

ABOUT CLERGY AND FAITH COMMUNITIES

The Role of Clergy and Faith Communities in End of Life Care

Except for conducting funerals and burial rites, many faith communities have relegated care for the dying to medical professionals. The hospital or hospice chaplain, likewise, frequently provides spiritual care at the end-of-life, rather than a person's own clergy.

There are a number of reasons why the clergy or faith community may retreat from a dying member--lack of familiarity with complex ethical issues, limited knowledge of medical treatments, and concern about interfering with the care provided by the hospital or hospice chaplain, and discomfort in dealing with issues of death. In some cases, a conflict between the beliefs and values of a religious tradition and the goals of medicine leads the faith community to withdraw care and support at this crucial time in the lives of its members.

Recently, efforts have been undertaken by various national and local organizations to increase the participation of faith communities in end-of-life care through outreach, education, and closer ties with palliative and hospice care providers. In each case, the partnership begins with respect for the fundamental beliefs and practices of the respective religious tradition.

Twelve Activities to Encourage the Participation of Faith Communities in End of Life Care

1. Ongoing education of members on beliefs about meaning of life, suffering, illness, healing, dying and death, and afterlife.
2. Raise awareness about fundamental religious values vis-à-vis medicine.
3. Offer educational forums on specific issues related to end-of-life such as advanced directives, funeral and burial customs, legal matters and estate planning, hospice care, etc.
4. Be an advocate within the medical system for respect of religious beliefs, practices, and prohibitions as well as for the importance of spiritual care at the end-of-life.
5. Help members clarify specific goals of medical care that are in keeping with religious beliefs and values.
6. Assist patients and families with difficult decisions regarding the direction of medical treatment and ethical dilemmas about withdrawal of life support, artificial nutrition, use of antibiotics, etc.
7. Provide spiritual care and counseling to patients who are terminally ill and to their families.
8. Mediate divine presence and affirm value and personhood.
9. Provide assistance in sustaining religious practices and rituals for patients in the hospital or unable to leave home.
10. Provide practical assistance such as respite for caregivers, meals, running errands, and housekeeping.
11. Ensure proper disposition and treatment of the body at the time of death, and conduct funerals, memorial services, and burial rites.
12. Offer bereavement counseling and grief support groups.

An Example

Sylvia is a 49-year-old Roman Catholic with end-stage pancreatic cancer. She and her husband have been active members of the local parish for over 20 years. Sylvia was a member of the altar guild, a lay Eucharistic minister, and part of a care team that provided pastoral care to a nearby nursing home on a weekly basis. Her husband works at the parish school.

While ill, Sylvia has remained strong in her Catholic faith and many persons have told her what an inspiration she has been to them. Although Sylvia prays for a divine cure, she accepts "God's will" and is actively preparing herself and her family for her death. A firm foundation in her religious faith prior to her diagnosis assisted Sylvia in "seeing God's goodness even in the midst of illness and hard times," and in trusting that emotional and spiritual healing was occurring even as her physical condition worsened.

The chaplain met with Sylvia and her family shortly after her admission to hospice care. Together they quickly identified several spiritual needs: daily sacraments (Sylvia used to attend daily mass), pastoral and grief counseling for Sylvia's

husband still in denial about her prognosis, family reconciliation needs as a result of a history of alcohol abuse by Sylvia's husband, and respite care for Sylvia's adult children who were piecing together her care at home.

The church administrator, a nun described by all as "the heart of the parish," agreed to organize members to provide daily sacraments to Sylvia in her home and to pull together a "care team" to give family members much needed breaks at regularly scheduled times. These services helped sustain Sylvia's strong identity as a church member and provided her with opportunities to "witness" to others. They also gave her peace of mind about the well being of her family.

Since the parish priest was relatively new and did not have know the family well, Sylvia requested that the chaplain track down the former pastor of the parish who had a close relationship with her husband and would be in the best position to facilitate a family reconciliation meeting and provide the husband with grief/bereavement care. He remained in close contact with the hospice chaplain throughout the course of Sylvia's illness and was able to respond at critical junctures to help shift the focus of hope and help them accept Sylvia's impending death. He has agreed to provide the husband with bereavement counseling.

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