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HAPPY EASTER

We at the Secretariat thank Father Paul Brekelmans for the teamwork he shared with us during the past six months and extend to him our hope for a bright future.

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This issue of the Sedos bulletin comes to you with the best wishes of the staff at the Sedos Secretariat for a happy and holy Easter Season.

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Coming Events:

EXECUTIVE COMMITTEE MEETING: May 4: 4:00 PM at the FSC Generalate

GENERAL ASSEMBLY: June 2: All day at the FSC Generalate

Notice:

THE SEDOS SECRETARIAT will be closed during the Easter holidays from April 15 to April 20 — both dates inclusive.

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SOME REFLECTIONS ON DEATH AND DYING IN THE WESTERN WORLD

by Sister Francis Webster - M.D.,M.P.H.

Death, the end of life inspires in all humans fear and grief regardless of race or culture. All the religions and the myths of a people deal with death and "what comes afterward". Their thoughts and ideas about death and the event itself have left their imprint in the world of art, literature and music. Today however, we will focus, not so much on the moment of death but on dying - that period of time which more immediately precedes death and in which the person is aware that, he, himself in person will soon die. It is true that all time after our birth is time preceding our death, but we are accustomed to see this time, and rightfully so, as living and not dying.
In one sense though, we are in the same position as the terminally ill, with only "X" days to live. In the normal mode of behavior like all men in health, I think, death is not for me but for "the other". As one author (1a) puts it: "In a hundred years we shall all be dust, but not I".

This morning I thought, we could spend time considering how "the other" dies and how we can be of help to him in this great crisis of his life. Hopefully, we will also find this study helpful to ourselves. For each of us "time is running out". How often has it not happened that someone, apparently in good health visiting a patient terminally ill, dies before the patient?

Last year there appeared in Time Magazine (2) a short article which reported a new commercial enterprise in Los Angeles, Calif. known as "THRESHOLD". This business undertakes to supply "death companions" for $ 7.50 an hour. The task of the "death companion" is to provide comfort and companionship to those dying alone and isolated - if they can afford the fee. Accompanying the article was a picture of an old man in bed wearing a torn sweater over his pyjamas and clasping the hand of the youngish woman who was learning to be a "companion" by visiting the indigent terminally ill in a nursing home.

As one reflects on this poignant picture there comes to mind the picture of another man not so old, but also suffering and dying and writing during his last days a beautiful poem of Praise to God in his Creation in which he exults:

> Be praised, my Lord, for our Sister Bodily Death,
> whom no living man can escape. Woe to those who
> die in mortal sin!
> Blessed are those who she will find doing your holy
> Will, for to them the second death will do no harm.

I think all of us would rejoice to see others die with the same joy and contentment as the little man of Assisi, peacefully praising the Lord for Sister Bodily Death.

While the idea of making a business such as "Threshold" out of a dying man's psychological need is repulsive, the fact that it can exist, points to a genuine lack in our present western cultural behavior. Other cultures have known paid mourners, but I have not heard of any (there may be some) who have had paid "death companions". It rather emphasizes that our companions during life seem to desert us as death approaches and that the dying in our culture often have to face death alone. This aloneness may be the physical and psychological isolation of an intensive care unit where professionals are very busy about many things or only psychological aloneness in a room where visitors come with masks of cheery faces and small talk that tries to deny the fact that the inevitable separation is not far off, or even perhaps in a place where no visitor comes at all.

Our 20th century Western culture responds to the notion of death with repression and denial. We see this in the common practise of embalming in USA and making the corpse look "natural", in the use of funeral parlors where death is held at a distance from the mourners, as well as in the development of cryo-technology which freezes the dead body and preserves it in liquid nitrogen (3a) against the day medical science has reached the point it can be thawed out and "resurrected"! In Los Angeles, Calif. there is a cemetery where "death" is banished and everything is done by way of landscaping, statuary and names to convey the impression that the cemetery is actually a pleasant park.

Perhaps, because there has been such a concerted effort to deny the reality of death and also perhaps because most people in the West nowadays die in a hospital rather than at home, there has been less and less contact with death at first hand. Nonetheless, there is increased interest and much curiosity about the topic of death and dying. Library shelves are full of popular and scientific books and journals, which carry articles on many facets of the topic: religious, psychological, different cultural approaches, literary expressions, medical views of the process of death and the newest possible interventions to prolong life, as well as the legal implications of some of the new medical possibilities. The use of machines which take over the function of an organ such as a kidney, or radically assist an organ such as the lung, the increasing use of transplantations of organs which poses questions to the donor body, have of late stimulated even more, this interest in death.

The health professions have always been dedicated to life and life saving. Those who seek help from them hope for health but if this is not possible expect at least life. Death is generally seen by the professional as failure. Consequently strenuous continuous efforts are expended to heal the sick, some of which stem basically

from a refusal to admit the "failure" that death has come indeed and the medical profession can do no more. Death for the professional, is the ADVERSARY to be overcome and not Sister Bodily Death, a friend who is being welcomed.

Suppose today, instead of looking at our health work in the context of the many successes it has had and the wonderful achievements it can point to, we take a look at the time of so-called "failure". At this point, I think many of us, maybe most of us, respond quite negatively. One reaction is to shy away from the incurably or terminally ill from a sense of uncertainty and from the feeling that "there is nothing we can do anymore". Is it really true to say "there is nothing we can do anymore"? We so often say this and more often think it. We justify our shyness by the comment that the "others whom we can help medically need our time and attention more". But suppose we accept that this attitude is not really honest and that "we CAN do something". Then we are faced with questions such as "What can we do? What does the one who is dying want us to do? What help can we give, that will really fulfill his needs?"

First, I would like to share with you some research findings obtained by working with the terminally ill. (4)

About ten years ago in the fall of 1965 a young Swiss psychiatrist Dr. Elizabeth Kübler-Ross was asked by four theology students of the Chicago Theological Seminary to help with a research project on "death" as the biggest crisis people have to face in their lifetime. As the group discussed the matter, they came to the conclusion that the only relevant way to study death and dying was to get the terminally ill patients to be their teachers. From them, they would learn what were the responses people made to this crisis and what were their needs.

From the material obtained from her hundreds of interviews with terminally ill patients, Dr. Kübler-Ross has been able to chart a psychological path, a common pattern of response, that the terminally ill patients, in USA at least, take. She has identified five stages through which these patients move, beginning with the initial shock of the illness to the final acceptance of death at the end of the road.

It is important for all who wish to help the dying to have some understanding of the psychic process which is going on. For this reason, and also to be able to understand ourselves, let us examine these five stages, denial, anger, bargaining, depression and acceptance.

1. The individual's first reaction to the possibility of a life threatening illness (which in the West in most cases is some form of malignancy or severe heart disability), was shock. This response was usually only temporary and gradually faded. Denial, especially in the case of malignancy, followed shock closely and Dr. Kübler-Ross found it existed in all the patients she interviewed regardless of whether they were told in the beginning that the illness was fatal, or themselves guessed it as the illness ran its course. Denial is the most radical of all the psychological defense mechanisms. Its use gives the person time to adjust to a threatening situation. Only in a few extreme cases did she observe that the patient maintained this denial until death.

Most patients she discovered soon experienced denial coupled with partial acceptance. It was this co-existence of denial and partial acceptance which was responsible for the patient's contradictory behavior, which the onlooker always finds so strange. The contradiction was expressed on both verbal and non-verbal levels. For example, the patient would refer to his illness as minor but at the same time agree to very radical surgical procedures.

The defense mechanism of denial was found to be most useful to the patient in the beginning of his illness but the need for it at various times was observed even to the end. Dr. Kübler-Ross considers this behavior of denial a healthy way of dealing with a long and painful illness. Her study showed also that the patients were very selective in their expressions of denial to others. If members of the family were also using denial and could not face the fact of a terminal illness, the patient in his contact with them expressed denial. On the other hand, he would often express full awareness of his condition to those who were willing to accept it. It was this selectivity which led to the differing impressions of the patient by those with whom he was in contact.

2. When denial became no longer possible, the patients expressed feelings of anger, rage, envy and resentment which were vented at random on doctors, nurses, staff, family, as well as anger at God, the Church and all religion. In many -perhaps most- the anger took a most basic form, i.e. anger that others were well and living and he was dying, that others who had lived long, were still living and well and he, who was younger, was dying when there was still so much to do, to be hoped for, and so much of life still unfulfilled. The rage was due to the patient's realization of his own helplessness and his acceptance of the helplessness of others.

From the standpoint of the medical staff and family this stage could be quite difficult. Too often, not understanding the cause of the anger, they reacted to it as a personal

affront. Their own angry response then added to the patient's hostility and his sense of abandonment by those he had loved and trusted as they cut short their visits, engaged in arguments etc. Those who cared intimately for the patient's needs whether nursing professionals or family, were especially the scape-goats in this stage of unreasoning anger. Yet, as Dr. Kübler-Ross observed, if we would put ourselves in the patient's position where his life's activities were so suddenly interrupted, his plans cancelled etc., we too would feel the same anger.

3. In time, the patient found denial did not work and anger did not help, so like a child he entered into bargaining. Perhaps if he pleaded nicely, God would be more favorable and the inevitable could be postponed. So he usually promised something. One is reminded of King Hezekiah's prayer when Isaiah told him that Yahweh had said he would die. The king pleaded and reminded Yahweh how faithfully he had served him. Yahweh heard his prayer and granted him fifteen more years of life.

When the underlying dynamic was a feeling of guilt, and the illness was seen as punishment, the minister of religion, the chaplain was often of great help in his position as mediator between God and man.

4. When the terminally ill patient could no longer deny the reality of his illness, when his rage had been dissipated and his bargaining abandoned he entered the phase of depression. The depression he experienced Dr. Kübler-Ross has divided into: a) reactive depression which deals with external such as unmet responsibilities, unfulfilled life expectations, tasks undone and b) preparatory depression which should be used to help him prepare for the impending loss of his loved ones and lead him on to the acceptance of death.

5. Having worked through the preceding stages, the patient was observed to arrive at a view of his coming end with a certain quiet expectation. Dr. Kübler-Ross does not see this acceptance as a happy state but considers it to be a stage void of feeling and likens it to early infancy. Theologian Gisbert Onshake (5a) after quoting E. Jüngl who wrote "there is a passivity without which man would not be human. This includes the fact of being born... and it includes the fact of dying", comments: "And who can say whether dying does not reduce us to a passivity like that of birth ?"

Physically at this stage Dr. Kübler-Ross's patients were usually tired and weak and slept often for brief intervals. Their circle of interest became much diminished and they preferred fewer visitors.

As the patient worked through the different stages, even the final stage of acceptance, his constant companion was hope. Nearly all the patients seemed to leave the possibility open for some cure, some new drug, discovery etc. For many, this hope was a rationalization which enabled them to continue to undergo more tests etc., but often the hope was really a temporarily needed denial. Experience showed that the dying are never without hope. The phrase "hopeless case" reflects much more the position of the doctor than the patient. Dr. Kübler-Ross found that when the patient stopped expressing hope, death was imminent.

Two painful conflicts were observed in connection with hope. The more painful of the two was present when the staff and family communicated a sense of hopelessness to a patient who still needed hope badly. In the other conflict, also a source of anguish, the patient was ready to die but the family was unable to accept that he had reached the end.

These interviews with terminally ill patients teach us how important it is for a person with a serious illness to have around him persons who not only care but understand. Of course, ultimately, each one must face death alone. Still, all along the way up to that moment of total aloneness with God, others can be of immense help. For each of the dying at certain stages in this process of growing toward total acceptance of death there was the deep need for someone who would stay with him. It is precisely in our very technological society, where death and the preparation for it are taboo, that most men find themselves helpless when confronted with death which, too often, is experienced as a wholly incomprehensible fate forced on them from outside.

It was further observed that, the patient who could look back on life with a sense of fulfillment and satisfaction and who had experienced meaning in his life of work and suffering, was found able to achieve the goal of final acceptance of death and gradual separation with very little outside help except silent understanding from those around. The less the person had integrated the lesser forms of dying (separation, pain, self-denial for the benefit of the other) in life the more difficult was the act of dying. For, to die as a humen being means to fully exhaust in the last phase of one's life the possibilities of one's own particular self development. The anonymous world of the hospital in Western Europe where over half of all the dying spent the last part of their life has great need of Samaritans who will help those dying in it to experience real growth and who will make it possible for them to achieve the maturity needed to make of death a free act of self-giving to God. It was Dr. Kübler-Ross's finding that, with help, almost all the dying could accomplish what she termed "this tremendous task". (4)

Each of the five stages discussed above obviously requires a special response from the person who seeks to be of help. During the phase of denial, the dying person needs a listener who is ready (except for emergency situations) to accept denial as long as the patient finds it necessary. He needs some-one who can offer hope even while not encouraging the denial, and who, later in the process, is willing to accept hostility without angry personal response and even to encourage the patient to express his deep anger. He needs some-one who can join in his bargaining with God knowing that God has answered such requests, in the past and who, during the phase of reactive depression, is alert to ways in which he can help the patient take care of his unmet responsibilities towards his family, business, etc. In the phase of preparatory depression just before death the greatest help is given by his simple presence without word or deed. It is then that the patient, faced with the loss of all he holds dear and life itself, has the need to have someone just "be there". This expression of sympathy supportive of his grief was found to be most deeply appreciated. The comforting presence of another person lets the patient in his acceptance of death know that he is still loved and not forgotten. The experience with the terminally ill shows very definitely that one must never "give up" on any patient. The patient beyond medical help is one who needs as much care, if not more, than the others.

It is most important that the intensive experiences of the end of life do not just slip away and appear to the dying as dec tion and fantasy but that each confrontation should become a tim or further growth to maturity.

Who is responsible to give this very necessary help to the dying? In the hospital atmosphere, where death is confronted as institutional enemy number one, and where the number of dying patients, especially in a large hospital, is great, it is easy for the medical and nursing staff to confine themselves to technical details and to develop a strong self-defensive screen which assists them to keep death at a distance. The specialization of the services needed, plus the constant changing of doctors and nurses in shifts and the pressure of time, results in a situation where no-one feels responsible to answer the agonizing personal questions of the dying. The task becomes a burden, most often shifted back and forth between those concerned with the patient e.g. the doctors and nurses, but also the relatives, friends and the chaplains. Each has reason to feel he is not responsible, yet each has special advantages and disadvantages which make him more or less suitable for the role of "companion".

Relatives and friends have the greatest degree of closeness to the patient, but usually suffer from a lack of inner distance from their own experience and from their fear of the effect their own anxiety and sense of loss will have on the dying person. In turn, the dying one hesitates to burden them with his emotions. In some cases too, the personal relationship for a variety of reasons is one of tension rather than closeness.

Though the doctor has the advantage of his medical knowledge about the patient he often feels ill-equipped to take on a personal assistance to the dying and in fact he seldom has the time for the intensive relationship the patient needs. Nonetheless, if he has made efforts to confront his own death, his bedside manner and his therapeutic decisions will be marked by a sensitivity and concern which the patient will sense. Although the patient is beyond his medical help, the doctor can still be a real psychological support for him.

The nurses and therapists have many opportunities of being close to the patient as they respond to his bodily needs but their many tasks also limit the time available to them for helping psychologically. In too many of them, also, an unintegrated fear of death is present and this influences their behavior more than they realize.

Since effective help for the dying requires that the "helper" has first of all learned to handle his own anxieties and feelings in the face of death, some training schools have introduced studies on the care of the dying within the framework of professional ethics. In whatever way it is done, the general concensus is, that it is important in the training of medical and other staff that there be not only study, but genuine confrontation with the meaning of phenomena, such as illness, pain, suffering, loss, separation, mourning, dying and death, since no amount of study can replace experience.

All of us have experiences we can draw on if we take the time for reflection. We have a "brush" with death as we say. A car nearly hits us, the plane we are in nearly crashes, we have a very stormy recovery from surgery etc. If we can face these and experiences of loss for what they are - we can appreciate that the last dying of a man can be prefigured also in saying goodby, in a separation, in the loss of the elementary possibilities of living. The more inclusively we regard these life situations and endure the pain or loss or parting in all its forms, the more we are able to face our own dying. The main element needed is not communication of knowledge to us which takes place intellectually but the transformation of our attitudes which only occurs at the deepest level of our person. It is therefore decisive in our dealings with a dying patient that we become aware of our own fear, that we do not deny it but learn to deal with it. There are many non-verbal ways of communicating fear. The patient quickly senses My fear and it adds to his anguish. This fear, of course, is ultimately MY attitude to MY own death.

By reason of his calling the priest is the one most strongly inclined towards deep personal conversation with the dying patient. Though it is one of his primary tasks to take part in a confrontation with the patients life crises and their interpretation, he often has the disadvantage that he may have to wear down a patient's prejudices against the Church and his office. If his conversations

are not superficial and he is not bound by ritual, then the priest like the others around the patient is confronted also with his own fear of death.

Traditionally as Catholics we have usually answered the need of the dying in terms of Sacrament but all of us are aware how often a dying person responds to the suggestion to call the priest to administer the sacraments by saying that he is not dying yet and that later on is time enough. I think most older priests have had the experience of "last minute" administration of the sacraments, because relatives feared to ask earlier. Some improvement has been achieved since Vatican II and the new understanding of the anointing as the Sacrament of the Sick.

Although it has been right to take away the stigma, that the Sacrament of the Anointing is a Sacrament of the Dying, still, the dying have need of a liturgical and sacramental celebration of death as one of the basic events of life and salvation. For the patient to properly appreciate this, there needs to have been a previous educative process so that the sacrament is understood. The Sacrament of the Sick is listed among the seven sacraments but very little attention has been given in the past to make it, not an object of dread, but a source of growth toward God.

If one is to understand dying as the consummation of one's life in God then it follows that one has to accept one's previous life. But because one's life has always been to some extent a life of self-assertion and self-interest there is need of God's forgiveness not only during life but especially at the moment of death. At that moment, man needs God's acceptance of his life and the assurance that "God writes straight with crooked lines".

The liturgy for the dying assures the dying person of the forgiving presence of Christ and God's unconditional acceptance of his life. The sacramental rite has also an important ecclesial significance. It makes present to all of those involved the reality of the whole Church by stressing, as it does, the Communion of Saints. In the liturgy of the dying, the Church accompanies the dying person to the "boundary" and, as it were, hands him over to God and the heavenly "community of the Saints". The presence of those who care and love brings home to the dying person the conviction that the human community of love is not destroyed by death. "To love someone means to say: you will not die." (5b) The presence of the priest is a silent and comforting sign of the hope that remains steadfast when everything is destroyed.

In a lecture to the nurses at St. Francis Hospital, Peoria, Illinois, Dr. Kübler-Ross said, "The Catholic Church has done well in helping people face death more realistically. I feel the new emphasis in the last rites as the Sacrament of the Sick is a good move. I would encourage the Church to administer the Sacrament once a year

to the whole community to remind them they are dying". It is an interesting idea! The Church this week, though, has given us her annual reminder in the ceremonies for Ash Wednesday. Perhaps as christian community we need to reflect more, to deepen our understanding of the rite of receiving the ashes and the whole meaning of Lent in the light of the great Paschal Mystery of Death and Resurrection.

We may ask the question: Who of all those we have mentioned, then, should be the one to help the dying person? The answer is, that the patient must be allowed to make his own choice of who is best able. Some suggest, however, that it is the responsibility of the medical and therapeutic team to ensure that the patient has at least one appropriate person, though the choice rests with the patient. So far as circumstances allow, the dying person must be aided to accept and shape the last phase of his life meaningfully.

The research of Dr. Kübler-Ross considers the achievement of the stage of acceptance as a tremendous task for the dying but I find it troubling that after all that effort she has described it as a stage devoid of feeling and not a happy state. At the end of her book "On Death and Dying" (5c) she makes another very challenging statement that "religious patients seemed to differ little from those without religion" in the way they faced death. She admits that the study did not clearly define what was meant by "religious person" but she does state that there were few among her patients who had what she terms an "intrinsic faith". These few indeed she felt were helped in dying by their religious beliefs but no more so than the few who were true atheists. Others were not relieved of conflict and fear by the religious belief they held.

Probably by "intrinsic faith" we could understand a genuine integration of faith into attitudes toward life and into daily living. That many people (most?) lack such an integration is one of the major challenges the church faces today. Technological man in the continual presence of overspecialization has a fragmented view of life and reality. There is a great need for that total integration of life which has been traditionally the function of religion.

The expectation that conflict and fear are necessarily relieved by religious belief, is, I think unwarranted. The christian may indeed experience the peaceable death of St.Francis but he may also be asked to share the Agony and Passion of his Master. What is important is that, like Francis and Christ each makes a positive offering of his life to God - "into your hands, O Lord, I commend my spirit."

The biological process of dying remains the situation of radical decision where man is asked how he has understood himself and his life. It provides a last possible way for man who is essential-

ly free to determine the pattern of his life. Recent works on the "Theology of Death" have suggested that death is a very privileged moment of human freedom as well as a culminating point of Christian Hope. We need a Theology of Dying so that all of us, the dying and those who care for them come to see this period as the blessed opportunity to learn to live more intensely and as the opportunity for the growth and development which makes death become the crowning point of a life which is freely offered to God our Father.

Christian faith invites the dying person to focus on life not death. While life includes death as an inner factor in itself, death is not the goal and horizon of life. What individuals see in this look on life can be very different, for there is an ambigous meaning to death experienced as the consummation of human life in God or as the final seal of impotence on a life that sought itself alone. If the individual has not consciously searched for meaning in life prior to his awareness of impending death, then he may try at the end to construct meaning from illusory experiences, because he has nothing else.

The search for meaning raises one of the many paradoxes of life. As mentioned above, the one who lives life to the fullest, who has achieved an intensity of unity or oneness through love and selfless concern for others, accepts death more easily, while the one who has not, fears it the most.

As theologian Gisbert Creshake (5c) wrote:

> "If dying is the consummation of life and entry into the life of God, then however paradoxical it may sound, the dying person must be strengthened in what he wants of life, in his hope and love of life. It is only if life has meaning that death has too and it is precisely this truth that has to be verified in the final stage of life. This theological demand falls in with the findings of the secular sciences which indicate that, in general, dying people have the desire to remain in contact with everyday life and want time to live, o it ever so short. It is precisely those who love life for whom death loses some of its terror...."

Because the "little hopes" of the dying person are pointers toward the "great" hope of a never-ending future to life, christian care for the dying must support and encourage all the dying person's "little hopes". Christian hope is communicated to the dying above all by the personal attitude of those near him, an attitude which, while it affirms life by expressions of love and concern does not suppress the reality of the imminence of death.

Like all aspects of our redemption in Christ, the redemption of the process of dying has only been partially realized and still waits completion. The christian, even if he has realized "dying" as an

element of true living, has only been able to do this usually in a fragmentary way - therefore his dying is experienced not only as consummation but also as the pressing in of non-existence, the bitter depths of misery and fear.
A great part of the alarm in dying is the negative experience of what is past. The more the person has expressed himself in life, possessing, consuming and doing things the more he MUST resist dying and suppress and deny death. It becomes clear then that it is not so much death, as the life that lies behind and which is now about to reach its conclusion that must be overcome. Thus death is the moment of truth.

Again in the words of Creshake (5d):

> "It is the latest moment for accepting that life does not belong to me and that it cannot bring about its own consummation and perfection by means of however extended a prolongation in time. In this way dying gives man his last chance to break out of himself, to leave his life, in which he formerly did not want to die with Christ, and to go forward towards God's future. This too, is shown by the evidence of dying people who have encountered a boundlessly expanding area of inner freedom precisely in confronting death."

The experience some have of "oneness" with others is accompanied by and may even be based on a sense of unity - an intimate relation of all that is created (3 b). This "cosmic integration of creation" has been uncovered not only through interviews with dying patients, but also through highly controversial (at least in U.S.) experiments with LSD and terminal patients.

The central task of the Church is to proclaim the Death and Resurrection of Jesus and in so doing to reveal the good news that in Him each of us is saved and our death is birth into life.
In our time, the Church, the People of God, had an even greater obligation than in the past to make provision for a humane and compassionate form of help for the dying. Ours is an age in which the dying and their relatives increasingly question whether it is worth the trouble to live through this last phase of life - a phase marked by physical pain, loneliness and fear. The answer they give will depend on how readily and gladly the christian community accepts the challenge to help and make this stage one of growth and development.

Only Christ has conquered death but we, the christian community have the task of seeing that life remains human to the end, that the person remains a person and does not become an object, a thing for research and experimentation. Only Christ's cross gives a positive meaning to death. Only in the shadow of His cross do our

deaths take on meaning. It is in community we have to help one another reach the stage of acceptance, the stage of free and conscious realization that the act of dying is a human event. As an expression of our christian brotherhood we need to find out what unspoken worries weigh on the incurably sick and aged, what help can be given to lighten the load of overburdened relatives. Death in which the dying person has to give himself up totally has the rightto demand that the living should not be stingy with their giving.

We cannot help the terminally ill patient in a really meaningful way if we do not include his family. They play a significant role during his illness and by their reactions contribute much to the patient's response to it. There will inevitably be changes in the household--some subtle, some dramatic--if it is the husband or wife who are ill. We must recognize that the family members go through states of adjustment similar to the ones described above for the patients. For instance, in the beginning they manifest strong denial by encouragement of trips to expensive clinics and to new doctors who they hope will give a different diagnosis. Then there is anger, often enough projected on the hospital personnel. There may be some "bargaining" followed by real depression at the coming loss of the loved one. The dying patient's problems come to an end, but the family's problems go on. In our concern for the dying we must not neglect help to the loved ones who are left behind. This is surely a role for a christian community of love.

Several organizations have arisen in the USA whose purpose is to help persons considered terminally ill to <u>live</u> their remaining days and to really grow as persons. For example: in the Lutheran General Hospital, Park Ridge, Ill., (6a) there is a program for the service of the terminally ill called the "Living until Death Program". This program relies on chaplains who visit the terminally ill patients regularly while they are in the hospital and continue with follow-up visits at home. Their purpose is not primarily to prepare the patients for death but to help them <u>live</u> each day as joyfully and peacefully as possible. Part of their care is also with the patient's family, helping them to adjust and deal with their own feelings. Another group (6b) is "Make Today Count" formed by people of all ages who have a terminal illness. They are banded together for the purpose of combatting the loneliness and isolation of the terminally ill, and for sharing and helping each other.

It is important to know that patients need to remain in control of their own lives as much as possible during this period, participating in decisions as before, spending as much time as possible in familiar surroundings, in other words <u>living</u>. As one author observed, it is not dying that is so difficult, but rather <u>living</u> until death.

Another somewhat different approach to living until death is St. Christopher's Hospice founded by Dr.Cicely Saunders in Sydenham, London, England, in 1969 (3c and 7). Most of the patients admitted to the Hospice live only two to three weeks before dying. Because the staff is not committed to prolonging life there are no "life" saving machines". The guiding philosophy is to keep the patient as consciously aware as is possible and to use only minimal dosages of pain killers i.e., dosages which meet the patient's need for pain relief but do not interfere with his personality or capacity for physical activity. At the Hospice, the patients are encouraged to feel their lives are still worth living and to make friendships. Prayer is very much a part of the day. In the chapel, the Chaplain (Church of England) has an interdenominational prayer service three times a day and, on the wards, morning and evening prayer is conducted by the nurses in turn. No-one, staff or patient, is obliged to belong to a church or join one though as one of the nursing sisters has said: "There is a certain amount of faith running around." (7). Many patients admitted to the hospice as agnostics, die that way but a large number have been found to return to the belief they were brought up in. Since St.Christopher's is not a hospital, children are welcome and visiting is allowed at almost any time. The nurses have time and are expected to become involved with their patients - even to attending the funeral. An out-patient program with visits by staff members helps patients die at home with the conscious support of their families. So "progress" in helping the dying comes full circle - once again the dying teach the living within the family context.

Another group that makes the newspapers fairly often, is the American Euthanasia Society (3c) whose thrust is the "Right to Die with Dignity". They promote the use of the so-called "living will" which asks that the person be allowed to die and not be kept alive by artificial means and that drugs be mercifully administered for terminal suffering even if they hasten the moment of death. This latter use of drugs is not considered to be active euthanasia, e.g. mercy killing which in most countries is still resisted legislatively though it must be admitted there is often much sympathy expressed for those accused of practising it either on themselves (by suicide) or on others for whom they are responsible. The "right to die with dignity" is a problem caused by the success of research-orientated medecine rather than its failure.

This right to die can be seen as corresponding to the right to live and the right to aid in dying to correspond to the right to aid in living - right up to its most intensive form, the wholly personal accompaniment of a dying person in all his needs.

Whether we, in our culture, will ever reach the ability to talk about death and dying with the same ease we show in mentioning the coming of a new baby, is a question. We can agree with Dr. Kübler-Ross that such facility would be extremely helpful and would be of the utmost value in helping the dying and their families.

Certainly those in the "helping" professions, religious, medical people, social workers need to become more aware of their responsibility in this regard. As a christian community we need to not only realize our obligation to a fellow-man but to appreciate the riches such involvements can bring to our own lives. For Dr. Kübler-Ross for example, it enabled her to find her own religious identity and to know there is a life after death.

In conclusion we can say the obvious, e.g. that the terminally ill patient has special needs related to his helplessness, isolation, suffering and fear. Care for the dying, if it is to be helpful demands the skills, relationships, and behaviour patterns needed in the care of all patients, seriously ill or not. But there must be recognition of the fact that medication does not take care of all the dying man's needs though it is important to control the degree of pain he has in order for him to maintain his emotional equilibrium. Sensitivity to his psychological needs, awareness of when to talk and when to be silent, willingness to be just a "presence" who spends time with him, are essential and necessary ingredients of real help.

Pastoral helpers of the dying need training as do other therapists. But above all they need a basic attitude which makes their assistance both humane and compassionate. Their main goal is to be a "companion", a listener to the dying, not a well-informed expert. The real companion makes it possible for the dying man to grow and unfold his own strength in the face of his own death so that he remains the subject of the last phase of his life and does not become an object of medical attempts to prolong it.

Death is without doubt THE crisis situation in one's life. How we face it depends on how we have faced the lesser crises before the separation, the disappointments etc. There is an old saying "Buried once, died twice". All change, all abandonment of old familiar patterns is fraught with anxiety, and some danger, and also excitement and fulfillment. No change is so great as the one we call Death.

IF I had done this... IF I had done that... IF...IF... Probably there are no better teachers to tell us what life should be than the dying--none so able to see clearly what things "waste" a life. We can help patients in the process of dying come to terms with IF and in the process learn how to live our own lives, live each day to its fullest. Faced with imminent death, everything around us becomes bathed in a new light. As one older woman looking out at the meadows and hills commented after a very severe heart attack: "Never have they been so beautifully green!"

Father Mayer-Scheu has written (1b):

> "Whoever becomes a true companion of a dying man, himself becomes a sign which makes possible what

may be a decisive experience of transcendence for the dying man. In such encounters a dying man can experience that dimension of life which in the Old and New Testaments is described as the experience of God accompanying man."

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SEDOS 76/144

MINUTES OF THE SEDOS EXECUTIVE COMMITTEE MEETING

7 April 1976 / SSND Generalate / 4 pm

Present: Brother Charles Henry, fsc (chairman), Sr. Claire Rombouts icm, Sr. Godelieve Prové, scmm-m, Sr. Mary Motte, fmm, Fr. Joseph Hardy, sma, Sr. Danita McGonagle, ssnd, Fr. James Lozé, sj, Fr. Paul Brekelmans, pa.

Minutes of the meeting of March 16, 1976 were approved.

Proposed collaboration between Sedos and Agrimissio to provide consultative services to Missionary Institutes and Dioceses: in principle, Sedos will collaborate with Agrimissio in supporting consultative services that will be asked of Mr. Terry Waite by the different dioceses, and this for a period of three years, beginning in 1976. The members of the executive committee of Sedos have requested that a brief document be drawn up, stating the terms of this support.

The Staff of the Sedos Secretariat: Sister Anne Duggan, secretary of the general council of the Ursuline Sisters has offered to give half of her time each week at Sedos until the vacancy of the executive secretary is filled. Mrs. Marie Storms — french secretary — has given notice that she will be leaving Sedos as of the 14th of April. The application of Sr. Joan Delaney - Maryknoll, was studied by the committee, and Brother Charles Henry will write to Sister Barbara Hendricks, Superior General of the Maryknoll Sisters and to Sister Joan to say that Sedos will be very interested in Sister Joan's collaboration at the secretariat, and that we will be looking forward to meeting with her when she comes to Rome (from Hong Kong) in June. Sister Joan has been in Hong Kong since 1955, where she has been actively engaged in both administration and education — particularly in the field of sociology. Her publications/research include among others, "A Survey of Religious Women in the diocese of Hong Kong" (published by the Association of Major Superiors of Religious Women, 1975), and "A Survey of Religious Women in the Diocese of Macao" (in preparation).

The preparations for the June Assembly: Father Lozé reported briefly on the preparations for the assembly to date: the preparatory meetings are now finished, and both Sister Denise Maravel, WS, and Father Masson, SJ, have presented draft outlines of their working/position papers. The next issue of the bulletin will contain more details of the assembly.

The day will close with the celebration of the Eucharist, and all the participants are requested to take part in this celebration. Sister Claire and Sister Godelieve have assumed the responsibility for the preparations for the liturgy.

The business meeting with the elections will be held before the noon break. In view of the elections, Brother Charles Henry will send a letter to all the member institutes requesting candidates for the offices of president and treasurer.

Delivery of the Sedos Bulletin: Sister Danita announced that she has notified the member institutes of the dates and pick-up points for the bulletin. For the present, the office staff is responsible for the editing of the bulletin.

Next meeting: May 4, 1976 at 4 pm at the FSC Generalate.

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INTERIM REPORT ON THE GENERAL ASSEMBLY

Within a month we shall gather for our General Body meeting. All members of SEDOS already contribute much to this meeting by their useful contribution and active participation in the preparatory meetings. On April 2nd we had our last preparatory meeting at the Generalate of the Christian Brothers. The two language groups (English and French) discussed on the remaining points of the questionnaire. This gathering ended with the eucharistic celebration in order to obtain the gift of the Spirit for our forthcoming assembly and for the work of Sedos.

Now remains the personal preparation for our June meeting. All are invited during this Paschal season to pray that we may reap the fruits of our work and that Sedos may be faithful to the mission entrusted to it by the Generalates and by the Church. This is why it is suggested that Sedos members during this coming month may reflect and pray over the topic of our meeting. If anyone has something to say on the subject she or he is invited to do so in writing.

When you receive the working papers on May 1st, please, do send within 10 days your reaction to these papers. You may express your disagreement, ask for more questions, express your disappointment as some aspects of the topic not being treated properly, etc. Thus on the 2nd of June the two lecturers will answer your questions at the beginning of the gathering, before we disperse into small groups.

The consolidated report of our sectional meetings could not be ready this time, since the Bulletin had to be printed earlier on account of the

(continued on page 147)

Qu'exige un Vrai Développement ?

Nous avons tiré cet extrait de la revue "Vivant Univers". L'article intitulé Crise du Système économique international: Aux Grands Maux Les Grands Remèdes est par Jacques Chonchol, professeur à l'Institut des Hautes Etudes Latino-américaines (Paris).

Cela dit (et l'histoire contemporaine le démontre), sur quelles bases fonder une nouvelle conception du développement?... Il nous semble qu'elles ont été très bien résumées par le premier colloque que le Centre international du Développement a tenu à Alger, en juin dernier (1975), sur le nouvel ordre économique international.

1. Le développement est un processus de changements profonds qui doivent toucher à la fois les secteurs économique, politique, social et culturel. Il doit être réalisé par le peuple et pour le peuple, à travers la participation des masses et à leur bénéfice.

2. Le propos du développement, c'est de développer les hommes, de les rendre plus capables de réaliser leurs potentialités humaines dans le contexte de leur situation historique et de leur spécificité culturelle.

3. Le processus de développement doit être orienté en fonction des besoins de l'homme et non de la croissance économique en soi. Par "besoins de l'homme", on entend avant tout les besoins de pure subsistance (nourriture, vêtement, logement, santé), sans négliger toutefois les besoins sociaux et culturels.

4. Le développement est pour tous les hommes et non pour une petite minorité de privilégiés. Le système économique doit donc être conçu pour satisfaire les besoins des masses, et non en vue de la production de biens pour un petit nombre.

5. Le développement se fait par le peuple et non en reléguant celui-ci au rang de "clientèle". Il requiert donc la participation intégrale des travailleurs, qui ne doivent pas être seulement les bénéficiaires du développement, mais aussi des agents. En outre, le développement implique des hommes disposant d'autonomie, socialement conscients, aptes à établir leurs propres priorités, prenant leurs propres décisions et les réalisant: cela suppose une décentralisation poussée, permettant l'option particulière et l'action locale. En fin de compte, la participation n'est pas un objectif du développement: elle est en soi le développement.

6. La stratégie de base du développement doit être un self reliance endogène et autocentré: il surgit de l'intérieur même d'une société particulière. C'est compter avant tout sur ses propres forces, ses propres ressources, son propre capital: en un mot, c'est libérer l'esprit créateur d'un peuple actif. Le self reliance n'implique pas en soi l'autosuffisance ou l'autarcie, mais bien la capacité d'être autosuffisant en cas d'épreuves naturelles ou de crises internationales. En outre, une vraie politique de self reliance vise à pourvoir sur place aux besoins alimentaires et à développer les ressources locales, tout en adaptant la technologie à la nature de ces ressources et au niveau social et culturel de la population.

7. Il n'y a pas qu'une seule voie de développement. Celle qui s'impose est à choisir selon la spécificité des situations culturelles, des valeurs à mettre en avant dans tel système de société, des ressources disponibles, des techniques utilisées et

des capacités créatrices de tel peuple. Il n'y a donc pas de formule universelle de développement et, en tout cas, ne peut prétendre à cette universalité l'actuelle formule de l'Occident industrialisé, qui a conduit à tant d'impasses.

8. Tout les pays ont besoin de se développer dans un nouveau contexte, et non seulement ceux du Tiers Monde. En ce qui concerne ces derniers, ils doivent faire face à des problèmes spécifiques qui ne sont pas faciles à résoudre: rapports internationaux inégaux, fascination populaire par la société mondiale de consommation, accroissement démographique rapide, inégalités sociales et régionales, misère des masses, manque de capitaux, influence exercée sur les systèmes économiques et sociaux de ces pays par les institutions internationales et par les techniques de pointe, etc... Quant aux pays développés, ils sont aujourd'hui confrontés avec les problèmes très graves dont nous avons parlé plus haut: sans doute en seront-ils obligés de revoir leurs modèles actuels de développement.

9. Enfin, il faut noter que le développement d'un pays doit veiller aux intérêts non seulement des générations actuelles, mais aussi des générations futures. Cela suppose que le système de production en vigueur n'aboutisse pas, sans souci de l'avenir, à l'épuisement des ressources non renouvelables. Cela demande aussi que ce système ait cure d'éviter la pollution tant des gens que de la nature, qu'il se soumettre aux contraintes de l'environnement, bref qu'il mène à un développement en harmonieux équilibre avec le milieu de vie.

Professeur Jacques CHONCHOL.

"Vivant Univers", No. 302 / Bimestriel / Janvier-Février 1976.

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INTERIM REPORT ON THE GENERAL ASSEMBLY, Continued from page 145

Easter vacation. It will appear in the next Bulletin along with the working papers.

Since I will be absent for a week at the end of April, whatever you send concerning the preparation of our General Assembly should bear the mention of Sedos: Mission Secretariat (Sedos General Assembly), Borgo S. Spirito, 5, C.P. 9048, 00100 Roma.

Thanks to all the members of the coordinating Body and all the members of Sedos for their wonderful cooperation.

—Father James Lozé, sj