SUBBTO 69, no. 1 (2024): 57-72
DOI:10.24193/subbto.2024.1.04

Palliative Care – The Alternative to Euthanasia*

Sorin-Grigore VULCĂNESCU**

ABSTRACT. I believe that better education about palliative care (PC) and its more intensive and widespread use, followed by the continued development of palliative medicine, are superior to any type of assisted dying. In this study I present *the Christian alternative*, the practical alternative to euthanasia and other options for ending earthly life, insisting on PC. It is the real, viable and acceptable example of *easy death*, with a Christian origin and mission, as opposed to the expansion of assisted death services, which have entered a process of de-Christianization, dissolution and discredit.

Keywords: palliative care, euthanasia, life, death, Christianity

Introduction

The approach of death is, without a doubt, a gloomy and difficult prospect in human life. The reasons for this are multiple concerning the design and especially in the experience of this stage, but one reason stands before the rest in the existential path of man: the fact that God did not create man to know death. Death is not from man's ontology. Death is neither of creation nor of the Creator. God is the Creator of life, not of death[1]. Death is a passage; not a passing

* This study develops and extends upon ideas presented in Sorin Vulcănescu, *Euthanasia. A moral theological-approach*, Mitropolia Olteniei Publishing, Craiova, 2023.

** Priest, Librarian and Associate Professor at the Faculty of Orthodox Theology in Craiova, Romania. E-mail: vulcanescu_sorin@ymail.com

1 "God, Who created human nature, did not create pleasure along with it, nor pain resulting from sensory activity, but he rather gave her mind a certain capacity for pleasure through which she could mysteriously enjoy Him. By linking this capacity (which is the mind's natural desire after God) to the senses as soon as he has been created, the first man saw his pleasure moving against nature, towards sensory objects, through the senses. But He who cares for our salvation providentially embedded in this pleasure, as a means of punishment, the pain, through which he wisely planted in

into non-existence, as stated by some ancients and some modern thinkers, but rather a passing unto resurrection, a moving to life, as is said in the prayers at the funeral service.

From a theological point of view, the Old Testament teaches us that death entered the world through the sin of the first parents. This is not an explanation for death (this is "a sign, the 'sacrament' or symbol of humanity[2] which affirms only the relation of sin to death), nor the *prototype of human death* (this is the death of Jesus Christ, as the New Adam)[3]. In the New Testament, an explanation for death lies in the Life, Death, and Resurrection of Christ, the pattern that Christians are exhorted to follow. The emphasis falls on the Resurrection of Christ and not on His Death, on the defeat of death through resurrection – resurrection as victory over death – and not on the moment itself. This reveals a process by which death was left "on the margin" and not made into an "independent theme", because there is a "contempt" for it, albeit different from the secularistic one[4]. With the focus being on Christ, the One Who overcame the chains of death and thus gave us new eternal life, Christian teaching remains the religion of the gift of life and respect for it: "A Christian perspective on dying is really a version of life. It is living and dying in the light shed by the Resurrection of Christ. This does not make dying any less difficult, but it brings it within the grasp of our humanity"[5].

From a medical point of view, the last decades have seen two main approaches to patients in the terminal phase of a disease. The first option has been that of care: in one's own home, in a hospital or in a specialized center, including palliative care (PC). The awareness that the approach of death will be accompanied by pain grows more difficult and profound the more the end of biological life is accompanied by pain and suffering – both for the dying, as well as for their family and those close to them. The second option has been a type of assisted death (euthanasia, assisted suicide or medically assisted suicide). Euthanasia and its *surrogates* have received a series of names – *good*, *easy*, *dignified*, *happy*, *merciful* or *compassionate death*. Euthanasia advocates have

---

the nature of the body the law of death, to restrain the folly of the mind which, contrary to nature, moves its desire towards the objects of the senses. Thus, due to the pleasure contrary to reason that penetrated the nature, there also entered the pain as an antidote conforming with reason. This is mediated by many passions, among which and from which is also death, and its purpose is to remove the pleasure contrary to nature, even to abolish it completely, so that the gift of divine pleasure can be shown in the mind". St. Maximus the Confessor, "Răspunsuri către Talasie", in: *Filocalia sau culegere din scrierile Sfinților Părinți care ne arată cum se poate omul curăți, lumina și desăvârși*, vol. III, Trans. Fr. Prof. Dr. Dumitru Stăniloae (București: Humanitas, 1999), 310.

2 Tom Morris, *Growing Through Grief. A Book and Discussion Guide for Grief Groups* (Cambridge YTC Press, 2008), 67.

3 Helmut Thielicke, *Living with Death*, Trans. G. Bromiley (Grand Rapids: Wm. B. Eerdmans, 1983), 164.

4 Helmut Thielicke, *Living with Death*, 32.

5 Ray S. Anderson, *Theology, Death and Dying* (New York: Basil Blackwell, 1986), 140.

twisted and desecrated these terms, radically changing their primary purpose and meaning in an extensive and sustained process of *disinheriting* them. Then they took them over and used them with a secularistic meaning and, often, as slogans[6]. But when the euphemisms are removed and the focus is strictly on the act itself, the discussions and consequences of the act itself are no longer about "killing the pain but killing the patients"[7].

I believe that better education about PC and its more intensive and widespread use, followed by the continued development of palliative medicine, are superior to any type of assisted dying. In this study I present *the Christian alternative*, the practical alternative to euthanasia and other options for ending earthly life, insisting on PC. It is the real, viable and acceptable example of *easy death*, with a Christian origin and mission, as opposed to the expansion of assisted death services, which have entered a process of de-Christianization, dissolution and discredit[8].

The alternative to euthanasia

Palliative care units are the alternative that does not involve direct intervention in hastening death, but instead deliberate, unconditional and competent care. This begins with the management of pain and suffering and continues with the process of preparing for *easy*, *dignified death* – most authentically exemplified by PC rather than euthanasia or its *surrogates* like terminal sedation[9]

---

6 Including *caregiving*, given that assisted dying is promoted by its proponents as *end-of-life care*. Willem A. Landman, *End-of-Life Decisions, Ethics and the Law* (Geneva: *Globethics.net Focus*, 2012), 71.

7 Emily Jackson, John Keown, *Debating Euthanasia* (Oxford: Hart Publishing, 2012), 83.

8 Undermining trust in PC – in Belgium, after the amendment of the law that allows the combination of PC services with euthanasia, through an unprecedented approach, confusion has been created among patients who, for fear of euthanasia, refuse admission to PC centers, which can become "euthanasia houses". Jan L. Bernheim, Kasper Raus, "Euthanasia embedded in palliative care. Responses to essentialistic criticisms of the Belgian model of integral end-of-life care", *Journal of Medical Ethics* 43/8 (2017): 489-494; Benoit Beuselinck, "2002-2016: Fourteen Years of Euthanasia in Belgium. First-Line Observations by an Oncologist", in D.A. Jones, C. Gastmans, C. Mackellar (Eds.), *Euthanasia and Assisted Suicide. Lessons from Belgium* (Cambridge: Cambridge University Press, 2017), 105-106.

9 Sedation before death – involves the administration of sedatives to "reduce awareness of stress to a tolerable level" or to "prolong unconsciousness". There are different types of sedation, from *palliative* (with the aim of stabilizing a tolerable level of pain) to *terminal* (in which sedatives basically replace the lethal agent). Outside of *palliative sedation* (although even here, due to confusing terminology, more controversies arise), the other types are not considered standard care practices in medicine, being equated with assisted dying wherein the goal is to intentionally hasten death. Timothy W. Kirk, Margaret M. Mahon, "National Hospice and Palliative Care Organization

and voluntary cessation of nutrition and hydration[10].

Palliative care is defined by the World Health Organization (WHO) as:

> "An approach that improves the quality of life of patients – adults and children – and their families who are facing problems associated with life-threatening illness. It prevents and relieves suffering through the early identification, impeccable assessment and treatment of pain and other problems, whether physical, psychosocial, or spiritual"[11].

The main goal of this type of care is to alleviate the pain caused by the disease, to reduce the suffering of the patient and the family and to manage all the symptoms of the terminal illness. This prepares the person and their loved ones for death, as well as for the period afterwards. Thousands of studies have been written about the benefits of PC for the patient, the patient's family, the health system etc. The most important objectives of PC are the following:

– primary attention is given to the patient's life and the elimination of the intention to hasten death[12]. This translates into constant concern for the well-being of the patient and his/her family from a medical, psychological, social, emotional and spiritual point of view[13]. More precisely, it involves alleviating of the pain caused by the disease and other painful symptoms, reducing suffering for the patient and the family, increasing physical and spiritual well-being;

(NHPCO) Position Statement and Commentary on the Use of Palliative Sedation in Imminently Dying Terminally Ill Patients", *Journal of Pain and Symptom Management* 39/5 (2010): 920; Catherine Bando, "Assisted Death: Historical, Moral and Theological Perspectives of End of Life Options" (*Theses and Dissertations*, 2018), https://bit.ly/2vMJux1, Accessed: 27.01.2024; Samuel H. LiPuma, "Continuous Sedation until Death as Physician-assisted suicide/euthanasia: A Conceptual Analysis", *Journal of Medicine and Philosophy* 38/2 (2013): 190-204.

[10] Voluntary cessation of nutrition and hydration – refers to the voluntary decision of patients in the terminal stage of a disease to give up food and water consumption. In these cases, the decision is considered by most specialists in the field to be a legal option and not a standard care practice in medicine, nor one identical to withholding or withdrawing nutrition and artificial hydration. Timothy E. Quill, "Dying and Decision Making — Evolution of End-of-Life Options", *New England Journal of Medicine* 350/20 (2004): 2032; Catherine Bando, "Assisted Death…" (*Theses and Dissertations*, 2018), https://bit.ly/2vMJux1, Accessed: 27.01.2024.

[11] World Health Organization, *WHO definition of palliative care*, 2023, https://tinyurl.com/mw52ajn8, Accessed: 02.06.2024.

[12] Elissa Kozlov, M. Carrington Reid, Brian D. Carpenter, "Improving patient knowledge of palliative care: A randomized controlled intervention study", *Patient Education and Counseling* 100/5 (2017): 1010.

[13] Kathleen Foley, "Patients Need Better End-of-Life Care Rather than Assisted Suicide", in: L.M. Medina (Ed.), *Euthanasia* (Detroit: Gale, 2005), 190.

– *facilitating an easy death*. This involves reducing pain and suffering to a tolerable level; effecting awareness of impending death through a series of open dialogues; supporting the resolution of personal and interpersonal issues[14] through planning and social, administrative, notarial counseling etc.; providing psychological and spiritual assistance for the patient and the family; and assistance for the family during the mourning period[15].

Physical and spiritual well-being or the holistic dimension

Considering the perspective of the founder of the hospice movement, Cecily Saunders, with regard to *total pain* (or *complex pain*), the relief of *physical ailments* is only one aspect within PC. Other dimensions (*emotional*, *social*, *spiritual*) must also be considered in care[16]. Psychosocial factors have been found to influence the patient's medical condition and length of survival[17]. In this sense, it is vital that PC staff optimize the holistic care of patients by prioritizing holistic assessment. This means maintaining basic concern for physical needs and providing special attention to the psycho-emotional, social and spiritual well-being of the patient and his/her family[18] as an integrated part of basic treatment[19], managed

[14] Camilla Zimmermann, "Acceptance of dying: A discourse analysis of palliative care literature", *Social Science & Medicine* 75/1 (2012): 217-224; Hannah Frith, Jayne Raisborough, Orly Klein, "Making death «good»: instructional tales for dying in newspaper accounts of Jade Goody's death", *Sociology of Health and Illness* 35/3, (2013): 419-420.

[15] Emily Butler et al. "The Efficacy of Hospice-In-Place Care Versus Traditional Inpatient Care", *The American journal of hospice & palliative care* 41/8 (2024): 863-872; Vanderbilt Center for Health Services Research, *Qualitative Research Core* (https://tinyurl.com/2avmefbs. Accessed: 28.08.2024).

[16] Cicely Saunders, *The Management of Terminal Malignant Disease* (London: Edward Arnold, 1978); Caroline Richmond, "Dame Cicely Saunders. Founder of the modern hospice movement", *British Medical Journal* 331 (2005): 238; John Ellershaw, Steve Dewar, Deborah Murphy, "Achieving a good death for all", *British Medical Journal* 341 (2010): 656-658.

[17] Maggie Watson, Jo S. Havilland, Steven Greer et al., "Influence of psychological response on survival in breast cancer: a population-based cohort study", *The Lancet* 354/9187 (1999): 1331-1336; Steven Greer, "Healing the Mind/Body Split: Bringing the Patient Back Into Oncology", *Integrative Cancer Therapies* 2/1 (2003) 5-12; Thomas Küchler, Beate Bestmann, Stefanie Rappat, "Impact of psychotherapeutic support for patients with gastrointestinal cancer undergoing surgery: 10-year survival results of a randomised trial", *Journal of Clinical Oncology* 25/9 (2007): 2702-2708; Barbara L. Anderson, Hae-Chung Yang, William B. Farrar et al., "Psychological intervention improves survival for breast cancer patients", *Cancer* 113/ (2008): 3450-3458.

[18] Sonja McIlfatrick, Felicity Hasson, "Evaluating an holistic assessment tool for palliative care practice", *Journal of Clinical Nursing* 23/7-8 (2014): 1073.

[19] Tiina Saarto, "Palliative care and oncology: the case for early integration", *European Journal of Preventive Cardiology* 2 (2014): 109; David A. Kain, Elizabeth A. Eisenhauer, "Early integration of palliative care into standard oncology care: evidence and overcoming barriers to implementation", *Current Oncology* 23/6 (2016): 374-377.

concurrently by interdisciplinary teams of specialists[20]:

> "The healthcare professional as healer therefore needs to address the whole person and will not practice exemplary medicine without attending to all patient needs, including spiritual needs. On these grounds, Sulmasy suggests that attention to the spiritual needs (that is, spiritual care) of patients is not only permissible, but a moral obligation for doctors"[21].

Based on these premises, it can be stated that the main advantage of the holistic model lies in the care for both the patient's condition and the patient, the family and the PC staff; also in the care for both the patient's life and preparation for death:

> "Holistic care is a comprehensive model of care, which is at the heart of nursing science. Holistic care recognizes the human being as a whole and the effect of psychological and spiritual health on physical well-being. By recognizing the person as a whole, holistic care attempts to identify the relationship between biological, social, psychological, and spiritual aspects. Medication, education, communication, self-help, and complementary treatment are some of the approaches to holistic care. A holistic approach is important when it comes to palliative care to improve the patient's life by addressing their emotional and physical well-being. Above all, it helps the patient to gain confidence and self-knowledge, and it also helps the nurse to gain a better understanding of how the disease affects the patient's life and needs. It is about improving harmony between the mind, body, emotions, and spirit in a changing environment [...] It is important to have a holistic perspective to understand the patient as a whole, due to the effect of spiritual health on the patient's psychosocial and physical health. The patient's autonomy, values, and beliefs should be respected from different perspectives, including religion, culture, and personal beliefs, by adopting an open and accepting view. Good spiritual health positively affects the patient's overall health. Several studies have shown that spiritual care has a positive correlation with improved immune function, positive coping strategies, pain control, and quality of life. In terminally ill patients, spiritual well-being, transcendence, hope, meaning, and dignity are closely related to pain management"[22].

---

[20] Steven Greer, Marie Joseph, "Palliative Care: A Holistic Discipline", *Integrative Cancer Therapies* 15/1 (2016): 8.

[21] Daniel P. Sulmasy, *The Rebirth of the Clinic: An Introduction to Spirituality in Health Care* (Washington, DC: Georgetown University Press, 2006); Megan C. Best, Bella Vivat, Marie-Jose Gijsberts, "Spiritual Care in Palliative Care", *Religions* 14/3 (2023): 320.

[22] Heven Tekeste, Nimo Osman, *Nurses' experiences of caring for patients' spiritual health needs in palliative care in India*, 2022, 4-5 (https://tinyurl.com/mrxy9d3z. Accessed: 25.08.2024).

Spiritual care: the epicenter of the holistic dimension of PC

Palliative care has developed as a specialty in recent times. As a field of care for the suffering or the dying, we can say that it has always existed. Since the first centuries, the Church has extended its mission to include caring for the sick and their families. In addition to taking care of the needs of the sick body, Christians also took care of the needs of the soul – even more so of Christians on their deathbeds. It is therefore not at all surprising that PC, even at its beginning, resembled and was identified more with an authentic Christian missionary activity than with a medical practice or hospital activity[23]. Today, more than ever, the need within PC for a holistic dimension with a central focus on spiritual assistance as a vital resource in finding the meaning and purpose of life is recognized[24], as is the need to develop aspects related to spiritual assistance[25]:

> "Addressing spirituality may become especially important in the face of a patient's life-threatening illness. A spiritual perspective is associated with better tolerance of physical and emotional stress and may reduce the risk of suicide and depression among patients with serious illness. Spiritual care can also be an important part of working with bereavement and grief"[26].

---

[23] David Clark, "Religion, medicine, and community in the early origins of St. Christopher's Hospice", *Journal of Palliative Medicine* 4/3 (2001): 356; James F. Drane, *A Liberal Catholic Bioethics* (Berlin: Lit, 2010), 193; Jane Seymour, "Looking back, looking forward: the evolution of palliative and end-of-life care in England", *Mortality*, 17/1 (2012): 4-5; David Clark, *Early origins of St Christopher's Hospice*, 2014, https://bit.ly/2Xg0QgO, Accessed: 13.01.2024.

[24] Alyson Moadel, Carole Morgan, Anne Fatone et al., "Seeking meaning and hope: self-reported spiritual and existential needs among an ethnically diverse cancer patient population", *Psycho-Oncology* 8/5 (1999): 378-385; John T. Chibnall, Susan D. Videen, Paul N. Duckro et al., "Psychosocial-spiritual correlates of death distress in patients with life-threatening medical conditions", *Palliative Medicine* 16/4 (2002): 331-338; Collen S. McClain, Barry Rosenfeld, William Breitbart, "Effect of spiritual well-being on end-of-life despair in terminally-ill cancer patients", *The Lancet* 361/9369 (2003): 1603-1607; Elizabeth Grant, Scott A. Murray, Marilyn Kendall et al., "Spiritual issues and needs: Perspectives from patients with advanced cancer and nonmalignant disease. A qualitative study", *Palliative and Supportive Care* 2/4 (2004): 371-378; Scott A. Murray, Marilyn Kendall, Kirsty Boyd et al., "Exploring the spiritual needs of people dying of lung cancer or heart failure: a prospective qualitative interview study of patients and their carers", *Palliative Medicine* 18/1 (2004): 25-33; Christina M. Puchalski, Robert Vitillo, Sharon K. Hull, Nancy Reller, "Improving the spiritual dimension of whole person care: reaching national and international consensus", *Journal of Palliative Care* 17/6 (2014): 646-648.

[25] Lucy Selman, Richard Harding, Marjolein Gysels et al., "The measurement of spirituality in palliative care and the content of tools validated cross-culturally: a systematic review", *Journal of Pain and Symptom Management* 41/4 (2011): 728-753.

[26] Miller, Megan et al., "Spiritual Care as a Core Component of Palliative Nursing", *The American journal of nursing*, 123/ 2 (2023): 55.

The European Association for Palliative Care (EAPC) has been involved in the introduction and promotion of spiritual assistance within PC, considered "the dynamic dimension of human life that relates to the way persons (individual and community) experience, express and/or seek meaning, purpose and transcendence, and the way they connect to the moment, to self, to others, to nature, to the significant and/or the sacred"[27]. Aspects of this dimension include belief in God and religious practices; the ultimate meaning of life and death, of self and values, and of suffering and pain; relationships with family and loved ones; and hope during the illness, including in the afterlife[28]:

> "Spirituality is about anything that pertains to a person's relationship with a higher power or nonmaterial life force. It involves different beliefs and is interpreted differently by each individual: some describe spirituality in terms of coming to know, love, and serve God, and another speaks of experiencing universal energy and transcending the limits of the body. Spiritual health helps people to have more effective interactions with their surroundings and live better lives, considering that it is about connecting with something that inspires security and trust. A person's spirituality is a reflection of their fundamental nature. It encompasses how they seek or express meaning and purpose in their lives. Spirituality contributes to pain relief in patients and is closely related to cultural beliefs and religious practices. Spiritual care is essential for patients suffering from terminal illnesses. It reduces depression, helplessness, and hopelessness and improves mental health among terminally ill patients"[29].

Spiritual care must be integrated into PC from the beginning so that the medical staff and the priest can work together. The Church must ensure that PC centers have a priest, who is prepared for this noble, but by no means easy, mission. In this sense, the priest will have to answer the patients' existential concerns, restore their hope in the continuation of life beyond biological death, prepare them for the encounter with Christ, confess and share with them. Belief in God can have positive effects in the management of terminal illness, as demonstrated by the testimonies patients:

---

[27] Steve Nolan, Philip Saltmarsh, Carlo Leget, "Spiritual care in palliative care: working towards an EAPC task force", in: *European Journal of Preventive Cardiology* 18/ 2 (2011): 88.

[28] Megory Anderson, Christina Faull, "Spirituality in Palliative Care", in C. Faull, S. de Caestecker, A. Nicholson, F. Black (Eds.), *Handbook of Palliative Care* (Hoboken: Wiley-Blackwell, 2012), 356-363.

[29] Heven Tekeste, Nimo Osman, *Nurses' experiences of caring for patients' spiritual health needs in palliative care in India*, 2022, 4-5 (https://tinyurl.com/mrxy9d3z. Accessed: 25.08.2024).

> "Well, I've had surgery, chemotherapy, radiation. I understand the side effects, the feelings, the anxieties, and the fears. I think that just helps me relate to patients and the families […] My illness also strengthened my faith, because I had a lot of prayer at that time, I was baptized at that time. So I think I kind of went through a transformation during my cancer treatment that increased my faith and strengthened it"[30].

Therefore, faith is the source of strength and peace that removes the fear of death, that strengthens the believer in the expectation of life after biological death[31].

The mere act of talking to someone can itself be beneficial, as we read from the testimonies of some patients severely affected by disease: "A young single father […] went to theatre, open and close. He was riddled with cancer. His pain relief kept escalating without any effect. We sat down and talked […] and got him to tell his story […] and his needs for opiates actually decreased significantly"[32].

The priest's mission will be more difficult when he meets non-practicing Christians, atheists or free-thinkers. These patients may have never before met with a clergyman, and the meeting could be decisive for the afterlife. For the priest, it can be an equally unusual meeting, due to the demands and particularities of his dialogue partner and the challenges of the meeting.

Spiritual assistance must also be directed to the patient's family. Family members suffer alongside the patient, sometimes perhaps even more than the patient when there is no acceptance of the circumstances. Therefore, the priest must be in permanent contact with the family members and support them with everything he can. In this sense, we must remember that the Church has always been concerned with the lives of its believers, especially in difficult times. Already, the Church allocates important funds to support the medical field and builds medical spaces, care spaces, housing for the families of those who are undergoing treatment in hospitals etc.

---

30 G. Pittroff, "The humbled expert: An exploration of spiritual care expertise", *Journal of Christian Nursing* 30/3, (2013):164-165.

31 Jonathan Koffman, Myfanwy Morgan, Polly Edmonds et al., "Cultural meanings of pain: a qualitative study of Black Caribbean and White British patients with advanced cancer", *Palliative Medicine* 22/4 (2008): 350-359; Peter Speck, "Culture and spirituality: essential components of palliative care", *Postgraduate Medical Journal* 92/1088 (2016): 341-345.

32 R. Keall, J.M. Clayton, P. Butow, "How do Australian palliative care nurses address existential and spiritual concerns? Facilitators, barriers and strategies", *Journal of Clinical Nursing* 23/21 (2014): 3201.

However, family members must also be with the patient. They must be by his/her side from a physical point of view, but also from a moral point of view. Likewise, the prayer raised to the Heavenly Father by those close to us is the one that works and achieves God's mercy. We have countless examples from the Gospel stories in which our Savior Jesus Christ heals suffering after family members or friends bring the sufferer, pray for him or confess the true faith. This prayer is the saving prayer, and healing comes from solidarity in prayer.

The involvement of the priest must be active around those who receive PC, but also around those who are thinking about assisted death. To the latter group, the priest can speak of human life as a gift from God; responsibility toward one's own life and death, towards family, community and God; and the meaning of existence through perfection already in this life. That is why the tact, erudition and openness of the priest must be among the choicest. The priest's mission does not end with the biological death of the patient, as he must then perform the proper services and bring consolation to the patient's family.

Spiritual care is important in the life of every person, whether healthy or sick. But according to the words of the Savior, it is vital in the case of the sick, because "It is not the healthy who need a doctor, but the sick. I have not come to call the righteous, but sinners" (Mark 2, 17):

> "Spiritual well-being has been identified as a core domain in the assessment of quality of life in the setting of serious illness. It has been shown to be as important as physical well-being when assessing quality of life in cancer patients. Quality of life measures identify a unique effect for the spiritual domain, distinct from psychosocial and emotional domains, and which enables some patients to enjoy life even in the midst of experiencing unpleasant physical symptoms"[33].

Medicine and Christian teaching have many more points in common and much greater potential for collaboration than we perceive and see today in the public scene. Even if the concern for spiritual life must be a continuous one, now and into the future, not only in moments of balance, but indeed every day; even if studies have demonstrated that spiritual care can lead to an improvement in medical condition has been noticed; still this care is missing from hospitals and often from PC centers. Recent studies linking improvement in the patient's condition to the provision of spiritual care[34] also indicate the following: improved

[33] Megan C. Best, Bella Vivat, Marie-Jose Gijsberts, "Spiritual Care in Palliative Care", 320.

[34] Megan C. Best, Phyllis Butow, Ian Olver, "Palliative care specialists' beliefs about spiritual care", *Supportive Care in Cancer* 24/8 (2016): 3295-3306; Megan C. Best et. al., "Australian Patient Preferences for discussing Spiritual Issues in the Hospital Setting: An Exploratory Mixed Methods Study", *Journal of Religion and Health* 63/1 (2023):1-19.

the quality of life, increased self-esteem, increased confidence, improved doctor-patient relationship, finding meaning in the experience of illness, and decreased care costs[35]:

> "Studies to date have shown that addressing the spiritual needs of patients in palliative care is associated with many positive outcomes for both patients and their relatives. Although the evidence base for spiritual care interventions is currently limited, more studies are currently being conducted. More consistency in the design of RCT's, in particular, would enable meta-analysis and thereby the drawing of broader conclusions on the efficacy of these interventions. Provision of spiritual care requires that institutions recognise the need for such care, including through providing staff training and support, which benefits both patients and staff, who are thereby also enabled to provide better support to patients"[36].

Spiritual care becomes the most important resource in times of crisis:

> "Someone who receives a life-threatening diagnosis such as cancer is confronted with existential questions such as 'why is this happening to me?', 'what will happen after I die?', or 'will my family cope after I am gone?'. This has been described as the 'existential slap'[37], or personal crisis, which accompanies the realization that death is a possible outcome, regardless of prognosis. Spiritual resources are required to cope with this crisis and if the questions that arise are not resolved, existential (or spiritual) suffering[38] can ensue[39].

For the measurement of spiritual well-being, the SWB32 questionnaire has been developed, consisting of four scales: "Relationship with Self, Relationships with Others, Relationship with Someone or Something Greater, and Existential, plus a global spiritual well-being item and a single-item scale for Relationship with God, for those with a religious faith including a personal God"[40]. Therefore,

---

35 Elizabeth Grant et. al, "Spiritual issues and needs: Perspectives from patients with advanced cancer and nonmalignant disease. A qualitative study", *Palliative and Supportive Care* 2/4 (2005): 371-378; Tracy Anne Balboni et. al., "Provision of spiritual care to patients with advanced cancer: Associations with medical care and quality of life near death", *Journal of Clinical Oncology* 28/3 (2010): 445-52; Dan Taylor et. al., "Spirituality within the Patient-Surgeon Relationship", *Journal of Surgical Education* 68/1 (2011): 36-43.

36 Megan C. Best, Bella Vivat, Marie-Jose Gijsberts, "Spiritual Care in Palliative Care", 320.

37 Nessa Coyle, "The existential slap - A crisis of disclosure", *International Journal of Palliative Nursing* 10/11 (2004): 520.

38 Megan C. Best, Lynley Aldridge, Phyllis Butow, Ian Olver, Fleur Webster, "Conceptual Analysis of Suffering in Cancer: A systematic review", in: *Psycho-Oncology* 24/9 (2015): 977-986.

39 Megan C. Best, Bella Vivat, Marie-Jose Gijsberts, "Spiritual Care in Palliative Care", 320.

40 Megan C. Best, Bella Vivat, Marie-Jose Gijsberts, "Spiritual Care in Palliative Care", 320

reconciliation, horizontally with one's own person, with one's neighbor and with the environment opens the way to vertical reconciliation with the Good God, thus realizing the feeling of acceptance and true preparation for meeting Christ.

Conclusions

Caring for the suffering is, first, an exhortation for the contemporary Christian. Christian teaching has identified the love of one's neighbor with the love of one's own person. Thus, caring for one's neighbor is a mirror condition, both for the cultivation of virtues and the knowledge of God's gifts.

Second, we are blessed to live longer than our forefathers. But sometimes this change also means experiencing more hardships and suffering more through the prolonging of old age and the dying process, given that medical advances extend our lives, but sometimes consequently expose us to a prolonged experience of medicalized and institutionalized death[41].

Thirdly, the *financialization* of life has also led to a *financialization* of death. In this sense, the costs of care for dying patients have been and are considered, in certain institutions, to be unnecessary or secondary. But man's life remains of the same quality, with the same value and dignity, regardless of suffering, illness or pain. Life is life, a gift is a gift, even if it interacts with illness or suffering. Care means concern for the patient's life and for his/her preparation for meeting Christ. Preparation means acceptance and reconciliation, not hastening death.

In this sense, we can overcome the obstacles of death foreign to our nature through a new treaty of *ars moriendi*,[42] in which man "need not fight death to the end; because he knows that the person on his deathbed is in God's hands, even though the process of death, of course, can be hard and cruel"[43]. Instead, it needs to reacquaint us with death and the dying and to prepare us for death. It could contain information and advice needed by both carers and those being cared for. This activity involves a preparation for both parties, about how dying can be managed in a simpler or easier way, without pain, with mercy, respecting faith, dignity, autonomy and, ultimately, the life of the patient[44].

---

41 Emily Jackson, John Keown, *Debating Euthanasia*, 8.

42 Catherine Bando, "Assisted Death…" (*Theses and Dissertations*, 2018), https://bit.ly/2vMJux1, Accessed: 27.01.2024.

43 Friedrich Heckmann, "Etica creștină și responsabilitatea Bisericilor față de procesul morții și moarte într-o societate seculară și postmodernă", in: M. Hartmann, V. Stanciu (Eds.), *Viața ca dar al lui Dumnezeu. Responsabilitatea creștină în perspectiva morții*, Trans. L. Boloș (Sibiu: Schiller 2018), 121.

44 The PC specialists made a series of recommendations regarding the care of the dying, including the creation of a sacred space for ritual and prayer, an environment that would restore the

Only through this preparation can contemporary man be refamiliarized with death and, at the same time, only in this way can the futility of assisted death and related options be demonstrated, or the primacy, uniqueness and authenticity of Christian fulfillment be revealed through palliative care.

BIBLIOGRAPHY

Anderson Barbara L. Yang Hae-Chung. Farrar William B. et al. "Psychological intervention improves survival for breast cancer patients". *Cancer* 113/ (2008): 3450-3458.

Anderson Megory. Faull Christina. "Spirituality in Palliative Care". C. Faull, S. de Caestecker, A. Nicholson, F. Black (Eds). *Handbook of Palliative Care*. (Hoboken: Wiley-Blackwell, 2012), 356-363.

Anderson, Ray S. *Theology, Death and Dying* (New York: Basil Blackwell, 1986).

Balboni Tracy Anne, et al. "Provision of spiritual care to patients with advanced cancer: Associations with medical care and quality of life near death". *Journal of Clinical Oncology* 28/3 (2010): 445-452.

Bando Catherine. "Assisted Death: Historical, Moral and Theological Perspectives of End-of-Life Options". *Theses and Dissertations*, 2018. https://bit.ly/2vMJux1. Accessed: 27.01.2024.

Bernheim Jan L. Raus Kasper. "Euthanasia embedded in palliative care. Responses to essentialistic criticisms of the Belgian model of integral end-of-life care". *Journal of Medical Ethics* 43/8 (2017): 489-494.

Best Megan C. et al. "Australian Patient Preferences for discussing Spiritual Issues in the Hospital Setting: An Exploratory Mixed Methods Study". *Journal of Religion and Health* 63/1 (2023): 1-19.

Best Megan C. Aldridge Lynley. Butow Phyllis. Olver Ian. Webster Fleur. "Conceptual Analysis of Suffering in Cancer: A systematic review". *Psycho-Oncology* 24/9 (2015): 977-986.

Best Megan C. Butow Phyllis. Olver Ian. "Palliative care specialists' beliefs about spiritual care". *Supportive Care in Cancer* 24/8 (2016): 3295-3306.

Best Megan C. Vivat Bella. Gijsberts Marie-Jose. "Spiritual Care in Palliative Care". *Religions* 14/3 (2023): 320.

Beuselinck Benoit. "2002-2016: Fourteen Years of Euthanasia in Belgium. First-Line Observations by an Oncologist". in D.A. Jones, C. Gastmans, C. Mackellar (Eds). *Euthanasia and Assisted Suicide. Lessons from Belgium*. Cambridge: Cambridge University Press, 2017, 101-113.

patient's sense of peace and comfort in the family, teams of permanent caregivers to keep vigil until death so that the patient would not die alone and respect for liminal experiences and aftercare. Megory Anderson, Christina Faull, "Spirituality in Palliative Care", 362.

Butler Emily. et al. "The Efficacy of Hospice-In-Place Care Versus Traditional Inpatient Care". *The American journal of hospice & palliative care* 41/8 (2024): 863-872.

Chibnall John T. Videen Susan D. Duckro Paul N. et al. "Psychosocial-spiritual correlates of death distress in patients with life-threatening medical conditions". *Palliative Medicine* 16/4 (2002): 331-338.

Clark David. "Religion, medicine, and community in the early origins of St. Christopher's Hospice". *Journal of Palliative Medicine* 4/3 (2001): 353-360.

Clark David. *Early origins of St Christopher's Hospice*. 2014. https://bit.ly/2Xg0QgO, Accessed: 13.01.2024.

Coyle Nessa. "The existential slap - A crisis of disclosure". *International Journal of Palliative Nursing* 10/11 (2004): 520.

Drane James F. *A Liberal Catholic Bioethics*. Berlin: Lit, 2010.

Ellershaw John. Dewar Steve. Murphy Deborah. "Achieving a good death for all". *British Medical Journal* 341 (2010): 656-658.

Foley Kathleen. "Patients Need Better End-of-Life Care Rather than Assisted Suicide". in L.M. Medina (Ed). *Euthanasia*. Detroit: Gale, 2005.

Frith Hannah. Raisborough Jayne. Klein Orly. "Making death «good»: instructional tales for dying in newspaper accounts of Jade Goody's death". *Sociology of Health and Illness* 35/3, (2013): 419-433.

Grant Elizabeth. et al. "Spiritual issues and needs: Perspectives from patients with advanced cancer and nonmalignant disease. A qualitative study". *Palliative and Supportive Care* 2/4 (2005): 371-378.

Grant Elizabeth. Murray Scott A. Kendall Marilyn. et al. "Spiritual issues and needs: Perspectives from patients with advanced cancer and nonmalignant disease. A qualitative study". *Palliative and Supportive Care* 2/4 (2004): 371-378.

Greer Steven. "Healing the Mind/Body Split: Bringing the Patient Back Into Oncology". *Integrative Cancer Therapies* 2/1 (2003): 5-12.

Greer Steven. Joseph Marie. "Palliative Care: A Holistic Discipline". *Integrative Cancer Therapies* 15/1 (2016): 5-9.

Heckmann Friedrich. "Etica creştină şi responsabilitatea Bisericilor faţă de procesul morţii şi moarte într-o societate seculară şi postmodernă". In M. Hartmann, V. Stanciu (Eds). *Viaţa ca dar al lui Dumnezeu. Responsabilitatea creştină în perspectiva morţii*. Trans. L. Boloş. Sibiu: Schiller 2018.

Jackson Emily, Keown John. *Debating Euthanasia*. Oxford: Hart Publishing, 2012.

Kain David A. Eisenhauer Elizabeth A. "Early integration of palliative care into standard oncology care: evidence and overcoming barriers to implementation". *Current Oncology* 23/6 (2016): 374-377.

Keall R. Clayton J.M. Butow P. "How do Australian palliative care nurses address existential and spiritual concerns? Facilitators, barriers and strategies". *Journal of Clinical Nursing* 23/21 (2014): 3201.

Kirk Timothy W. Mahon Margaret M. "National Hospice and Palliative Care Organization (NHPCO) Position Statement and Commentary on the Use of Palliative Sedation in Imminently Dying Terminally Ill Patients". *Journal of Pain and Symptom Management* 39/5 (2010): 914-923.

Koffman Jonathan. Morgan Myfanwy. Edmonds Polly. et al. "Cultural meanings of pain: a qualitative study of Black Caribbean and White British patients with advanced cancer". *Palliative Medicine* 22/4 (2008): 350-359.

Kozlov Elissa. Reid M. Carrington. Carpenter Brian D. "Improving patient knowledge of palliative care: A randomized controlled intervention study". *Patient Education and Counseling* 100/5 (2017): 1007-1010.

Küchler Thomas. Bestmann Beate. Rappat Stefanie. "Impact of psychotherapeutic support for patients with gastrointestinal cancer undergoing surgery: 10-year survival results of a randomised trial". *Journal of Clinical Oncology* 25/9 (2007): 2702-2708.

Landman, Willem A. *End-of-Life Decisions, Ethics and the Law*. Geneva: Globethics.net Focus, 2012.

LiPuma Samuel H. "Continuous Sedation until Death as Physician-assisted suicide/ euthanasia: A Conceptual Analysis". *Journal of Medicine and Philosophy* 38/2 (2013): 190-204.

McClain Collen S. Rosenfeld Barry. Breitbart William. "Effect of spiritual well-being on end-of-life despair in terminally ill cancer patients". *The Lancet* 361/9369 (2003): 1603-1607.

McIlfatrick Sonja. Hasson Felicity. "Evaluating an holistic assessment tool for palliative care practice". *Journal of Clinical Nursing* 23/7-8 (2014): 1064-1075.

Moadel Alyson. Morgan Carole. Fatone Anne. et al. "Seeking meaning and hope: self-reported spiritual and existential needs among an ethnically diverse cancer patient population". *Psycho-Oncology* 8/5 (1999): 378-385.

Morris Tom. *Growing Through Grief. A Book and Discussion Guide for Grief Groups*. Cambridge YTC Press, 2008.

Murray Scott A. Kendall Marilyn. Boyd Kirsty. et al. "Exploring the spiritual needs of people dying of lung cancer or heart failure: a prospective qualitative interview study of patients and their carers". *Palliative Medicine* 18/1 (2004): 25-33.

Nolan Steve. Saltmarsh Philip. Leget Carlo. "Spiritual care in palliative care: working towards an EAPC task force". *European Journal of Preventive Cardiology* 18/ 2 (2011): 88.

Pittroff G. "The humbled expert: An exploration of spiritual care expertise". *Journal of Christian Nursing* 30/3, (2013): 164-165.

Puchalski Christina M. Vitillo Robert. Hull Sharon K. Reller Nancy. "Improving the spiritual dimension of whole person care: reaching national and international consensus". *Journal of Palliative Care* 17/6 (2014): 646-648.

Quill Timothy E. "Dying and Decision Making — Evolution of End-of-Life Options". *New England Journal of Medicine* 350/20 (2004): 2029-2032.

Richmond Caroline. "Dame Cicely Saunders. Founder of the modern hospice movement". *British Medical Journal* 331 (2005): 238.

Saarto Tiina. "Palliative care and oncology: the case for early integration". *European Journal of Preventive Cardiology* 2 (2014).

Saunders Cicely. *The Management of Terminal Malignant Disease*. London: Edward Arnold, 1978.

Selman Lucy. Harding Richard. Gysels Marjolein. et al. "The measurement of spirituality in palliative care and the content of tools validated cross-culturally: a systematic review". *Journal of Pain and Symptom Management* 41/4 (2011): 728-753.

Seymour Jane. "Looking back, looking forward: the evolution of palliative and end-of-life care in England". *Mortality* 17/1 (2012): 1-17.

Speck Peter. "Culture and spirituality: essential components of palliative care". *Postgraduate Medical Journal* 92/1088 (2016): 341-345.

St. Maximus the Confessor. "Răspunsuri către Talasie", in *Filocalia sau culegere din scrierile Sfinților Părinți care ne arată cum se poate omul curăți, lumina și desăvârși*. vol. III. Translated by Fr. Dr. Dumitru Stăniloae. București: Humanitas, 1999.

Sulmasy Daniel P. *The Rebirth of the Clinic: An Introduction to Spirituality in Health Care*. Washington, DC: Georgetown University Press, 2006.

Taylor Dan. et al. "Spirituality within the Patient-Surgeon Relationship". *Journal of Surgical Education* 68/1 (2011): 36-43.

Tekeste Heven. Osman Nimo. *Nurses' experiences of caring for patients' spiritual health needs in palliative care in India*. 2022, 4-5. https://tinyurl.com/mrxy9d3z. Accessed: 25.08.2024.

Thielicke, Helmut. *Living with Death*. Translated by G. Bromiley. Grand Rapids: Wm. B. Eerdmans, 1983.

Vanderbilt Center for Health Services Research. *Qualitative Research Core*. https://tinyurl.com/2avmefbs. Accessed: 28.08.2024.

Watson Maggie. Havilland Jo S. Greer Steven. et al. "Influence of psychological response on survival in breast cancer: a population-based cohort study". *The Lancet* 354/9187 (1999): 1331-1336.

World Health Organization. *WHO definition of palliative care*, 2023. https://tinyurl.com/mw52ajn8. Accessed: 02.06.2024.

Zimmermann Camilla. "Acceptance of dying: A discourse analysis of palliative care literature". *Social Science & Medicine* 75/1 (2012): 217-224.