
PART FOUR

RELIGIOUS COMMUNITIES: COMMUNITIES OF FAITHFULNESS AND CARE

I n order for community members facing illness and death to become prophetic witnesses, religious communities themselves must give witness to faithfulness and care. If we expect sick and dying members of our communities to speak the truth about illness and death, then our communities must be *honest* with their sick members. If religious are called to witness to an appropriate reliance, then our communities must be *reliable*. If religious are to give an example to church and world of letting go and not clinging to the last remnant of life, then congregations must show that they do not abandon their suffering sisters or brothers but rather that they *care* for them.

We should not believe that becoming a community of faithfulness and care occurs automatically. Conflicts are inevitable. Congregations may experience tensions between the cost of caring for their sick members and the financial demands arising from their mission. International congregations may experience tensions between the need for financial resources expressed by their younger provinces in Third World areas and the increasing costs of medical treatment for their community members in the United States. Furthermore, because of cultural or ethnic differences within this nation,

communities may not understand the real needs of a sick brother or sister. Issues with which individuals have wrestled during their lives may become more acute as they reach the end of them.

Furthermore, in many congregations, the death of a member is a sign of the numerical diminishment of the community itself. As its own members face death, the community is forced to confront the question of its own impermanence, its own issues of continual renewal and possible nonrenewal. The questions of a dying religious may be replicated on another level by his or her community. The temptations of denial which the individual faces may reflect similar temptations facing her or his whole community. Unless it faces these issues, however, the community cannot be present to its aging and terminally ill members.

Religious need to experience their communities as healthy places and their sisters or brothers as people who live healthy lives. When a religious is resisting the onslaughts of disease, he or she needs the encouragement of the community. As illness progresses, communities must become places of care, giving both physical and spiritual comfort to the patient. As diseases enter into their last stages and death approaches, religious need the presence of their sisters or brothers and need the reassurance that they will not be abandoned. This may sometimes become a practical question of where sick members will spend the last part of their lives. In addition, it evokes deeper questions of whether others really care about them and their dying or what they will leave for others after they are gone—whether their lives have had meaning.

Those caring for sick members of the community may also need to ask what are their own expectations regarding their suffering sisters or brothers and whether these expectations are realistic. For example, some sick and dying religious may feel alienated—because of pain or past experience—no matter how present community members remain. Often there are times when a care giver will want to make everything

right and "fix" things when the appropriate response is merely to remain present and powerless with the one who is suffering.

Questions:

- ▶ What is the relation between friendship and care in healthy years?
- ▶ Has it been my experience that I try to "fix" things in order to deny the reality of my own or another's condition?
- ▶ Can I name a time when I felt powerless in the presence of another's suffering or dying?
- ▶ How do I, as a companion, encourage honest expressions of grief on the part of a community member who is dying? Can this be ritualized?
- ▶ How do we become a community of reliability and compassion?
- ▶ How do I sustain presence throughout another's illness and dying?

PART FIVE

GUIDING PRINCIPLES

A number of ethical principles follow from the vision described above. Congregations may want to consider the following principles as guides for community policies, knowing that they will need to adapt them according to the lived reality of the particular congregation. These principles also reflect an understanding of health care as it is experienced in the United States at the present time. International communities will likewise need to make appropriate adaptations to other nations and cultures.

► *Attitudes toward life, health, and death.*

Religious are stewards of their physical, mental, and spiritual health. This stewardship is a life-long task. Congregations are therefore called not only to care for their sick members but also to encourage all their members to be concerned about preserving this precious gift of health in all its dimensions.

Since life is a gift from God, religious are called not only to maintain life but also to return this gift in full freedom to God at the appropriate time . As stewards of the gift of life, religious use the means at their disposal to resist illness. Yet, they also accept their mortality. They believe that, as they are united with Christ in his dying, so are they destined to rise with Christ to new life.

► *Care of sick or aging members of the congregation.*

Religious communities should be environments where chronically sick or aged members feel at home and truly a part of the community. To the extent possible, communities should support the independence of their sick members and provide them with planned programs of care in the community setting. This includes formal pastoral care and hospice care, together with the active engagement of friends and other members of the community.

Caring for a sick sister or brother is a reciprocal ministry. Sick and dying members are not merely the objects of ministry. They also build up the larger community by means of their prayers and presence. Through their illness, they can help their sisters or brothers confront their own limits and mortality.

In caring for a sick brother or sister, a community is called to express its love generously while at the same time respecting other needs and the communal good. Congregations increasingly are called to struggle to find a balance between their use of resources for the care of their sick and aging members and other financial demands related to their mission. There is no simple way

of resolving this tension. Yet, by confronting this issue directly, religious communities provide an important witness to the larger society in respecting the dignity of persons while acknowledging the reality of limited resources.

► *Health care decisions.*

When a religious is suffering from serious disease, decisions regarding treatment, especially end-of-life decisions, should be made jointly between the religious and his or her congregation. Joint decision-making itself is a witness to faithfulness and trust as well as to a mutuality of concern and care. To ensure that such decisions are respected when religious can no longer speak for themselves, they should not only complete advance directives, especially the durable power of attorney for health care, but also discuss their requests with the agents they designate. Members of religious communities should inform their families of these decisions but also assure their families that they will be included when illness and death overtake the religious.

Both the dignity of the individual and the nature of religious life require that communities and other caregivers be truthful to their sick and dying members. Religious who are sick should be told about the seriousness of their disease and be given reasonable expectations regarding their prognosis, including the probable progress of the disease and whether they are dying. It is unjust to maintain a sick member's false hope. Rather, communities are called upon to accompany their members during this final journey, enabling them to come to the point of acceptance.

Religious have the right, like all people do, to refuse all forms of treatment that are burdensome and do not offer a reasonable hope for benefit. Catholic moral tradition regarding health care is not simply to preserve life at all costs. At the late stages of a terminal disease, a shift in the burden of proof regarding treatment occurs. Aggressive treatments directed toward cure, which are appropriate in the early stages of a disease, may no longer be appropriate. Forms of treatment requiring high technology at relatively great cost ought to be weighed against concerns for the common good of the community.

Questions:

- ▶ Do these principles make sense?
- ▶ What might these principles suggest for a health care policy for our province?

None of us lives as our own master and none of us dies as our own master. While we live we are responsible to the Lord, and when we die we die as Christ's servants. Both in life and in death we are the Lord's. (Rom 14: 7-8)

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Members of the task force included David L. Brecht, OSA; Maryanna Coyle, SC; Nannette Gentile, DC (chair); Phyllis Hughes, RSM; Richard J. O'Donnell, OS Cam; Phillip Thomas, OCD. Ted Keating, SM, was staff liaison to the task force.

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