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The Manner of Our Dying is the report of a September 1997 meeting of the NCCB-sponsored Dialogue Group of Scientists and Catholic Bishops. It was prepared by the Committee on Science and Human Values with the assistance of the dialogue participants. The Administrative Committee unanimously approved the text in March 1998, and the undersigned hereby authorizes its publication.

Monsignor Dennis M. Schmitt, General Secretary, NCCB/USCC

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We are all alike in death, if not in our dying. Violence or accidents strike some down abruptly. We can only offer prayers for them and seek to comfort those left behind, remembering our own inevitable death as we do so. For the great majority, though, dying is a process that begins when we know we have a terminal illness, or when age and declining health signal that our remaining time is no longer measured in years. Those whose death still seems remote can embrace the dying, easing their passage to a world that faith tells us is not a black void but light and indescribable love. Death cannot destroy human community, since the passage into death is a change, not an end. Respectful care for the dying strengthens the bonds between the one bedridden and the one at the bedside.

As its teaching on the "communion of saints" shows, the Church has always felt itself to exist both in time and eternity. Christians pray for the souls of those who have died and feel a serene intimacy with family and friends, especially parents, whom they look forward to seeing again one day. That is the particular wisdom Christianity brings to the contemplation of death. One need not expect an afterlife, however, to offer the dying companionship. The Christian view is quite consistent with the strict scientific notion of death as the natural consequence of life. Jesus' words, "You shall love your neighbor as yourself," apply with greater force to the experience of dying than to any other, simply because death grants no exceptions. We are all neighbors in our mortality.

Present Situation. Sadly, dying in the United States is far too often cold and hard. Americans, determinedly optimistic and progressive, are uncomfortable with time's inexorable toll. We try to shut decline and death away from public view, to mourn in private, to look on the bright side and carry on. Our health care system reflects this culture, focused as it is on aggressively curing disease no matter the cost, employing the most sophisticated technology, and constantly inventing new weapons to press the fight.

This attitude, a great treasure as long as reasonable hope for cure remains, is unrealistic in the face of imminent and inevitable death. It has led to the creation of a technologically oriented medical system that knows better how to prolong the dying process than to serve people well once all likelihood of cure—or all likelihood of living with incurable illness—is past. In the words of a 1997 report from the Institute of Medicine called Approaching Death, "Many deficiencies in practice stem from fundamental prior failures in professional education. Undergraduate, graduate and continuing education do not sufficiently prepare health care professionals to recognize the final phases of illnesses, understand and manage their own emotional reactions to death and dying, construct effective strategies for care, and communicate sensitively with patients and those close to them."

Better Care for the Dying. Sound health care is service to life at every stage, including the final one, not simply a response to illness. Catholic tradition, enunciated most clearly in the Congregation for the Doctrine of the Faith's 1990 Declaration on Euthanasia, makes a critical distinction between ordinary and extraordinary means of sustaining life. The application of this principle depends upon circumstances and will change with the development of new technology. Generally speaking, however, we are not obliged to take burdensome measures that fail to offer proportionate benefit—for example, life-support systems that are either ineffective or impose unreasonable suffering. When cure seems impossible and death looms, health care should comfort, offering effective pain control and making provision for patients' physical, psychological, and spiritual needs, so they can prepare to leave this world in peace. The curative care of traditional clinics and hospitals should give way to palliative care, whether provided at home with appropriate medical support or in special inpatient units, hospices, nursing homes, and graduated care facilities. To do otherwise is often to prolong suffering needlessly, causing medicine to violate its own ancient principle: "First, do no harm."

The growth of the hospice movement in its various forms and the compassionate attention of physicians active in organizations like the American Academy of Hospice and Palliative Medicine have done much good in recent years, but cultures change slowly. A pioneering 1995 survey called "SUPPORT," which followed 9,000 patients hospitalized with life-threatening health problems, showed that only 17 percent benefited from the 3,000 hospice programs in the United States, most of which provided care at home. Patients generally exercise little control over the managed care (or managed cost) system that has evolved around us. The SUPPORT study tracked people who had expressed a wish to die at home. Remarkably, about 60 percent of those who wanted "very much" to die at home actually did it, as opposed to about 40 percent of those who had no such desire. The only factor that consistently predicted the place of death was the availability of hospital beds; if a spot is open, in other words, the dying patient ends up hospitalized. This suggests that the medical system operates almost mechanically, without sufficient sensitivity to circumstance or individual preference.

The Church's Contribution. The Church contributes to improved health care in the United States by giving the dying material, emotional, and spiritual comfort through its own health facilities and its network of parishes and social service agencies. The Church also offers helpful moral insight, refined over centuries of experience. The fear of dying is one of the most basic of human emotions. A teacher of young people in the Church's parishes, a principal in a school, a Sunday school teacher, or a hospital chaplain is likely to have experienced much of her or his career watching young people in the days before death. The Church provides a means to alleviate the fear of dying.

The Church's determined defense of life, which includes defending the dignity of dying people, is eloquently expressed in Pope John Paul II's encyclical The Gospel of Life (Evangelium Vitae). That document's message finds an echo in the following recommendation from Approaching Death: "For those who seek to build public understanding of death as a part of life . . . , one model can be found in the perspectives, spirit, and strategies that have guided efforts to promote effective prenatal care and develop mother- and family-oriented arrangements for childbirth. "If one believes that death is not an end but a change, then our passage from this world merits the same gentle care as our arrival.

Social demographics makes an expanded vision of health care, one that takes the whole cycle of life and death into account, increasingly urgent. The fastest growing segment of the population, up by half a million in the 1990s, is those over 85. In