed to ease a patient's severe pain and accept that his life will thus be shortened?

When intensive care was developed during the 1960's it was a clear and obvious fact that the first priority of medical care was to save life. Patients received intensive treatment with an abundance of technical apparatus that certainly sustained life but which also often entailed that a patient's spiritual and psychological needs were not seen as important. Death became institutionalised and individualised, i.e. moved from the home to the more anonymous environment of a hospital where a patient often awaited death without the presence or help of relatives. This resulted in that death, for many, became an unknown reality. Even today various studies show that only one in ten people aged twenty-five have experienced the death of someone close to them. 1) Death is becoming an abstraction, something that does not exist and thus something we need not concern ourselves with. One speaks even about the genesis of history first "free-from-death generation". It is only when accidents and catastrophes occur that death receives greater attention.

In recent years the intensive technical treatment of the incurably sick and of dying patients, which characterised medical care at the end of the 1900's, has been questioned. We have seen that questions regarding the quality of life are just as important - and in some cases more important - for patients than access to effective medical treatment. The same studies, as mentioned above, show that an increasing number of people die at home, in old people's homes or other specific forms of housing. 2) The same studies show that relatively few people die alone. There is a positive and increased awareness that death is an important and difficult process in a person's life in which one needs other people's support and human warmth. But since many elderly people live alone and death for many is a long process, these people are still very vulnerable. During the last few years it has become clear that the national health system does not always give elderly people the care they need.

1.3 The changed task of medical care

Modern medicine began with the Greek Hippocrates of Kos (c. 460-377 BC). Traditionally it has been distinguished by three characteristics: 1) it is free from political and religious affiliations, 2) it is founded on scientifically proven methods, 3) the work of doctors is regulated by independent professional ethics, consisting of firm obligations and prohibitions. According to Hippocratic ethics, a doctor has a personal responsibility, if possible, to cure, often to relieve but always to console his patient, but also to refrain from dangerous, harmful or lethal forms of treatment like abortion or euthanasia, even if the patient himself requests it.³⁾

Modern medical care challenges this view regarding the roll of the doctor and the purpose of medicine. The close proximity, which existed in earlier times between doctor and patient, is being in many ways replaced by a developed and sophisticated technocracy and bureaucracy. Certainly the patient generally receives appropriate care but the existential and ethical questions, which may arise in relation to his treatment, are seldom given sufficient attention. Due to the demands made for greater efficiency and the priority given to economic issues within the healthcare system medical care workers are often forced to work at a high tempo and thus find it difficult to view patients as fellow human beings. When the distance between doctor and patient increases, the different and varied fields of application given to medicine are on the increase and when the general public gains clearer insights into how the healthcare system is run, there is a risk that medical care can become an ideology, i.e. the risk that it becomes an instrument in fostering fixed individual, social or political goals.

In our multicultural context it can be difficult to agree on how we together can resolve ethical issues. However, we may never be content with accepting the lowest common denominator as a norm and delegating to each individual the right to rule over life itself. When we in our society wish to have a moral foundation, we must learn from the experience and wisdom, which are conveyed by the traditions that from the beginning contributed to strengthen and secure the fundamental values of society. Thus, this letter is not just meant for the Catholic Christians of the Nordic countries. We will also explain to other Christians and to all those of good will how our own tradition wrestles with questions of life and death and how it in theory and praxis can contribute to defend and protect the inviolability of human life.

2. The testimony of the Bible

The biblical view of life has as its starting point that God created life and finds joy in it. It is this that gives life its value and dignity.

2.1 The Old Testament

Man is created in the image and likeness of God (Gen 1:27). But his awareness of being related to God developed rather slowly throughout the history of Israel. At the beginning of his long journey in faith, man becomes very soon aware that he is alive and that this physical existence is in itself of great dignity. In many ways the Bible speaks about the eternal value of life and of man's gratitude to God for the great gift he has been given. He rejoices that he is not dead and that he can praise God. His continued existence is seen by him as proof of God's blessing. Death entails that the service of worship which life is, is broken. He passes into a

meaningless shadowy existence, Scheol, where he no longer can praise God. Therefore the psalmist cries:

What profit would my death be, my going to the grave?
Can dust give you praise or proclaim your truth? (Ps 30:10)

This insight that man is called to a life with God comes successively. If Israel fears God and keeps his laws and commandments long life is promised to coming generations (Deut 6:2). Man is exhorted to make a fundamental moral standpoint: "See, I have set before you this day life and good, death and evil" (Deut 30:15).

Life and goodness belong together. Without life there are no prerequisites for goodness and for all the other positive values of life, how unpretentious they may be. However, as we all are well aware, life is not always happiness and bliss. Due to the transitoriness of human life we come into contact with its imperfection, which is especially expressed in sickness, suffering and death. The Bible bears witness to the constant experience of the suffering person. Holy Writ does not paint a pretty picture of human existence. Instead it reminds us that misfortune indiscriminately befalls the believer as well as the non-believer, the virtuous as well as evildoers. Job, God's virtuous and faithful servant, experienced his due share of misfortune and sorrow. The Book of Job portrays suffering in a rich and succinct manner. In one passage Job says:

"Why is light given to him that is in misery, and life to the bitter in soul, who long for death, but it comes not, and dig for it more than for hid treasures; who rejoice exceedingly, and are glad, when they find the grave? Why is light given to a man whose way is hid, whom God has hedged in? For my sighing comes as my bread, and my groanings are poured out like water. For the thing that I fear comes upon me, and what I dread befalls me. I am not at ease, nor am I quiet; I have no rest; but trouble comes." (Job 3:20-26)

Even in the abyss of suffering, man can find God.⁴) In his vulnerability he becomes aware that he cannot save himself. He needs help from somewhere else. Slowly Israel deepens her insight that the covenant she entered into with the Lord is not meant to secure the people's political success. Instead Israel is to bear witness to salvation in a deeper way for other lands and peoples. Through the prophets the people of God learn to understand that temporary setbacks, suffering and even death do not mean that God has abandoned them. God, who is almighty and merciful, will, in the end, defeat death. Yes, there is hope. Nothing is lost in God's plan of salvation. Not even death is an obstacle for God.

"Thy dead shall live, their bodies shall rise. O dwellers in the dust, awake and sing for joy! For thy dew is a dew of light, and on the land of the shades thou wilt let it fall" (Is 26:19).

2.2 The New Testament

Jesus Christ, the Saviour of the world, fulfils God's promise of a new creation. He is truly the One who is "life" itself and "the light of all men" (Joh 1:4). By becoming man God wished to show us how our lives should be. When Jesus Christ dies and rises again death is annihilated and through baptism we are partakers in this mystery and are part of his life. In Christ we are no longer subject to the realms of death.

During his earthly existence Jesus defended and supported life in many ways. He heals the sick, he forgives sinners, he consoles the grieved and even gives life to many who have died. Furthermore, he teaches his disciples to dissociate themselves from violence and to treat all people equally, no matter their origin, faith or way of life. He is always in the service of life and shows in his actions what he promised in words: he has come: “that we may have life, and have it abundantly” (Joh 10:10).

Even though Jesus was God, he does not act as if he were superior, but as a fellow human being. He can rid the world of calamity, illness and death but, instead, he subjects himself to these conditions in order to share our humanity. As it is written about Christ in the letter to the Hebrews: “For because he himself has suffered and been tempted, he is able to help those who are tempted” (Heb 2:18). By his suffering and death he voluntarily took upon himself the whole of humanity’s individual and collective failures and weaknesses. On the Cross, Jesus came to know man’s experience of hopelessness when he exclaimed: “My God, my God, why hast thou forsaken me?” (cf Ps 22:2; Matt 27:46; Mark 15:34). He is there with all those who suffer. The Cross reveals God’s love and care. Hopelessness and death do not have the last word. By his resurrection on the third day Jesus unveiled for us the victory of life and the meaning and goal of human life. Man is not meant for the grave but called to share in the glory of God for all eternity.

Jesus wanted to continue his work on earth. Therefore he called his disciples and gave them the role of leadership among believers. Jesus gave them this exhortation: “Heal the sick, raise the dead, cleanse lepers, cast out demons. You received without paying, give without pay” (Matt 10:8). In the Acts of the Apostles we read how the disciples after Jesus’ death and resurrection, heal the sick as a sign of salvation through him. Man is not at the mercy of blind fate, but is called to enter into a new relationship with God where bodily and spiritual health is a sign of the coming of the kingdom of God. In Christ the whole of creation finds itself in a state of transformation where death and corruption constantly are pushed aside in order to make room for a new creation. Therefore Paul writes: “For this perishable nature must put on the imperishable, and this mortal nature must put on immortality. When the perishable puts on the imperishable, and the mortal puts on immortality, then shall come to pass the saying that is written: ‘Death is swallowed up in victory.’ ‘O death, where is thy victory? O death, where is thy sting?’” (1 Cor 15:53-55).

In summary: the Bible teaches us that life is something good and desirable which God has given to us as a gift and over which he alone rules. Human life is thus inviolable. At the same time we also learn to hope for something better that will come. We are called to eternal life. Our biological existence here on earth is thus not an absolute good. 5) Life need not be prolonged at all costs and it can be given as a gift for the benefit of others. Jesus cured many but he himself died for us on the Cross in order to win for us the Kingdom of God and to prepare a place for us in the embrace of the Father. The disciples continue in the name of Christ to assist the sick and the weak but they themselves are prepared to die in order to bear witness to life after death.

3. The Christian view of medical care

The Church has always preached about works of mercy 6) as a way for the faithful to imitate Christ and to show Christian love in concrete actions. By giving food to the hungry, water to

the thirsty, clothes to the naked, dwelling to the stranger and care to the sick we bear witness, just as the first Christians did, that God loves all people and that his kingdom is among us. But since we meet Christ in the needy and the suffering, we who help are not better than those who receive help. He who takes care of a fellow human being is a disciple of Christ who said: "I was sick and you visited me" (Matt 25:36).

Care of the sick must therefore be seen as a meeting of equal persons where both he who administers care and he who receives care enrich each other. In this meeting spontaneous reactions arise which we all recognise as an expression of our natural tendency to help people in need and our natural reaction to trust the sense of responsibility of other people and their professional competence. When these positive and spontaneous reactions or "manifestations of life" take place mutual trust and confidence between the people concerned arise and it is this which is the foundation of medical care.

3.1 The dignity of the patient

A patient may never be seen only as "a case" or be reduced to a body that must be treated. Because every individual has an inherent dignity, a patient is first of all a fellow human being. Therefore the patient, if it is possible, or his relations, must be informed and consulted before any treatment involving him commences or is discontinued and also when medical tests are to be taken. A patient must be seen as the vulnerable human being he is and thus receive help in the difficult situation in which he finds himself when he becomes seriously ill. Medical treatment must be seen from an holistic perspective which embraces the personal needs of the patient.

3.2 Then dignity and vocation of medical care workers

Doctors and nurses may never be regarded only as a means to be used by someone else. They are not just professional and skilled workers paced at the disposal of society or individual patients. According to the Christian position these people have a special vocation and are entrusted with the great responsibility of caring for ill people. Included in this responsibility is an ethical form well tried by experience - the Hippocratic tradition - that strengthens them in their commitment to the service of human life. This ethical tradition within the medical profession must be respected. Doctors and nurses have "a grave and clear obligation to oppose [any actions that are contrary to the ethical tradition within medical care] by conscientious objection", especially abortion and euthanasia.⁷⁾ We appreciate the initiatives which have been taken in many of our dioceses to found associations and networks of Catholic doctors. These associations and networks can give our doctors an excellent opportunity to exchange experiences, to gain further education in ethics and to enter more deeply into their Christian identity in the service of life.

3.3 Other concerned parties

Finally, it is part of the Christian position regarding medical care to also take into consideration any other concerned parties. Medical care is not an isolated reality that only touches the life of the patient and the medical staff. It is also a part of a greater context. After the patient himself, those who bear the main responsibility for the well being of the patient are

his relatives. It is important that these people are given the opportunity to get all necessary help from society when they need it in order to care for their relative at home. If this is not possible, then hospitals and medical care establishments must implement measures allowing relatives the opportunity of visiting as often as is possible for them and, if they so wish, allowing them to actively partake in the medical care given to the patient.

Everything that takes place in our hospitals and medical care establishments also concerns many other people, both directly and indirectly. For example, the general public's trust and confidence in medical care are jeopardised when immoral treatments are accepted and if one cannot trust that doctors and nurses always put the well being of the patient first. It is also important to be reminded that the resources given to medical care are limited and that there are also other areas which are of importance for the common good of society, e.g. schools, social work, aid to developing countries, research, culture, care of the handicapped and care of the elderly. Health must, therefore, be seen as one of the many values that society must promote. It is not the only one. One must ask oneself if it is acceptable from a Christian perspective that more and more money is invested in order to meet our growing demands for better health and quality of life when other people in our world lack even the most basic necessities of life.

The Church presupposes an holistic view regarding medical care. One should not only care for the patient's physical well being but also his psychological and spiritual needs. Man is not just a body and does not live "on bread alone" (Matt 4:4). Man is a person. Freedom and self-fulfilment are values that must be protected. This implies that neither patient nor doctor and medical care workers are to be subjected to political pressure or undue scientific ambitions. They may not be lead into acting unethically by subjecting either the sick or the healthy for oppression. One has always to view the issue of health from a perspective that proceeds from respect for and love of every human being.

4. Questions in connection to medical care at the final stages of life

According to the Christian faith death is not the end of existence but a transition to a new form of life. "For God so loved the world that he gave his only Son, that whoever believes in him should not perish but have eternal life" (Joh 3:16). Therefore all those who die in Christ can look forward to seeing God face to face. None the less the process of dying, just as the process of being born, can be very painful. The dying person can experience fear and anxiety since he is faced with an unknown reality and begins to lose his ability to breathe, to perceive and to exist in space and time. Therefore it is important that a dying person is surrounded by human warmth and care, that he is given all necessary spiritual guidance and comfort and has qualified medical treatment at hand, especially for the alleviation of pain.

In the Sacrament of the Sick the Church offers unsurpassed grace and comfort. This sacrament is not only meant for those who are at the brink of death but can also be received by those who are seriously ill, or those who feel weak due to the advancement of years. Its principal grace "is one of strengthening, peace and courage to overcome the difficulties that go with the condition of serious illness or the frailty of old age" (Catechism of the Catholic Church, n. 1520). It is important to give the sick members of our parishes the possibility of receiving the sacraments of reconciliation, communion and anointing of the sick. The responsibility of spiritually accompanying and comforting the dying is not just that of the priest. Relatives, friends, medical staff and other fellow human beings can by their very

presence at the side of the sick and, e.g. reading passages from Sacred Scripture, be a source of great comfort.

4.1 Alleviation of pain

Human life is transitory and therefore, unavoidably, involves a certain amount of pain and suffering. God does not desire that we should suffer; therefore we are not to consciously look for physical or psychological trials. None the less, when such trials occur they are given meaning in the life of a Christian. Through our trials we can be united with Christ who suffered for us and who in a mysterious way still suffers together with his Church. Therefore the apostle Paul could write: “Now I rejoice in my sufferings for your sake, and in my flesh I complete what is lacking in Christ’s afflictions for the sake of his body, that is, the church” (Col 1:24). He who suffers can thus offer up his discomfort or afflictions for the sake of someone else and by his prayers be united with and pray for other people who are being tested. Therefore a patient can of his own accord refrain from accepting treatment for the alleviation of pain. However one may never come to the conclusion that every ill patient would make this choice.

Severe pain can weaken a person’s courage, weaken his life of prayer and in other ways be an obstacle in receiving appropriate care at the final stages of life. Therefore the Church teaches that doctors are to provide a high standard of treatment for the alleviation of pain and assume that patients who cannot give their consent would request this treatment.⁸⁾ It is true that treatment of patients with analgesic drugs can in rare cases shorten their lives.⁹⁾ This risk can be tolerated under the condition that the prescribed doses are within the limits for what is seen as a high standard of medical praxis and that the intention is no other than the alleviation of pain.¹⁰⁾

We hereby wish to emphasize the importance of a high standard of palliative care at the final stages of life. This care, which aims to alleviate the pains of illness and to integrate the patient’s physical, psychosocial and spiritual needs, ought to be an obvious element in medical treatment, given to all those who need it, started at the appropriate time and pursued until the patient passes away. No patient who suffers from an incurable illness is to be seen as “fully treated” from a medical point of view.

4.2 Termination of intensive medical treatment

There are other situations where a patient receives intensive care and his life is maintained mechanically, e.g. respirators. The question then arises if it is morally acceptable to discontinue intensive treatment and allow the patient to die if his health cannot be restored.

According to the tradition and teaching of the Church, a balance must always be achieved between the proposed method of treatment and its benefits and the possible negative consequences, including all medical risks, pain or fear. According to this teaching a patient is in principle obliged to allow himself be receive treatment and a doctor obliged to provide the treatment - if the treatment has a reasonable chance of restoring the patient’s health and does not entail all to many negative factors. However a doctor is not simply morally obliged to begin or continue treatment if the medical benefits are negligible in proportion to other pains

or difficulties, and if therapy only prolongs the process of death. 11) The decision to possibly terminate a life-sustaining treatment obviously must be taken only after consultation with the patient, with his relations if he is not conscious and if necessary with other specialists. Irrespective of the choice made, the regular care of the patient must continue. 12) To terminate medical treatment in these or similar cases is not a form of “passive” euthanasia or mercy killing.

4.3 Euthanasia

Even when a patient is irrevocably in the process of dying and there is no possibility of saving his life, a doctor is the protector and servant of life. This also applies to those close to the patient. However, there are many voices in society which advocate that a doctor ought to be allowed to intentionally kill a patient if the patient requests it or gives his permission.

In the strict sense of the word, euthanasia means “an action or omission which of itself and by intention causes death, with the purpose of eliminating all suffering. Euthanasia’s terms of reference, therefore, are to be found in the intention of the will and in the methods used”. 13) A request for mercy killing is often grounded in the need for dialogue, in depression, in a state of anxiety when faced with death or the fear of being an overwhelming encumbrance to the medical system or a burden for relatives. These fears and apprehensions must naturally be taken seriously. Medical care workers must therefore be close to the suffering patient and by loving care give support both to the patient himself and his family. The position of palliative care must therefore be strengthened so that medical care workers become more qualified in this field and thus be of benefit to the patient. However, not all patients who need treatment for the alleviation of pain receive it and, unfortunately, are not always received in an appropriate manner. Compared to other more prestigious medical fields, e.g. genetics or surgery, palliative care is still given low priority and neglected. Politicians, medical care workers and relatives have thus an important task to make sure that in many different ways the final stages of life also become a meaningful period in the life of each person. Studies have also confirmed that which medical care workers, pastors of souls and relatives already ascertained: the final stages of life can also be a time full of unexpected possibilities, and even become a source of joy both for the terminally ill patient and those close to him. 14)

In the ethical debate it is often argued that euthanasia should be allowed since every person has the right to decide over his own body and his own life. Receiving help to commit suicide or to kill another human being is, however, not a personal matter or private affair. Man is a social being who is part of a community. What we do with our bodies and our lives concerns others. Other people also need to be protected. Euthanasia is an immoral action because it violates the bodily integrity of its victims, it violates the person who has to perform this deed and violates other people especially the handicapped, who despite difficult trials in life wish to continue living a worthy life. These people, who often feel extremely vulnerable in the debate on euthanasia, need the support of society by, among things, hearing it clearly proclaimed that life is always inviolable and worthy to be lived, despite one’s medical condition or supposed social advantage. Owing to all these reasons it is important that human life is protected right up to the moment of death and that euthanasia is not allowed by law.

Besides the fact that euthanasia is contrary to the ethics of medical care workers, it does not take the possibilities of palliative care into consideration and that violating the integrity of the human person is also a serious sin against God who has commanded us not to kill (Ex 20:13; Deut 5:17). Therefore Pope John Paul II, in his encyclical *Evangelium vitae*, confirms, “In

harmony with the Magisterium of my Predecessors and in communion with the Bishops of the Catholic Church, I confirm that euthanasia is a grave violation of the law of God, since it is the deliberate and morally unacceptable killing of a human person.”¹⁵⁾

4.4 Terminal sedation

Lately in our Nordic countries a new form of euthanasia is being discussed. The term “terminal sedation” is used to describe an action that involves a doctor anaesthetising a dying patient and discontinuing all medical treatment until death occurs.¹⁶⁾ In these cases death usually occurs within a few days and up to a week after being anaesthetised. Advocates of this action maintain that it is an acceptable and legal form of euthanasia because it contains two elements that are allowed today: the administering of an anaesthetic and the termination of treatment.

Since the intention and purpose of this action is to kill the patient, terminal sedation should be seen as a regular form of euthanasia and thus forbidden. The distinguishing factor between this method and other methods where a patient’s life is intentionally brought to a close, is the instruments that are used. Terminal sedation is in itself also problematic and uncertain. Medical praxis has shown that patients can experience pain and discomfort even when anaesthetised. In a situation like this terminal sedation would irrevocably deprive the patient of the possibility of awaking and requesting help. To deny a patient the possibility of communicating with those around him in such a definitive way, and possibly changing his opinion on how he should be treated, is seriously unethical.

4.5 Donation of organs, tissue and cells

From a biological point of view death is not an instantaneous event but more or less a prolonged process in which the unitary and integrated functions of the body gradually decline. In the past the moment of death was normally linked to the moment the heart ceased to beat. The possibility of sustaining a person’s blood circulation using artificial means has made this assumption problematic and brought to the fore the insight that a person’s identity is foremost connected to his potential or his actual possibility of being self-aware, of reflecting and of communicating with others. When this faculty is irrevocably lost (what is usually termed brain death) a person can also be regarded as dead. The Church does not use medical criteria to define death, but through theological and philosophical reasoning has arrived at the same conclusion as medical science, which implies that she implicitly accepts the so called brain death criterion. The Church’s competence lies in theology and philosophy. Therefore the Holy Father said recently: “In this regard, it is helpful to recall that the death of the person is a single event, consisting in the total disintegration of that unitary and integrated whole that is the personal self. It results from the separation of the life-principle (or soul) from the corporal reality of the person.”¹⁷⁾

These theoretical questions are of great relevance today due to the possibilities we have of, among other things, being able to make use of the organs, tissues and cells of a deceased person and transplanting them to order to help seriously ill people. With the great shortage of donated organs etc. which we have today in the Nordic Countries, this possibility of saving other peoples’ lives, by donating our bodies after death, should be welcomed. The donation of an organ can be a person’s last free act of love on earth. Therefore we encourage all Catholics

in our dioceses to promote the culture of life by taking a definite position in this important question.

The donation of an organ should even be seen within the field of medical care as a free act of love that embraces the whole person. Therefore the consent to be an organ donor is to be confirmed clearly with the help of a high standard of medical praxis before any surgical act on the dead body takes place. It is also important that the body of the deceased donor is treated with respect.

5. The contribution of the Church to medical care in the Nordic Countries

Since the time when the Nordic countries became Christian, the Church has been an important social figure in society and has always assisted the poor, the sick, prisoners and other marginalised people. This is especially the case with religious orders of sisters who have conveyed the care of the Church to the sick and weak here in the North.

5.1 Catholic medical care in the Nordic Region

After the reformation, the Catholic Church returned to the Nordic countries during the 19th and 20th centuries. Gradually it made itself known in different areas of society. This is seen most clearly when the Church manifested itself through its special work for the sick and the elderly. Up to our own time religious congregations of sisters and brothers have taken upon themselves the responsibility of looking after seriously ill people and the dying by giving them security and comfort. In many ways they have worked to relieve their pains and helped them to bear their fear and anguish. Moreover they have tried to help patients be reconciled to God by receiving the sacraments: confession, Holy Eucharist and anointing of the sick. Today it is not usually religious sisters and brothers who exercise this apostolate, but individual catholic doctors and nurses in public hospitals and medical care establishments. Together with other people of good will they engage themselves in giving love and aid to the sick and the dying so that they with dignity can enter into eternal life.

5.2. New initiatives

In order to help terminally ill people be treated with care and respect for God as the Lord of Life, several houses for hospice care have been established under Catholic and ecumenical management.

6. Summary

In this pastoral letter we the bishops of the Nordic countries, have attempted to draw attention to certain questions asked today in relation to medical care at the final stages of life. These questions have been elucidated by analysing the situation today with the help of the testimony of revelation and the teaching of the Church, by explaining the principles which are the foundation of Catholic philosophy regarding medical care and finally to apply these principles to concrete questions. These principles have their starting point in the experience of our

relationship with God throughout history and the knowledge of the Gospel of the salvation of man in Christ Jesus. However, our philosophy regarding medical care has also its starting point in the convictions we share with many other people of good will. Among these common convictions, we can mention respect for the inviolability of human life and the equality of all human beings, our special responsibility for the weakest members of society and respect for the integrity of the medical profession.

Many of these values today are being questioned by short-sighted scientific and political interests and also current ideas that isolate the human person from community. As we called attention to earlier, the danger with this type of individualistic mentality, which among other things asserts the right to euthanasia, is that other concerned parties are forgotten. The request for euthanasia must be taken seriously; however not by allowing the patient to be killed but by attending to him in the process of dying until his life comes to an end in a natural way and commending it into the hands of God.

Death is a natural occurrence, which in its own time, must be accepted by all and which ultimately is the doorway into a new life with God. But as long as we live it is life itself, a wonderful gift from God, that we are called to serve, especially among our seriously ill brothers and sisters. Together with Pope John Paul II, we reject a “culture of death”. We respond to his call for a “general mobilisation of consciences and a united ethical effort to activate a great campaign in support of life.”¹⁸⁾ We hope that this letter will help to contribute in promoting a “culture of life” in the Nordic Countries. But above all we hope that it will promote respect for the human person, created in the image and likeness of God, redeemed in Christ and called to eternal life.

Exhortations and suggestions

1. We urgently request the elected members of our parliaments and our governments to further develop palliative care in our Nordic Countries. The terminally ill and the dying need more help and support at the final stages of life. According to our position, euthanasia is an unacceptable alternative which undermines the importance of palliative care and jeopardises human dignity. No person should ever be given the possibility of taking the life of an innocent fellow human being. Therefore euthanasia should continue to be forbidden.
2. We request all the Catholic Christians in the Nordic Countries to be especially attentive to the situation of the sick in our churches. Therefore we suggest that in every parish, according to their needs and their possibilities, draw up a pastoral plan so that the elderly and the sick receive regular visits and the possibility of receiving communion if they cannot come to church. This Apostolate of Visitation can if needed be exercised by trained ministers of the Eucharist who have been appointed thereto by the bishop.
3. We exhort all parish priests to regularly provide the sacrament of the sick in their respective parishes. We suggest that the sacrament be celebrated communally, appropriately within the celebration of the Eucharist in order to emphasise the communal bond among and with the sick.
4. We encourage Catholic teachers, nurses and pastors of souls to receive further education in palliative care and to be aware of the special medical and spiritual needs of the dying. We

welcome also private initiatives to found houses for hospice care under Christian management.

5. We exhort all our fellow Christian brothers and sisters and all people of good will to actively promote respect for life and actively partake in the general debate and in democratic processes so that the inviolability of human life will increasingly become more respected in our society.

World Day of Prayer for the Sick, 11 February 2002

1. Cf. Döden angår oss alla. Delbetänkande från kommittén om vård i livets slutskede (SOU 2000:6) s. 19. (Death concerns us all. Interim report from the committee dealing with medical care at the final stages of life. Reference SOU:2000:6, page 19.)

2. Ibid., page 28.

3. The tradition of the Catholic Church has from the Church Fathers to our present pope, always regarded the Hippocratic tradition as the nucleus of ethical care. Cf. Gottfried Roth "Hippokrates in Päpstlichen Dokumenten," in *Acta Medica Catholica (Belgica)*, 2 (1995), page 101-102. Also section 2 and 3.

4. John Paul II, *Salvifici doloris*, 1984, chapters 3-5.

5. "Earthly life is a fundamental but not an absolute good. Hence the limits of the obligation to keep a person alive must be specified." Cf. the document "Some ethical questions relating to the gravely ill and the dying" issued by the Papal commission *Cor Unum* 27 July 1981 in *Enchiridium Vaticanum*, 7. *Documenti ufficiali della Santa Sede 1980-1981*. EDB, Bologna 1985, page 1165.

6. These works of mercy are divided into seven corporal and seven spiritual works: 1) feed the hungry 2) give drink to the thirsty 3) clothe the naked 4) shelter the homeless 5) visit the sick 6) comfort the imprisoned 7) bury the dead 8) counsel the doubtful 9) instruct the uninformed 10) admonish sinners 11) comfort the sorrowful 12) forgive offences 13) bear wrongs patiently 14) pray for the living and the dead.

7. John Paul II, *Evangelium vitae*, 1995, n. 73.

8. Cf. "Declaration on Euthansia" issued by the Congregation for the Doctrine of the Faith, 5 May 1980, *Acta Apostolicae Sedis*, 72 (1980) pp. 547-548.

9. A patient with severe pain can be treated with morphine, among other drugs, which reduces his respiratory capacity and can shorten the patient's life. However, studies in the field of palliative medicine have shown that in many other cases analgesic treatment can prolong life because the patient relaxes and is free from pain. On this issue cf. *Catechism of the Catholic Church*, n. 2279.

10. Cf. Pius XII, address at the International Conference of Doctors and Surgeons, 24 February 1957, *Acta Apostolicae Sedes*, 49 (1957) p. 146; also John Paul II, *Evangelium vitae*, 1995, n. 65.

11. In Catholic tradition a distinction is made between proportional and disproportional, ordinary and extraordinary treatment. Cf. “Declaration on Euthanasia” issued by the Congregation for the Doctrine of the Faith, 5 May 1980, *Acta Apostolicae Sedes*, 72 (1980), p. 551.

12. Cf. Papal Council for Pastoral Assistance to Health Care Workers, *Charter for Health Care Workers*, Vatican Press, Vatican City, 1995, n. 120, p. 98.

13. John Paul II, *Evangelium vitae*, 1995, n. 65. For a precise analysis of the term euthanasia and its terminology cf. Helene Pande “Eutanasi. Førsøk på klargjøring og avgrensing av begreper”, *Tidsskrift for Den norske lægeforening* nr 24, 1997: 117:3548-3550.

14. Cf. Ira Byock, *Dying well: peace and possibilities at the end of life*, New York: Riverhead Books, 1997, also Eva Sahlberg Blom, *Autonomi, beroende, livskvalitet: livets sista månad för 56 cancerpatienter*, Uppsala: *Acta Universitatis Upsaliensis*, 2001.

15. John Paul II, *Evangelium vitae*, 1995, n. 65.

16. Cf. Nina Husom in *Tidsskrift för Den norske lægeforening* 3/2001 and Torbjörn Tännsjö in *Dagens Nyheter*, 25 March 2001, A4.

17. Cf. John Paul II, Address to the 18th International Congress of the Transplantation Society, 29 August 2000, n. 4.

18. John Paul II, *Evangelium vitae*, 1995, n. 95.

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