Response: Walking with Our Brothers and Sisters in Suffering

回應：與病苦中的弟兄姊妹同行

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I thank Dr. Erica Lee for contributing her article, and Dr. Julia Cheung for inviting me to write this response. It gives me the opportunity to reflect on the issues of Dr. Lee's article from both theological and medical perspectives. In my response, I will mainly focus on situations where patients are seriously or terminally ill.

Medical illnesses, suffering and death are facts of life. In our daily lives, we may encounter situations when our family members, relatives or friends become seriously ill. At some point we may need to decide whether to continue with certain medical procedures, but making this decision can be very stressful for the patients and their families. On the one hand, we believe that human beings are born with dignity, as all humans are created in the image of God (Gen 1:27), such that their lives should be respected and they should be provided with

the appropriate medical care. On the other hand, we also want to alleviate the pain of our patients, but while some of the pain is directly caused by the disease, some is related to the medical procedure. As the disease progresses, the patient's life expectancy will be shortened. In the remaining days, the patient's quality of life will become more important than before. It is also at this time that the consideration of continuing or withdrawing from treatment becomes more complicated.

Regarding the above issues, Dr. Lee has given us a very good and detailed discussion in her article. Basically we are to decide whether a treatment is ordinary (proportionate), which should always be provided to the patients; or that the treatment is extraordinary (disproportionate) and we have no absolute obligation to use it.[1] According to *Evangelium Vitae*, "To forego extraordinary or disproportionate means is not the equivalent of suicide or euthanasia; it rather expresses acceptance of the human condition in the face of death."[2] When judging whether a treatment is ordinary or extraordinary, we can follow ethical principles and guidelines, taking into account the seriousness of the disease, the hope of recovery after the treatment, the reasonable desires of the patient and their relatives, the quality of life of the patient and whether the treatment is excessively burdensome for the patient and the society, etc. However, in real-life practice, this decision is not always so obvious and straightforward. There may be conflicts

1 *CCC*, 2278.

2 John Paul II, *Evangelium Vitae*, 65.

of values between different stakeholders. There could also be limitation of resources which make certain treatment infeasible. As a result, the clinical team must always exercise their judgment to decide the possibly best treatment plan for the patient.

As Dr. Lee's article has already provided a very comprehensive explanation on the views of different schools of thought on this topic, I am not going to add other similar points. Instead, I would like to share with readers my experiences in daily medical practice, particularly during my time working in a hospice (or palliative care unit) before I eventually specialized in family medicine as my lifelong career. I hope what I share can help readers understand how the clinical team can help patients make decisions about treatment options.

Palliative care is one of the specialties in the medical field. It "improves the quality of life of patients and that of their families who are facing challenges associated with life-threatening illness, whether physical, psychological, social or spiritual."[3] It is also supported by the Church[4] and considered as "a special form of disinterested charity," and so "it should be encouraged."[5]

As patients in a hospice are all suffering from serious illnesses such as cancer, we quite often have to face the issue of whether to

3 World Health Organization, *Palliative Care* (5 August 2020), https://www.who.int/news-room/fact-sheets/detail/palliative-care [accessed 29 Sep, 2024].
4 Cf. John Paul II, *Evangelium Vitae*, 65.
5 *CCC*, 2279.

withdraw a treatment. In fact, this is not a momentary decision, but a process over a period of time. When caring for these patients, we need to look at them from a holistic perspective. After a patient is diagnosed with a serious disease, he may have undergone a series of medical procedures and know that his last day of life will be in the foreseeable future. In addition to physical pain, he may feel depressed and worried about his family and loved ones. He may have stopped working for a period of time due to his illness and may be facing financial strain in his family. There may also be spiritual problems, such as unsettled relationships with his family, with God, and with oneself. In this emotional state, the patient may not be able to correctly decide on the best treatment option for him. So the most appropriate thing to do at this moment is to relieve his pain first.

Within the clinical team, apart from doctors and nurses, we can also have healthcare professionals from other disciplines, for instance, pharmacists, clinical psychologists, physiotherapists, occupational therapists, dietitians, bereavement counselors, medical social workers, pastoral care colleagues, as well as other hospital supportive staff and the many volunteers dedicated to supporting and caring for patients. We work with the entire team to provide different treatment modalities to relieve the patient's pain and help him reflect, reconcile and plan for the rest of his life. Gradually, the patient will feel better and be more able to discuss his treatment plan openly. In addition, family members should also be involved. From a holistic perspective, all humans have their physical, psychological, social and spiritual dimensions. As human beings have their social dimension, they are not alone. They have a special relationship with their families. Family members play an important

role in the patient's life, and the patient also plays an important role in the lives of his family members. Therefore, when the patient suffers, his pain also becomes the pain of his family. What will become of the patient means a lot to the family. Therefore, the importance of taking care of the family cannot be ignored. Each family member should also be supported and comforted, and their own ideas, concerns and expectations about the patient should be explored. They should be involved in discussions about the patient's treatment plan, especially so when the patient becomes comatose, as they should be the ones closest to the patient and best aware of the patient's needs and wishes.

While the final treatment plan may not be clear at first, it will emerge sooner or later after many discussions within the clinical team and between the team and the patient and family. During the discussion, everyone needs to rely on rational thinking, respect the emotions of the others, consider the limitations of the actual situation, and respect everyone's own conscience. In addition, different healthcare professionals can provide opinions relevant to their expertise to others, whether patients, family members, or other team members. It is a dynamic and interactive process that continues over time, much like discernment as we seek God's guidance in a church community. The outcome can be quite different from what we initially expect. The patient and the family may change their minds and see things differently: Treatment that was once considered burdensome may not feel so burdensome now; the patient may want to extend his life for the sake of his loved ones; or the patient may be content with his life, and having an inner peace, he can now let go and accept death as a part of human nature.

Finally, I would like to say that when caring for patients and their families, we need moral principles and guidelines to help us live in accordance with the teachings of the Church. At the same time, we still highly value a personalized and holistic approach, so that treatment plans can be made in the context of the living conditions of patients and their families, thus allowing flexibility and avoiding rigidity. In fact, these two directions should be complementary rather than mutually exclusive. Upon reflection, I found that while working in the hospice was indeed a very valuable experience, and what I have learnt has been of great help to my later career as a family physician. Although the patients I serve are now in the community rather than in a hospital, they are basically in the same situation in that they also have to deal with challenges and difficulties in life. Life is a mystery, all humans have their moments of happiness, but pain is inevitable. Sometimes we can feel lost with the questions of suffering. Despite this, in our daily work, if we walk with our brothers and sisters in need and try our best to help relieve their suffering, we will find that the Holy Spirit is actually with us, and the entire journey is a transcendent process toward God. May God have mercy on all patients and their families.