Spiritual issues in suffering: creating a dialogue between clergy and palliative care providers

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Spirituality in western hospice and palliative care has become increasingly defined in secular terms, effectively dissociating it from the major faith traditions. This may significantly limit the ability of palliative care organizations to address the spiritual needs of patients whose spirituality is primarily defined in religious terms. We hypothesized that a dialogue can be initiated between clergy representatives from a specific faith tradition and palliative care practitioners from various health-related professions to inform a deeper level of mutual understanding which could facilitate development of palliative care programs attuned to the specific needs of patients sharing that tradition. A conference at a spiritual retreat center in Romania was organized during which participants were introduced to the Total Pain concept of Dame Cicely Saunders. Other sessions were devoted to small group work in which participants examined clinical/pastoral problems related to suffering, ethical issues at the end of life and spiritual care of the dying. A final session was devoted to plenary dialogue and identifying future directions. Outcomes of the conference included recognition of the need for interdisciplinary training in palliative care across all disciplines, a commitment from several attendees to start faith-based hospice organizations and development of the first graduate degree in palliative care in Romania. The enthusiasm of the participants and the universal nature of the spiritual issues discussed support the feasibility of developing similar conferences for representatives from other major faith traditions.

Keywords: Caregivers, Interdisciplinary dialogue, Palliative care, Religious faith, Spiritual care

Introduction

Addressing spirituality or spiritual distress is recognized as a very important component of palliative care, one of Cicely Saunders' four domains of total pain.[1,2] However, spirituality in western hospice and palliative care in recent years has been increasingly defined in secular terms that effectively dissociate it from the major faith traditions. This discontinuity limits the degree to which hospice and palliative care can be fully integrated holistically within a given faith tradition. It also limits the ability of hospice and palliative care providers to effectively address spiritual or existential issues related to their patients' suffering in as much as they are not prepared to fully understand their patients' spirituality in its full religious context.

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The major pioneers of hospice and palliative care in the mid-late twentieth century were from a common faith background, Western Christianity. They shared a common reverence for an even earlier and long-standing Judeo-Christian tradition that informed their basic assumptions about the nature of suffering and its relief. However, current practice and teaching regarding spirituality within hospice and palliative care is a reflection of the secular culture, largely a syncretistic mixture of ideas borrowed from eastern religions, the residual echoes of Judeo-Christian tradition in the west, and ideas taken from popular culture. Thus, it is now possible, for example, to see strong advocacy for such practices as physician-assisted suicide and euthanasia within the hospice and palliative care community, even by those who revere the founding pioneers of the movement who would never have tolerated such practices. It is

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precisely the adherence of the pioneers of hospice and palliative care to their religious faith that informed such attitudes proscribing the practice of physician-assisted suicide and euthanasia. Effectively, secular spirituality is rapidly becoming the normative spirituality defining hospice and palliative care in the west. It may be no wonder that many individuals are suspicious or unwilling to enroll in hospice when the essential ethos of many hospice organizations may project an ambivalence or even condescension toward prospective patients who adhere strongly to a given faith tradition. Indeed, patients with strong religious convictions may have difficulty relating to some of the basic assumptions and values held by many hospice and palliative care providers/organizations.

Hospice and palliative care programs are developing within other cultures and religious contexts.[3–6] The western secular perspective on spirituality presented in the palliative care literature may not resonate well or fully with patients from traditional religious faiths. Would it not be appropriate for Hindus, Buddhists, Muslims, Jews, and adherents of all the great faith traditions as they introduce hospice and palliative care to their communities to inform and define the spiritual aspects of the care they provide from their own religious traditions? In other words, would not hospice and palliative care taught, developed, and practiced within a given faith tradition have very unique characteristics that would not only inform attitudes and behaviors regarding controversial issues like physician-assisted death but also address the unique spiritual needs of adherents of the given faith tradition in a deeper and more profound manner?

We hypothesized that a dialogue can be initiated between representatives of the theological, ethical, and spiritual (pastoral care) aspects of a given faith tradition and palliative care practitioners from various health-related professions to inform a deeper level of mutual understanding consistent with the given faith tradition. Such a dialogue could then lead to palliative care specifically attuned to the needs of patients sharing that faith tradition.

Methods

A $2\frac{1}{2}$ day conference at a spiritual retreat center in Romania was organized and convened in June 2008 to which approximately equal numbers of individuals representing theological, ethical, and pastoral care expertise were invited to participate with a similar number of health care professionals with expertise or interest in hospice and palliative care (Table 1). Seven of the 65 attendees came from both backgrounds (clergy who were also hospice and palliative care providers). The vast majority of Romanian citizens are professing members of the Christian faith of which the majority are members of the Orthodox Church. Demographics of invited participants to the conference reflected this distribution (Table 1).

Plenary lectures were designed to provide attendees with a common ground for dialogue. The conference began with an introductory overview of hospice and palliative care framed within the context of the recognition and care for human suffering exploring and reviewing each domain of Dame Cicely Saunders' Total Pain concept.[1] Plenary lectures or theological reflections introduced the individual themes for small group interdisciplinary case-based discussions which occupied a half-day each. The themes for each half-day were presented in the following sequence: the nature of suffering from a traditional Christian perspective; ethical issues and human suffering from a traditional Christian perspective; and pastoral or spiritual care of human suffering within the Christian tradition (see Table 2 for the general themes illustrated by individual case scenarios discussed in small groups in each half-day session). After each plenary lecture or reflection, the attendees were assigned to small groups of approximately 10 individuals each. Care was taken to assign approximately equal numbers of palliative care providers or health professionals and clergy representatives in

Table 1 Demographics of conference attendees

Profession (number)	Male	Female	Orthodox Christian	Other Christian faiths	Palliative care provider
Metropolitan (2)	2		2		1
Bishop (1)	1		1		1
Monastic (12)	5	7	12		1
Priest in Pastoral Care (5)	5		5		3
Theologian (7)	7		7		1
Physician (21)	6	15	18	3	11
Nurse (5)	1	4	4	1	5
Social Worker (8)	1	7	3	5	8
Psychologist (1)		1		1	1
Other[a] (3)		3	2	1	2
Total (65)	28	37	54	11	34

[a]Health care administrators and educational staff.

Table 2 Summary of conference structure and content

Themes for half-day sessions	Sub-themes from case scenarios[a]
Overview of hospice/palliative care	Introduction of total pain concept
Theology of suffering	The nature of suffering *What is suffering? Who suffers? Why is there suffering? Is it a punishment from God?* The relationship of sin to suffering *Do we ever need to suffer? Do some deserve to suffer? Can suffering be redemptive?* The silence of God in the midst of suffering *How can a merciful God allow suffering to occur?* Denial and Suffering *What is the appropriate response to patients who do not want to confront their suffering? Is healing without cure possible?* Suffering and death *Is it evil to wish for, even pray for, the death of one who is suffering?*
Ethical issues and suffering	The principle of double effect *If there is a small but real chance that a medication prescribed to relieve severe pain might also shorten the life of the one who is suffering, would it be a sin to take the medication? Does enduring unnecessary pain increase sanctity?* Prolongation of life by artificial means *As new life-prolonging technologies become available, is there a religious/moral obligation to prolong biological life even beyond the natural history of a fatal progressive illness?* *Does deteriorating quality of life justify withdrawing a chronic life-sustaining therapy (e.g. chronic hemodialysis)? How much of a reduction in quality would justify such a change?* *Is there an ethical difference between withholding a life-sustaining therapy and withdrawing it once started?* Withholding information for compassionate reasons *Is lying to a patient ever justified? Is it a truly compassionate act or avoidance of a difficult and painful conversation? What kind of hope could be based on lies?* *What are the ethics of preventing patients from preparing for their death? How can the truth of bad news be shared while still generating realistic hope?* Physician-assisted suicide and euthanasia *How should caregivers respond to requests to 'end my suffering?' Is a desire for one's suffering to end or even a desire for death inherently wrong?*
Spiritual care and suffering	Finding/restoring meaning in the midst of suffering *What have been primary sources of meaning in a person's life? How does a terminal illness affect these sources of meaning? How does the loss of meaning that may occur with a terminal illness affect one's identity as a person and one's relationships? How can caregivers help dying patients find/restore meaning in their lives?* Depression and Spiritual Distress *How can psychological distress be differentiated from spiritual distress? What is the role of prayer versus medication in treating spiritual distress? How can psychological (psychiatric) and spiritual care be integrated in a holistic manner?* 'Bargaining with God' – religiosity, desperation, and denial in search of a cure *Can one 'make a deal' with God? What kinds of spiritual interventions can be offered to help this form of denial?* Exacerbation of the spiritual distress of the dying by insisting they live *Is it sometimes necessary to give the dying permission to die? How can caregivers recognize and address this problem?* Disruption of relationships and spiritual pain *What is the interface between social and spiritual pain? How do relationships affect spiritual pain? How can caregivers address the social aspects of spiritual distress?*
Wrap up and next steps	

[a]Examples of questions offered to stimulate discussion in the small interdisciplinary groups regarding the various subthemes of the workshop are presented in the table in italics.

each group. Discussion of specific cases (see the Appendix for actual case scenarios) relevant to the theme for that half-day session then ensued. A series of questions was provided to facilitators to stimulate discussion, if needed, otherwise spontaneous discussion based on review of the assigned case was encouraged. Notes were taken in each group of themes emerging from the discussion and these were later presented at the end of each session in a plenary time of sharing and larger group discussion. A final half-day session was devoted to a review of the conference, further exploration in a plenary context of emerging themes, and future directions to pursue.

Results

Several observations and general themes emerged during the conference, which were a result of the intellectual ferment created by interactions between attendees who were health care providers and those who represented the perspective of clergy. Reports from the small group discussions revealed that there had been a long-standing need to find a common language

for effective discourse between these two groups. It was generally felt by attendees that the small group discussions by being focused on realistic clinical and pastoral scenarios helped greatly to facilitate a common dialogue and understanding. There was also acknowledgement that the issues being discussed at the conference were of deep interest and practical relevance regardless of professional background. Importantly, for most, if not all participants, the conference represented the first real opportunity they had ever had to discuss and reflect upon these issues in such a mixed company. There was a general consensus that one's individual understanding of very difficult problems in clinical or pastoral care was enriched considerably by exploring the perspectives of other professional backgrounds, even when the majority of those present shared many of the same basic assumptions (e.g. a traditional Christian perspective on moral issues).

The small group interactions also created a simulated opportunity for members of each discussion group to function, at least temporarily, as interdisciplinary teams. Although some of the health care providers, by virtue of their training and experience in hospice and palliative care were familiar with the process of working in an interdisciplinary team, for many of the participants including some of the clergy, this was unfamiliar territory. It became possible for many participants to break down or at least become aware of the preconceptions and prejudices that can develop within the professional and cultural silos that typically form within higher education. Although experiencing the often rich and complex dialogue within the small groups created considerable excitement among participants, challenges were evident in that establishing a process for hearing all perspectives was critical as was the need to fully integrate the outcomes or recommendations emerging from such interdisciplinary interactions in a way that would ultimately benefit those who are suffering.

Even in such a relatively homogeneous society with respect to cultural values and religious faith as is the case in Romania, it was evident from the discussions within the conference that there has been a dramatic lack of dialogue between health professionals and the clergy, even in areas where there are clear overlapping interests and expertise. It also became evident from the discussions that there are very few, if any, opportunities for seminarians and students in the health professions in Romania to interact together in an educational setting during their training. A common problem identified during the small group discussions is the difficulty that Romanian physicians have in telling painful truths (e.g. communicating a terminal diagnosis or prognostication in advanced illnesses) to patients. There was a general sense from some of the discussions that the challenges that many physicians in Romania have with presenting bad news to patients might be made easier or at least quite different, if an ongoing dialogue between health professionals and clergy could begin during the educational process. It was proposed that clergy could continue to collaborate very effectively with physicians in this painful but essential task by helping prepare their parishioners to face their mortality as a spiritual task. In effect, clergy would gradually assist in a cultural frame shift in which Romanian patients would want to know their diagnosis and prognosis because of the spiritual implications.

Another major theme that was developed and enriched by the small group interactions was the participants' understanding of the nature of suffering. While theologians at the conference were often able to share deep philosophical and religious insights into the nature and origins of suffering from a traditional Christian perspective, the shared experience and perspective of health professionals who care for human suffering on a daily basis created a unique synergy in the discussions of the case scenarios. The small group case-based discussions represented a special forum in which to test the deeper theological perspectives on suffering, grounding them in the context of the real-life distress of individual persons which so frequently confronts clinicians and pastors. Specific theological insights about suffering that emerged during discussions at the conference included the concept that to the extent that clinicians and pastors participate in the relief of suffering they are God's co-workers in the world; life at its deepest level cannot be understood without confronting and experiencing suffering; and fundamentally, suffering is not the greatest evil for traditional Christianity, rather separation from God is. In other words, the voluntary suffering of the Incarnate God is seen as transforming and giving meaning to individual human suffering.

Distinguishing between depression and spiritual distress was identified as a challenging problem. While it was recognized that clinical depression will require medication for effective treatment, it was also emphasized in the discussions that depression frequently represents an aggravated form of spiritual crisis. Medication to address the depressive symptoms makes it possible to focus on deeper spiritual problems which ideally would be addressed pastorally in collaboration with the interdisciplinary team.

Finally, considerable discussion was focused on religious faith in which hope for a cure may be focused versus denial. A strong faith in the possibility of divinely mediated cure was considered to not be the same as denial although superficially it may at times appear to be so. Faith in God's ability to cure disease, tempered by an acceptance of whatever may come, as God's will, was identified as being quite

distinct from denial which is so often seen at times during a patient's journey toward acceptance of a terminal diagnosis.

Discussion

Of the greater than 6 billion people inhabiting this planet, approximately 85% are adherents of some form of religious faith.[7] Those individuals who have identified themselves as non-religious or atheist comprise only 15% of the world population.[7] The remaining 85% who have an identified religious faith are distributed approximately as follows in order of decreasing numbers based on data from mid-year 2002: Christians (33.1%), Muslims (20.0%), Hindus (13.5%), Buddhists (5.9%), and other religious groups including Sikhs, Judaism, ethnic religions, and new religions making up the remainder (12.5%).[7] Considerable research interest and effort has been devoted to differentiating between the effects of spirituality and religious faith on health outcomes including the relative impacts of these two factors on psychological adjustment and quality of life in cancer patients.[8,9] Most of these studies have been done in western, 'developed' countries with highly secularized cultures and hospice programs. In these studies, observations have been made suggesting that the 'spiritual' factors of meaning and being at peace as differentiated from explicitly religious factors were more closely correlated with better outcomes. This begs the question of how tightly coupled spirituality and religious faith are in different faith traditions and cultures. Again, in western societies where individual autonomy is often prized above most other values, such observations may be quite pertinent. However, in many other societies and faith traditions where being integrated within a larger community of faithful is more the norm, these observations may not be so applicable. Indeed, it may be impossible to make what may seem an artificial distinction between spirituality centered in meaning and peace of mind versus religion when meaning may be primarily centered in the actual religious faith of adherents.

The impact of conferences like this one is often difficult to measure or determine. There are clear limitations of what can be achieved in a 2–3 day conference of this type. However, by the end of the conference, several attendees had made commitments to develop hospice/palliative care programs directly as a result of their attendance at the meeting. Where previously, very little formal activity in the area of hospice and palliative care had been sponsored by the Orthodox Church in Romania, several new programs are now underway including, among others, hospice programs that have been initiated in Cluj/Napoca (St Nectarios' Hospice), a hospice team at Varatec monastery in Moldavia, and a hospice program sponsored by an Orthodox parish in southern Romania (Holy Martyrs Julian and Juliana parish). As a follow up of this conference, a workshop on spiritual/pastoral care at the end of life was held for 40 Orthodox priests in Bucharest. Several Orthodox clergy attendees at the conference also recommended the formation of an international Orthodox palliative care working group to serve in a consultative capacity to other Orthodox groups outside Romania who might be interested in developing hospice/palliative care programs. There was recognition at the end of the conference of the need to incorporate specific training in spiritual care at the end of life for seminarians. Preferably, this would be done collaboratively, wherever possible, with health professional schools in the same community to facilitate an interdisciplinary dialogue early in the formation of all professionals involved in the care of the dying. As an additional outcome of the conference, interest in the development of graduate level multidisciplinary training in palliative care was generated. This interest has culminated in the creation of the first Romanian master's degree program in Palliative Care at Transilvania University in Brasov (please see Table 3 for an outline of the 2-year curriculum). The first class will matriculate in

Table 3 Structure and content of masters program in palliative care at Transilvania University, Brasov, Romania

First semester	Credits	Second semester	Credits
Year I modules			
1. Scientific research methodology	7	5. Media training and medical communication	5
2. Biostatistics and medical informatics	5	6. Organizing and management of palliative care services	13
3. Evidence-based clinical management in palliative care	11	7. Internal audit and risk management	5
4. Aspects of palliative oncology and non-oncologic disease	7	8. Suffering, spirituality, and culture in palliative care	7
Year II modules			
1. Bioethics	6	Independent/supervised research (thesis required)	30
2. Medical legislation – legal issues and palliative care	5		
3. Communication and multidisciplinary support in palliative care	7		
4. Advanced symptom management	8		
5. Nursing in palliative care	8		
6. Strategies in medical marketing	4		

the fall of 2010. The master's program in Palliative Care has been designed as a multidisciplinary training experience. It is open to anyone with an undergraduate university degree who has an interest in palliative care including individuals from health care (e.g. nurses, social workers, physicians) as well as non-health care backgrounds (e.g. clergy, theologians, administrators, academics, etc.). There will be some flexibility built into the educational experience taking into account the needs and professional goals of individual learners and their prior backgrounds. A seven credit course entitled, 'Suffering, Spirituality, and Culture in Palliative Care' organized and primarily taught by a physician is a reflection of the impact of this conference on the educational design of this graduate level educational program. The conference also attracted the attention of the national news media because of its unique coupling of clergy and health professionals. The longer-term impact of the conference on education of seminarians and health professionals, clinical and pastoral care at the end of life, and how Romanian culture addresses the whole topic of palliative care remains to be seen.

The primary goal of this conference was to create a common ground of understanding for effective dialogue and collaboration between clergy and health care providers who share a common faith tradition as they address major spiritual issues in palliative care. To apply this concept to a more diverse, pluralistic culture, a two-step approach may need to be taken. First, it would be essential to make sure that palliative care providers who share the same religious faith as their patients have had the opportunity to develop a coherent understanding and approach to addressing the spiritual needs of their patients with advanced life-threatening illnesses. Conferences modeled on the one described in this manuscript could facilitate this process for health care providers from specific faith traditions as they interact with clergy from their own faith tradition. Once this approach has been applied to each major faith tradition within a religiously diverse region or country, a second conference could be organized. It would be focused on bringing together palliative care providers and theological representatives from the individual faith traditions who have already experienced the initial faith-specific conference with health care providers/theologians from other faith traditions to explore the unique differences and points of convergence theologically, liturgically, and culturally between the several traditions for better mutual understanding. This, in turn, could lead to more sensitive and thoughtful care provided to persons of different cultural and faith backgrounds based on a deeper level of understanding of the spirituality derived from different religious faith traditions.

This conference demonstrated the feasibility of bringing together health care providers working in hospice/palliative care and religious leaders responsible for theological education, religious practice, and pastoral care of the dying to work on developing mutual understanding as well as explore potential ways to collaborate in the care provided. Orienting all conference participants to a basic understanding of the philosophy of hospice/palliative care helped create a common ground for discourse which was then centered on the great existential questions that become so prominent in human experience when life itself is threatened. The content of the questions and case scenarios for small group discussion are so fundamental and universal that similar conferences with minor modifications addressing unique cultural issues should be feasible within any major faith tradition. Integrating deeply held religious beliefs specific to the faith traditions of palliative care patients and their families will facilitate the spiritual work of the dying.

Appendix: Materials – cases for small group discussions

Half-day session devoted to theology of suffering

- *First case scenario*: A 56-year-old university professor develops continuous intense upper abdominal pain radiating to her back. Computed tomography demonstrates a large mass in the body of the pancreas with multiple metastases in the liver. When she learns of her terminal diagnosis, she asks you: 'Why must I suffer? Why is God punishing me?'.
- *Second case scenario*: A widowed 39-year-old mother of two children, ages 12 and 14, has just been told that her metastatic breast cancer is progressing rapidly in spite of therapy. Although tearful, she states that her Christian faith will sustain her through this trial. Two months later she is needing to rest most of the day and needs assistance with bathing. She is visibly anxious but insists that God will heal her.
- *Third case scenario*: The parents of a 5-year-old girl who is now comatose from progression of her malignant brain tumor are keeping vigil at her bedside. They turn to you and ask through their tears: 'Why has God abandoned us and our daughter? Why is He silent in the midst of our suffering?'.
- *Fourth case scenario*: A 58-year-old man positive for hepatitis C with cirrhosis of the liver is diagnosed with progressive hepatocellular (liver) cancer. He is experiencing increasingly intense right upper abdominal pain but refuses to take pain medication, stating: 'I deserve to suffer because of my past drug abuse that caused this cancer'.
- *Fifth case scenario*: An 85-year-old man is diagnosed with far advanced renal (kidney) cancer and has several painful bone metastases. He is a self-described agnostic: 'How could God allow such suffering in the world, including mine?'. His family complains that he

is sedated all the time from taking too much pain medication. He states that he takes enough medication to be 'as comfortable as possible' and 'I don't want to have to think about my suffering'.

- *Sixth case scenario*: An Orthodox priest's wife has been bedridden for over 20 years with a slowly progressive neurologic disorder. She has been minimally responsive for several years and requires total care. In confession, her husband states that he feels ashamed and guilty because of a desire for her death so that he could see an end to her suffering.

Half-day session devoted to ethical issues and suffering

- *First case scenario*: A pious 70-year-old woman is experiencing increasing pain in her abdomen from progressive colon cancer. She refuses any increase in her pain medication because she has heard that the pain medication may shorten her life and 'that would be a sin'.
- *Second case scenario*: An 85-year-old female has a several years history of progressive dementia (Alzheimer's disease). Her family is concerned that she is now eating very little and that she will 'starve to death', unless a feeding tube is placed. She has been bedfast for several months, has lower extremity contractures, a sacral decubitus ulcer, and cannot utter more than a few intelligible words during a 15 minute encounter.
- *Third case scenario*: A 46-year-old blind diabetic man who has end-stage kidney disease and has been undergoing hemodialysis for several years complains that the quality of his life is progressively worsening. He wishes his suffering could end. He understands that he could stop dialysis and that death would come within days but is concerned that this may be a form of suicide.
- *Fourth case scenario*: A brilliant 22-year-old university student with prospects for a great academic career develops chronic severe headaches. Imaging studies show an advanced incurable malignant brain tumor. When he is next seen, his father takes you aside and insists that you should not tell him the diagnosis because 'it will rob him of hope'.
- *Fifth case scenario*: Although great efforts have been taken to relieve the intense pain experienced by a 35-year-old woman with advanced metastatic cervical cancer, she continues to suffer intensely. During a visit to her bedside in the hospital she asks you for help 'to end my suffering'.
- *Sixth case scenario*: A 64-year-old woman is delirious and dependent on a ventilator after developing multiple organ failure following an abdominal operation complicated by intestinal leakage and severe infection. After several weeks without improvement in her condition, her family is asking that the ventilatory support be stopped and that she be allowed to die. A family member arrives from a distant town and states that 'stopping care now would be equivalent to killing her!'.

Half-day session devoted to spiritual care and suffering

- *First case scenario*: A 49-year-old physician with a very busy clinical practice develops increasing fatigue, weight loss, and vague abdominal discomfort. She is eventually diagnosed with advanced, widely metastatic gastric cancer. She is no longer able to practice medicine. With her reduced level of activity she becomes increasingly irritable and at times tearful and states: 'My life no longer has any meaning'.
- *Second case scenario*: A 61-year-old devout man with newly diagnosed pancreatic cancer based on biopsy of a solitary liver metastasis is complaining of increasing difficulty sleeping, fatigue, poor appetite, low mood, and an inability to enjoy activities that previously gave him pleasure. Upon further questioning, he also expresses a profound sense of guilt and hopelessness.
- Third case scenario: A 64-year-old man with advanced lung cancer has been a religious skeptic most of his adult life. As the debility associated with his cancer progresses, he becomes desperate for any option that might provide a cure. He makes his confession and is formally reconciled to the faith of his youth, receiving the sacraments of holy unction and communion. When it becomes evident that he is still getting weaker and will die soon, he becomes angry and despondent saying: 'I did my part. Why hasn't God done His part?'.
- *Fourth case scenario*: A 38-year-old woman with advanced ovarian cancer is now bedfast and extremely cachectic and emaciated. Her husband has taken extended leave from work to remain at her bedside day and night. He continually encourages her to 'get better because your children and I will not be able to go on living without you'. Her abdominal pain that was previously well controlled is now no longer responsive to strong opioid pain medications.
- *Fifth case scenario*: A 53-year-old divorced man with pancreatic cancer metastatic to the liver has had progressive upper abdominal pain radiating to his back for several weeks that has been responsive to escalating doses of morphine. He has been increasingly isolated socially since his divorce 5 years ago and has not seen his three children since that time. He now presents with excruciating pain no longer responsive to morphine.
- *Sixth case scenario*: An 82-year-old grandmother with advanced heart disease is experiencing increasing levels of breathlessness despite maximal medical management of her congestive heart failure. This has kept her from attending Liturgy which has been her greatest source of meaning and comfort. In despair, she expresses her wish to you that 'if only the Lord would take me'.

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