

Communicating Information to the Incurably Sick

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1- Introduction

The title indicated by this presentation is far-ranging, for communicating information may be understood as the transmission of truth at various levels, I would say, in an analogical and non-ambiguous sense, even if truth is as a great river that gathers in one current the waters that come from diverse tributaries.

There is inquiry that concerns clinical, diagnostic, and therapeutic aspects, as well as the course of the illness and its prognosis; there inevitably is inquiry that concerns the expectation of death with its possible pains; then, there is that truth which concerns the psychological past of the patient and his memory; and finally, there is the moral, theological, and eschatological truth that, in the case of a believer, represents the final hope of a landing place for the journey travelled.

Usually, in the deontological literature directed to doctors, clinical inquiry is discussed that focuses us above all on this question: How much truth should be offered to the patient concerning the diagnosis of an illness and on the prognosis of recovery or death?

Certainly, this type of information has special relevance and presents problems and doubts for assisting personnel, but we know that the response concerning what to say in terms of a prognosis of death depends upon multiple circumstances: first and foremost on the degree to which the conscience of the subject is capable of handling the information positively, and this condition depends in turn upon the degree to which the subject can contextualize this information at that precise moment with the meanings of his life, and of his experience across his past and at that precise moment under our examination.¹

¹ In order to enrich the evaluation of the various aspects of the problem within the most recent literature, consult: KÜBLER-ROSS, E., *La morte e il morire*, Assisi, Cittadella 1982 (original title: *On Death and Dying*, New York: MacMillan 1969); PEGORARO R., *Comunicazione della verità al paziente*, in "Medicina e Morale", pp. 425-446; SGRECCIA E. – SPAGNOLO A.G. – DI PIETRO M.L., *L'assistenza al morente*, Milano, Vita e Pensiero 1995; WOODALL G.J., *Medicina Veritatis: il rapporto*

In short, the argument concerning truth to the patient involves the contribution of various sciences and scholarly works of diverse origins: medicine, psychology, sociology, communications, ethics, theology, etc. Besides confronting this argument, a call to collaboration is involved – in truth and veracity -- among various professional figures and workers: This illumination of truth is hardly able to radiate itself not only within the soul of the patient, but also within the culture of the doctor and health care workers, relatives, and society. Therefore, the reader may understand the undertaking that today has come to be immense concerning this topic, beginning especially in the 1950's and thereafter increasing in attention.²

2 – *The repudiation of death in current society*

The difficulty of manifesting the truth about death and dying to the same sick person is seen today also within the society of healthy people due to a “repudiation” that characterizes, more or less consciously, society as a whole and the behaviors of individuals.

This fact, which has been brought to light by an abundant literature in religious sociology since the famous volume of P. Ariès³, has been described as characteristic of

pluridimensionale tra la verità e la medicina in “Medicina e Morale” 1997/4, pp. 739-759; SGRECCIA E., *Il malato terminale e l'etica della solidarietà*, in “Programmi clinici in Medicina”, monograph issue edited by ROMANINI A., and SPEDICATO M.R., Padova, Piccin 1998, pp. 20-29; SGRECCIA E. – VIAL CORREA J. de DIOS (ed.), *The Dignity of the Dying Person*, Vatican City, Libreria Editrice Vaticana 2000; FLORI A., *Il dovere di informare il paziente senza più limiti*, in “Medicina e Morale” 2000/3, pp. 443-447; BONETTI M. – RUFFATTO M.T. (ed.), *Il dolore narrato*, in “Comunicazione in Società”, n° 5, Torino, Centro Scientifico 2001; PETRINI M., *La cura alla fine della vita. Linee assistenziali etiche pastorali*, Roma, Aracne 2004; JAMETON A., *Information Disclosure, Ethical Issues of*, in POST S.G. (ed.), “Encyclopedia of Bioethics”, 3rd ed., Thomson 2004, pp. 1265-1270; SGRECCIA E., *Manuale di Bioetica*, vol. I, IV ed., Vita e Pensiero 2007, pp. 572-936.

² It is important to gather together all of the bibliography on this topic. See in this regard within the studies cited of R. PERGORARO (note 1) the comment on some works of great weight, even if not recent: PERICO G., *I malati hanno diritto alla verità?* In “Aggiornamenti Sociali”, 10, 1959, pp. 545-554; IDEM, 1967, pp. 93-125; IDEM, *Il diritto del malato a sapere*, 3, Roma, Armando Ed. 1983, pp. 171-180; IANDOLO C., *L'approccio umano al malato. Aspetti psicologici dell'assistenza*, Roma, Armando Ed 1979; IDEM, *Parlare con il malato. Tecnica, arte, errori della comunicazione*, Roma, Armando Ed. 1983; IDEM, *Il malato inosservante*, Roma, Armando Ed. 1985; DEMMER K., *Christi vestigia sequentes*, Roma, PUG 1988.

³ ARIÈS P., *Storia della morte in Occidente: dal medioevo ai giorni nostri*, Milano, Rizzoli 1978 (orig. title in French: *Essais sur l'histoire de la mort en occident: du Moyen Age à nos jours*, Paris 1975); IDEM, *La mort inversée*, in “La maison Dien” 1970, pp. 57-88; MORIN E., *L'uomo e la morte*, Roma, Newton Compton 1980; ELIAS N., *The Loneliness of the Dying*, Oxford, Basil Blackwell 1985; FUCHS W., *Le immagini della morte nella società moderna*, Torino, Einaudi 1973; TENENTI A., *Il senso della morte e l'amore della vita nel Rinascimento*, Torino, Ed. Einaudi 1977; IDEM, *Processi formativi e condizionamenti del senso della morte e delle sue espressioni* (secc. XII-XVIII), *Ricerche di storia sociale e religiosa*, 15-16 (1977), pp. 5-21; VOVELLE M., *Mourir autrefois: attitudes collectives devant*

an era in which, because of the synergistic effect of various factors (those of the secularization of culture and society, the experience of well-being and the concrete possibility of a material affluence able to be enjoyed for a long time, the increase of the average life-span) in first-world countries, manifests the “darkening of vision” concerning the thought of death and the escape from suffering. At the same time, paradoxically, another person’s life easily comes to be thrown away as something without value, and an individual just as easily inflicts death in order to protect his own ephemeral satisfaction and the enjoyment of his own liberty.

“We are living, therefore,” – wrote Silvano Burgalassi, “the meaning of life and death in a schizoid manner. For this same reason, the fact that we all are stretched out strongly toward an impossible immortality accompanies at the same time a human life very little considered (it is enough to think of the most frequent deaths on the streets, homicides, etc.). We do everything in order to live well and for a long time, and then we throw away life, scorning it with the greatest ease (in abortions, criminality, drugs, and euthanasia).”⁴ It is a society that not only has lost its sense of life and death but, in its majority demonstration, is afraid of reflecting on the same reality and looks to cancel out any signs of it. One speaks, for this reason, of the “taboo” of death, of the darkening of any reminders concerning death in public relations, or of a “hiding” of its presence. The emphasis is put upon health, productivity and the organization of free time.

This type of culture certainly does not manifest itself to populations of the various continents in a uniform manner, and even within the same country there may be found its cohabitation with other types of cultural attitudes. However, I believe that one might agree with the conclusions of Burgalassi when he affirms that “the hypotheses seem to us to have to be reduced to two, being:

1. In a society in which individual and collective living are connected strictly to a particular option at its base (faith) and in which the anthropological paradigms (presence of acts oriented toward the transcendence of self, very strong connotations of identity, a panged network of relational arguments, values socially shared) may characterize social living, the dignity of each human life comes to be respected to the

la mort au 17ème et 18ème siècle, Paris, Gallimard 1974 (orig. title: *La morte e l'Occidente dal 1300 ai nostri giorni*, Roma-Bari, Laterza, 1986).

⁴ BURGALASSI S., *Il morente oggi, tra rimozione delle immagini di morte e desiderio di immortalità*, in SGRECCIA E. – SPAGNOLO A.G. – DI PIETRO M.L. (ed.), *L'assistenza al morente*, op. cit. pp. 81-97.

greatest extent, and in it death assumes its particular dignity. Death and life are considered to be equally sacred events, that is, removed from man's will and able to be remodelled only at the level of a superior vision: with life and death as stages of passage towards eternity. Therefore, a "superior" option along with a very stringent globality seem to characterize the optimal conditions for a correct vision of life and death.

2. When options become watered down or confused, and when they loosen their grasp of the four fundamental anthropological paradigms just cited (as a consequence of a narcissistic falling back upon themselves, through a kind of disorientation that strikes each individual, through the absence – anomia – of strong relational arguments and the non-hierarchization and incoherence of values only partially shared), life and death become subordinated to immanent elements whose primary character is given by profanity. With the same, life and death appear as events no longer sacred nor central with respect to the priority motions of our time (money, well-being, personal freedom and autonomy, leisure (*loisir*), etc.). A "selective" principle is introduced that -- dominated by the new option of an imminent basis – favors certain segments of life (for example, youth) or certain lives held to be more worthy than others (those of the norm compared to those of the handicapped, those of the inhabitants of industrialized nations compared to those of the third world, etc.).”⁵

Society thus flees again, to the degree to which it has become secularized, from the truth concerning the value and meaning of life and death. Consequently, it does not help but rather is an impediment within the order that serves the advantage of truth.

One notices the same repudiation of death within contemporary medical practice. In Western countries, the evolution of medical science always has seen more to affirm itself by a more medically scientific and objective type of setting, often diminishing the same limits between research and medical assistance. If this approach on the one hand has brought about the acquisition of new and better knowledge, by way of the tendency to objectify sickness, on the other hand it has contributed to altering the nature, traditionally charitable, of the medical art. One of the consequences has been that death, at first considered as a natural event within the same field of medicine, now has become considered as bankruptcy, limit, and failure.

⁵ BURGALASSI S., *Il morente oggi*, op. cit., pp. 83-84.

3 – *The repudiation of death within the conscience of the healthy individual*

There exists much literature examining, with the aid of psychology, the stamias, dynamics, and routes that the idea of death encounters in its impact upon individual conscience, which certainly compares itself with society, but which also enjoys the relative autonomy of individual reflection and interiorization.

Before summarizing that which the literature and experience have assembled in this area of the human mind, it is necessary to bring some distinctions to light. The first distinction is between the concept of death lived in everyday reality, and the event of dying placed in the conscience of the dying person: Death comes to be conceptualized as a fact, a fact that concerns everything and as such also each one of us, but it is felt to be something remote, or lived by people near to us...a fact that frightens but which is lived as “thought.”

Dying is a human act, personal more than any other, not only because it comes to be lived by the person, but because it summarizes the personal background and meaning of all life, and it pushes outward toward a reality that the person can either await or refuse, according to the attitude of the same person.

This act/event becomes objectified in the concept of death, but it comes to be felt as impending, even when it is thought of as a faraway occurrence: It is the true grounds for fear, and at times it is a nightmare that disturbs even infancy, periods of sleep, and the games of youth, properly because it will be ours, belonging to each one of us.⁶

It is right and opportune then that one may speak of the thought of death's having an influence on the equilibrium of people even when they are still healthy, properly in view of appeasing a person concerning this thinking in the light of truth, before yet speaking of communicating information to the patient who is threatened by a grave illness or perhaps by an unfavorable prognosis, and finally of the truth of communicating (and how to communicate) it to the dying person.

The thought of death in the background of everyday life is presented within the philosophical literature as a source of uneasiness, but in a different way. According to

⁶ SANDRIN L., *La psicologia del malato di fronte alla morte*, in SGRECCIA E. – SPAGNOLO G.A. – DI PIETRO M.L. (ed.), “L’assistenza al morente”, op. cit., pp. 221-231; ZILBOORG G., *Fear of Death*, in “Psychoanalytic Quarterly” (1943), 12; BECKER E., *Il rifiuto della morte*, trans. It. by G. GASTONE, Torino, Ed. Paoline 1982 (Orig. title: *The Denial of Death*, New York, Free Press 1978); CAPOGRASSI G., *Introduzione alla vita etica*, Roma, Ed. Studium 1976.

some philosophers, such as A. Schopenhauer, it will be “the muse of philosophy”; to M. Heidegger, the thought that defines the most profound truth of man is his “being for death”; to Max Scheler, it is “the worm nested in the center”; and for William James, it is “the skull that sneers upon our banquets.”

The psychoanalyst Zilboorg affirms: “Behind the sense of insecurity, in front of danger, behind the sense of discouragement and depression, nests the fundamental fear of death, a fear that can undergo the most complex formulations and which manifests itself in multiple indirect ways. The neurosis of anxiety, the various states of phobia, a great number of depressive manias and suicide, and many schizophrenias amply demonstrate the constant presence of the fear of death...We may hold peacefully that the fear of death is always present within our mental working.”⁷

According to other philosophers, this phenomenon is explained by the instinct of preservation that all animals have in common, but according to others, maybe more adequately, one understands by way of the fact that “man is split in two: One half belongs to the animal world, and the other half belongs to the world of symbols and ideas: ‘He is a worm and a meal for worms,’ as Becker writes, ‘but he is self-consciousness, a creative being who ranges within his mind from the immensity of the cosmos to the most infinitesimal particles.’”⁸

If we have put this reflection into place, still before our dwelling on the truth of expressing it to the gravely ill or dying person, it is because the “repudiation of death” and the “fear of dying” penetrate profoundly into the subconsciousness at the daybreak of our childhood (it seems that the first questions on the reason for dying may be verbalized already by 4 years of age). If they do not come to be clarified at that age or become repressed, they poison life and the gusto of life with bitterness, upsetting and deforming behaviors and rendering moments of pain or those of approaching old age or grave illness ever less acceptable. It is necessary to make peace right away with death in order to express the meaning of life, and in order to be able to consider, with serenity, the person’s approaching death such that he may recognize it to be the same door as that of a further life, one that is “more abundant.”

We must concern ourselves first and foremost with illuminating the mystery of death in the minds of children, adolescents and preadolescents, who are in health with

⁷ ZILBOORG G., *Fear of Death*, op. cit., p. 465.

⁸ BECKER E., *Il rifiuto della morte*, op. cit., p. 45.

the truth that frees us. The life of the dying person needs particular consolations that should be facilitated, then, by the positive meaning of the life that has been lived.

Those persons among children and youth who have made peace with pain and death and feel capable of helping those people whom they find concretely in pain and death, open themselves to dialogue and service. It is the world of positive solidarity, composed of those people who, having accepted their own cross, with the strength of love within themselves, help others to carry their cross. Alongside and in the face of this world, if another person appears out of it from among those people who have run away in the face of pain, in the face of life irremediably compromised by impending death, in their eyes death destroys the human character of the person similar to us or to our kinsman.

This exterior and social escape denounces an interior flight and not without effect. The effect is not only that of managing the void surrounding the bed of the incurable sick person. Rather, this escape develops, by way of an imminent logic, an antisociability, a relationship in the negative, a type of destructive potential.

First and foremost within the same subject, a conflict comes to establish itself, a “non sense” in the confrontations of life that, to the extent that it is masked and distorted, impedes the same subject from realizing himself in a “project of life.” Life becomes, as Heidegger stated it, “inauthentic.”⁹ However, to the eventual negative effect that takes place within the subject, one adds an effect that we could say in medical terms is secondary, but serious, at the social level. He who flees from the presence of death and the dying person sets into action *defense mechanisms*. These mechanisms are substantially twofold: *the ludic or evasive* and *the aggressive*. The “entertainment” of the society of well-being is no longer only recreation, but it often is “turning elsewhere” in the literal meaning of the term.¹⁰ The passage thus from the attitude of flight of a ludic character to the aggressive and suppressive mechanism is brief: because in the definitive, one gives the suppression of pain only if it suppresses

⁹ SGRECCIA E., *Il malato terminale e l'etica della solidarietà*, in “Programmi clinici in Medicina,” monograph issue, vol. 3, n° 3, ed. by ROMANINI A. and SPEDICATO M.R., Padova, Piccin 1998, pp. 20-29.

¹⁰ In this regard, the philosopher of law E. Capograssi writes: “What has been born within our society is a true and proper, vast and precise, elaborated and manifold science and experience of amusement . . . amusement that hides the pain of life. In order to face a surgical procedure, general anaesthesia is necessary...Upon this diversion is added a lack of interest in factory work, and disinterest in political life. In this condition, presuppositions are created concerning the other terrible game that is war. War arises when people bore themselves.” And yet, “Suicide is the most abbreviated form of amusement.”

whoever suffers or whom one thinks to be the cause of suffering for us. I quote, among many, the anthropologist L. V. Thomas who, after an historical-comparative study between cultures of different continents, adds to this conclusion: “There is a society that respects man and accepts death: the African. There is also another, deadly, thanatophobic, obsessed and terrified by death: Western.”¹¹ It is to this society, the Occidental, that we must add how one acts in the sense of marginalizing the elderly and the handicapped, where he poses the problem and the fact of eugenic euthanasia for deformed newborns, and of terminal and social euthanasia for the incurably ill.

I add what G. Campanini writes: “Euthanasia reunites itself to the process of secularization that pervades our society and expresses itself above all as the supreme form of demand of independence of man also – and most of all – in the face of God and consequently as rendering suffering fruitless.”¹² The notorious “Manifesto on Euthanasia” of 1974 affirms on the other side: “It is cruel and barbaric to require that a person be maintained in life...when his life has lost all dignity, beauty, significance, and prospective of the future.”

A supporter of euthanasia already affirmed several years ago: “If war is too important to be entrusted to generals, medicine is too important to be trusted to doctors. For this reason, in our opinion, the social putting to death of senile elements and of each group of mentally handicapped persons and of unproductive members of society is not yet morally acceptable for society, and certainly it is not so for the members of the health care profession, which may be the sluggishness that they take in adapting their medical treatments to new situations.”¹³

This thrust of negative and murderous sociability, motivated by economic causes, comes to be denounced in such a manner also by a medical historian, Franchini: “The acquisition of sophisticated therapeutic means capable of preventing man from dying, from illnesses that up until a short time ago were mortal or absolutely incurable, carries a cost that hampers its generalization, for which society cannot permit itself the luxury of sustaining it, and for this reason it also could be said bitterly that to the degree

¹¹ THOMAS L.V., *Antropologia della morte*, Milano, Ed. Rizzoli 1976.

¹² CAMPANINI G., *Eutanasia e società*, in AA.VV., *Morire sì, ma quando?*, Milano, Ed. Paoline 1977, pp. 58-66.

¹³ WILKS E., referenced in the article of RENTCHNICK P., Editorial on “Médecine et hygiène”, 29-02-1984, p. 654.

that medicine progresses further, that much more it is difficult to care for the sick person.

The inevitable conflict between society and individual brings us to the tragic moment of having to decide which patients must be left to die.”¹⁴

We then could come to this further conclusion: The society of well-being is at the point of planning the escape from suffering with the programmed abandonment of those whose care comes to weigh too much upon the “well-off”; this abandonment can take the legalized form of euthanasia or that anonymous form of generalized “therapeutic abandonment”, which someone has called “social euthanasia”. In order to avoid this negative thrust and to edify in the mind of young people and adults a “peace” with pain and death, a pedagogical way is necessary in which one may realize, with the effort of reason and will at the natural level, and also with a maturation of faith at the supernatural level, knowing well that in the reality of the formative process, in the “I” that each person enriches and opens, the two components – the natural and the supernatural – meet each other and integrate with each other in synergy.

During the process of natural maturity, the person comes to be led by reflection upon the maturity of action. During adolescence, life opens itself to action with joy and looks for friendship: Love for life and the good seem to come to birth spontaneously. Capograssi says: “At its dawn, action is abandonment, free and thoughtless work, free creation of a world rich in form, free expansion of practical fantasy, of the fantasy of the will, free fervor of construction, liberty, spontaneity, enjoyment.”¹⁵

During a youth more aware of limits, the love affair finishes, the dream breaks apart, and the river becomes subterranean. Action is inferior to the end goal, and between action and life is set the valley of tears, the rocky mountain. Reason discovers *distances*, and the same thought becomes toil. It is as if the end were growing further away, and other people prove themselves to be living for themselves and not for me; reality presents itself as harsh, presented as it is in itself and not as I want it for myself. Action becomes a burden, reality is crushed into pieces, and single acts are felt to be detached and disproportionate to the end. It is the disproportion between action and

¹⁴ FRANCHINI A., *Le grandi scoperte della medicina nel XX secolo* in “Enciclopedia delle scienze”, Roma, Città Nuova Editrice, 1984, pp. 387-399.

¹⁵ CAPOGRASSI G., *Introduzione alla vita etica*, op. cit., pp. 14-28. For the considerations that follow, resuming what I wrote in the work: SGRECCIA E., *Il malato terminale e l’etica della solidarietà*, op. cit., pp. 21-26.

end, between thirst and the remoteness of the spring. It is at this point that the individual feeds the temptation of inertia, *the temptation of the reduction of the End* to particular and individualistic ends, and pride and egoism close the ring around the subject and render him an individualist and no longer an open person. Being unable to reach the horizon, he denies and repudiates it; the temptation of fear intervenes; and the fear of hurling oneself into the world of society is like the fear of hurling oneself into a treacherous river. Reflux and crisis come, and the hour of the search for his own individualistic well-being arrives.

It is this hour of the search for entertainment, of turning from another side. One looks to suppress toil and effort, one gives way to antisociability, or sociability overturned, of which we already have hinted, available to augment the logic of flight and of the suppression of pain. It is the ethic of abandonment of the supernatural end. It concerns that which Fromm calls “flight from freedom” and is an escape from responsibility, fleeing from being and from life. The third moment, which we could call the moment of *maturity*, is that during which the *acceptance of pain as value* and of *value as life and love* plays a precisely determining role. R. Guardini warned of it when he wrote, “That which we have called “meaning” in its wider significance, idea, essence, value or however we wish to express ourselves, that which is absolute in its value has a twofold appearance: It signifies on the one hand preciousness, dignity, and fullness that renders people happy. It means then at the same time bond, burden, difficulty, and destiny. Each height that ever may be raised within the conscience of men also has become a yoke for them. All that is noble also brings suffering. Values are pains.”¹⁶ *The discovery of value or of values* is the most decisive and creative moment of the ethical life, and it also is the most demanding moment; value roots itself in the good, and the good is within the depth of being, in the life of persons above all, in their interior and transcendent greatness. “The notion of good,” writes Maritain, “is one notion at the outset that springs up suddenly, under a certain visual angle, in order to reveal a new face of being, a new intelligible mystery coexistential with being. One uncovers this prospective in the depth of being with love, in front of which it places itself, in relationship with that which it defines itself.”¹⁷ Value speaks of relation with the good, and it is the good that engages attention in front of a subject; the good is

¹⁶ GUARDINI R., *Fede, religione, esperienza*, Brescia, Ed. Morcelliana 1985, p. 23.

¹⁷ MARITAIN J., *Nove lezioni sulle prime nozioni di filosofia*, Milano, Vita e Pensiero 1979, p. 78.

being, it is being when it is placed in front of desire. Being that is the most worthy of the name, on this earth, is the human person; the being through essence, the source of each existence, is the personal God. However, if value is a good for the person to realize, it also is a good that must break the chains and the captivity of egoism, which calls the person to place himself in a state of responsibility in front of the real, in front of persons, in further analysis in front of God. Here is the way; value, the good, being, the person; and through the person one opens himself to love and sacrifice. In this manner, by way of the discovery of value, irresponsibility ceases and desperation ends. Capograssi writes: “Certainly irresponsibility is finished: The consciousness of a necessity is born, one that comes to render action as a serious and dense thing in all seriousness of life. A mysterious thing is born: duty.”¹⁸

At this point, the individual transcends himself and accepts realizing value as duty, freely, even if accepted with great effort. Theological ethics, that concerning the end and fullness, enters in correlation in this manner with deontological ethics, that of daily duty. Between one and the other, value then finds its place: person-value.

It will be good not to forget that value has a cost! “Here, experience is most peculiar, and here precisely is the wanting ‘to want’: My will is a will that comes to be imposed upon me, but in short it is my will and the action is wanted by me ... In this wanting not-wanting is all of ethical life.”¹⁹ This journey is completed during youth, and in any case before the moment of grave illness.

The incurable sick person is a test of Christian maturity because he brings in himself the value of life that reaches its moment of greatest existential obligation, of greatest risk of psychological destructuring, or alternatively, of opening to ultimate maturation. On the part of persons close by the sick person, this moment will have to become a catalyst of solidarity meant in a positive sense, of mature ethical commitment in which love for brother testifies to itself by sacrifice and oblation of service.

One uncovers and discerns in these hours of human obligation whether love for neighbor and solidarity are authentic or not, if the respect for life is based upon truth and not upon use, and if society is of solidarity or utilitarian. If by the end, medicine serves to care for and sustain the journey of the patient, in the moment in which he is “more patient” and where there may not be a guarantee of health for the “*bien portant*”,

¹⁸ CAPOGRASSI G., Introduzione alla vita etica, op. cit., p. 56.

¹⁹ CAPOGRASSI G., Ibidem, p. 65.

this attitude will result in being clarified at this crucial moment. It is true that, for whoever has faith in the value of the redemptive sacrifice of Christ and of the Christian, for whoever has hope in the resurrection, for whoever possesses the certainty that the love of Christ is present – be it in the suffering person or in the caring person (“you have done it to Me” – Mt. 25) – there exists a strength infinitely superior over every sense of merely human solidarity. Nevertheless, it also comes to be known that whoever loves man for who he is, and not simply for how he is useful, implicitly affirms the transcendence and assumes the Transcendent. The interlocutors of the Last Judgment, of which Matthew speaks in chapter 25, demonstrate in fact the being of unaware benefactors and anonymous Christians who when they were acting on behalf of a brother, they were not thinking explicitly of Christ and for this reason in the parable, they ask, “Lord, when were you ever there? When did we ever see you hungry, thirsty...sick and assist you?” And it is properly to them that Jesus gives assurance: “All of the times that you did it...you did it to me.” In each case, this social attitude presupposes a pedagogy of values, a maturative discovery in the ethical life of persons.

It is certain that the truth of faith, where it is announced and welcomed, strengthens human maturity that consists in the oblation of love, which occurs with the example of Christ and with His help. The Christian knows that with faith and the Sacrament, in particular with the Eucharist, he participates in that act of love that Christ lived upon the cross for the salvation of the world and, it is granted him to unite his own offering at each moment of life in that act of love, especially in the moment of sacrifice and of his own death. And it is through this act that pain becomes love and redemption, and death throws open the doorway to new life, as the Apostolic Letter *Salvifici Doloris* reminds us: “The Cross of Christ throws salvific light, in a most penetrating way, on man's life and in particular on his suffering. For through faith the Cross reaches man *together with the Resurrection*: the mystery of the Passion is contained in the Paschal Mystery.”²⁰ That which we would like to underscore yet another time is how this maturity is asked of the Christian, in order to make peace with pain and death, already in catechetical formation along the journey of Christian formation, in order to make “sense” of daily life.

²⁰ GIOVANNI PAOLO II, Apostolic Letter *Salvifici Doloris*, 11 February 1984, n° 21.

It is not for nothing that the Encyclical *Evangelium Vitae*, in its second part, offers the four foundations for an evangelization of life: Creation, the Incarnation, Easter, and the final Resurrection. Life that is a gift of God is assumed by Christ, our life comes to be offered on the cross with that of Christ, and from the Resurrection it is called to the resurrection and to the fullness of life in eternity. “Christ's blood reveals to man that his greatness, and therefore his vocation, consists in the sincere gift of self. Precisely because it is poured out as the gift of life, the blood of Christ is no longer a sign of death, of definitive separation from the brethren, but the instrument of a communion which is richness of life for all. Whoever in the Sacrament of the Eucharist drinks this blood and abides in Jesus (cf. Jn 6:56) is drawn into the dynamism of his love and gift of life, in order to bring to its fullness the original vocation to love which belongs to everyone (cf. Gen 1:27; 2:18-24).”²¹

I have lingered for a long time on the theme of the thought of death lived in advance, and upon the necessity to make peace with death by way of a mature awareness of its connection to earlier life and, as its synthesis, to eternal life. The pain that follows fragility and puts the same trust of man in himself to the test comes to be treated and fought because it is a limit, suffering, and temptation, but its deeper and ultimate treatment is in its offering of love. We will take up this thought again when speaking of agony.

The truth of faith and reason is the strength that is called to build the maturity of the meaning of life in order to give meaning to pain and death, and to make peace with that reality so as to obtain peace and victory and not only resignation.

4 – Communication with the sick during the diagnostic and therapeutic stages

So far, we have spoken of the truth in relation to the meaning of life, and as construction and preparation for giving positive meaning to pain and death. We now draw closer to the sick person in order to remember the function of truth that accompanies diagnosis and serves as part of the global therapy of the person.

²¹ GIOVANNI PAOLO II, Encyclical Letter *Evangelium Vitae*, 25 March 1995, n° 25.

It has only been for the past few years that this theme has become a specific object of study, especially within the setting of “palliative therapy”.²²

The context mostly is that of patients sick with tumors where the communication of diagnoses becomes demanding.

This methodological type of study gained force after, in the environment of the United States, it was ascertained that doctors who were using a communicative style with patients that was based on friendship, honesty, empathy, and active listening -- that is, of the “affiliative type” as it was defined -- observed more positive results from their procedures.²³

At present, specific university courses on communicative techniques have come to be offered in the United States at the “American Academy on Physician and Patient” (USA); in Europe at the “Medical Interview Teaching Association”, at the “Cancer Research Communication Campaign” and “Counselling Research Centre”, and at the course devised by the OMS, “Communicating Bad News”; and in Italy at the courses of the Italian School of Palliative Medicine.

As the authors Gabriella Marosso and Marco Musso²⁴ recollect, the OMS makes reference today to three models of communication: *The model of complete closure*, *the model of complete openness*, and *the model of individualized openness*.

The first model, suggested as paternalistic, is theoretically the least suggested however, in reality, it could be said that many doctors might prefer to adopt this communicative style, or at least they adopt it in certain situations. If it is thought that the information would be too traumatic, it is foreseen that if given much information, the patient would be led to demand explanations of every type and detail; in this case, the information given should be personalized; but the rapport would become too involving and would mean accompanying the patient all the way to the end, burdening the doctor along the patient’s entire way. For these reasons, with this model, the doctor chooses to share information, perhaps that of a generic or marginal type with a relative who might act as an intermediary, one who then would have the task of remaining silent

²² MAROSSO G. - MUSSO M., *La comunicazione con il malato in fase diagnostica e terapeutica*, in BONETTI M. – RUFFATTO M.T. (a cura di), *Il dolore narrato: La comunicazione al malato neoplastico*, Torino, Centro Scientifico Editore 2001, pp. 15-29.

²³ BULLER M.K. – BULLER D.B., *Physicians’ communication style and patient satisfaction*, J. Health Soc Behav 1987, no. 3, pp. 375-88.

²⁴ MAROSSO G. – MUSSO M., *La comunicazione con il malato in fase diagnostica e terapeutica*, op. cit., p.22.

concerning the gravest news in a kind of “conspiracy of silence”. It often may be thought or supposed on the part of this category of doctors that the patient himself does not want to know. Nevertheless, this model always demonstrates itself to be more unsuitable, not only because many lawsuits against doctors (in the USA, 85%) have as their motive a lack of communicating the truth following diagnosis;²⁵ but also because from an ethical point of view concerning this method, beyond damages that might be brought about at the property and economic level, the patient is prevented from preparing himself in detachment or in death: This effect is negative at the psychological and human level and obviously can have serious repercussions at the spiritual level. Reasons of justice and honesty, about which we will elaborate shortly, retain this model to be inadequate, when for particular treatments (biopsy and other investigations) the consent to the procedure requires information concerning the type and reason for the same procedure and its risks. In a short while, we will examine the case, rather rare, that may be put forward concerning the so-called “right not to know”.

The second model anticipates complete openness and often, on the part of its advocates, it is thought that it may pertain to the patient, confronted with the known situation that has been described, to decide also in the first person which treatment to follow among the variously foreseen hypotheses. Critics of this model signal that the patient -- informed bluntly and scarcely of any details of the diagnosis available, and placed in the midst of pessimistic prognoses or decisions to make – can unconsciously make room for defense mechanisms, those of *denial* (I feel fine, I have nothing wrong with me!), *avoidance* (incommunicability with the doctor), *anxiety* and *depression*. It is necessary to think that few patients are capable of confronting the situation with courage so as to assume responsibility in the first person, and of demanding complete information even prognostic in nature.

The third model is that which comes ideally to receive the most consensus, always keeping open the problem of how to communicate: Information comes to be given at the level of declared friendship and loyalty, to the extent and at the moment in which objective data become available, and with a prospective of treatment and

²⁵ On presentations of this situation concerning such charges against doctors, see FIORI A., *Il dovere del medico di informare il paziente: senza limiti?*, in *Medicina e Morale* 2003/3, pp. 443-447.

openness in trust that never must come to an end. It is the model that enjoys the most consensus, but it also is the most arduous, particularly because it is individualized.²⁶

The patient at times urges on with questions, going beyond that which have been ascertained, and the doctor is compelled to say phrases of the type: “I cannot say it again”, “We have yet to see”, etc.

It is certainly a model more consonant with the personalized doctor-patient relationship, but it demands much, and it is for this reason that the doctor who is not prepared for collaboration sometimes prefers to keep himself protected, in harmony with the first model.

Synthesizing this information, after this exposition of various models in light of Catholic moral teaching, the following points may be underscored²⁷.

The doctor-patient rapport is based upon trust, and consequently there exists on the one hand a duty of justice that the doctor, endowed with professional qualifications, should disclose truths with regard to the object of that same rapport; on the other hand concerning the patient, there is instead a right to information, confirmed at this time by international laws and norms and by deontological rules.²⁸

This moral obligation and this juridical right do not entail that everything the doctor might know should be said, but rather that which has relevance to the understanding of the real state of the person and the gravity of the situation. It is obvious, for this reason, that lies should be avoided, and it is incumbent that the reality of the situation, within the limits of verified knowledge, should be laid out, avoiding drastic messages but leaving space for hope to arise, and a guarantee of closeness and assistance always must be provided because if it is true that justice demands truth, it also is true that such communication must be accompanied by charity.

The authors insist upon recommending graduality and attention to the moment psychologically best suited for communication, and moreover that understandable and fraternal language be used.

²⁶ JAMETON A., *Information Disclosure: Ethical Issues of*, in POST, S.G. (editor), *Encyclopedia of Bioethics*, op. cit., pp. 1265-70.

²⁷ WOODALL G.J., *The multifaceted relationship between truth and medicine*, in “*Medicina e Morale*”, 1997/4, pp. 739-759.

²⁸ CENDON P., *I malati terminali e i loro diritti*, Milano, Giuffrè Editore, 2003, pp. 112-127; See for Europe, *La Convenzione di Oviedo* of 1997.

However, that which we have said up to this point about the meaning of life and the maturity of the patient remains important: It is necessary that clinical truth be framed positively by anthropological truth, that is, by the conscience that has made a synthesis -- whether in the doctor or in the patient – of the global meaning of life, such that peace with pain and death may be reached.

Decorum in the face of the truth of an unfavorable diagnosis rests upon a spiritual state that is built up over years and, if over the years it has not been constructed, it is necessary to strive to build it even in the shortness of time suggested such that the announcement of “life that does not die” may be possible, that of the Revelation of Christ Died and Resurrected, present and working in the Church and with the certainty of eternal life.²⁹

While helping the patient, circumstances may transpire due to charity and out of respect for the good of the patient, that could induce silencing the gravity of an illness: When the psychical fragility of the subject may be presumed such that it could induce him toward suicide, or otherwise explicitly when the “right not to know” may be invoked.

In the first case, I am in agreement with moralists in mitigating the revelation of integral truth in order to have time to prepare the subject to receive such information, and to receive it healthily. Consequently, they may always speak the truth that expresses the reason for treatments and the duty of the moment.

The request “not to know” an unfavorable diagnosis is one of the problems that have been posed in recent times and now is being introduced into international laws.³⁰

This condition assumed by the ill subject often may be accompanied by the presence of a fiduciary who also will be responsible for informed consent. The general obligation to observe this commitment to the patient is commonly acknowledged on the part of moralist and juridical authors³¹, but I believe that it always is related to the duties of the doctor when comparing the life of the patient and the ethical-deontological conscience of the same doctor. Examples may be given in which revealing the worsening of a situation may be such as to render impossible the hiding of impending death without giving rise to damage in the patient or in others.

²⁹ ZORZA R.M., *Un modo di morire*, Roma Ed. Paoline 1982.

³⁰ CONVENTION OF OVIEDO, art. 10, comma °2.

³¹ CENDON P., *I malati terminali e i loro diritti*, op. cit., pp. 124-125.

At this point, it is necessary to mention the so-called *living will* or life testament, or better, “advanced directives” that are being applied in various countries after the suggestion given in the “Manifesto for Euthanasia” of 1974³² and the insertion of some provisions within international documents.³³

It is a written text of the patient, drawn up and completed in the form of a testament, which intends to give validity of therapeutic directives to the doctor in case the patient is not able to express himself during the final phase of his life. This document has come to be presented as a substitute or prolonging of the patient’s consent in order to avoid procedures from being practiced on the same patient that he judges contrary to his will (generally, so-called “therapeutic obstinacy”), or it may be requested that such treatments be interrupted should certain conditions of the patient come to pass.

The literature on the topic is becoming numerous³⁴; at times, the provisions introduced are those that involve procedures or omissions that take the form of the practice of euthanasia.

In discussion is the merit of the validity of a document drawn up in advance, through which the permanence of the expressed will may not be secured, when the patient may find himself in concrete conditions never before encountered.

Furthermore, from an ethical point of view -- the position of which is contrary to euthanasia -- it is claimed:

- a) that such documents may not be obligatory for patients,
- b) that the doctor may remain free in the face of the written text and in the midst of the eventual delegate of the patient, not to be bound by clauses that he might judge unacceptable either for clinical or ethical reasons,
- c) finally, it is required that the document not contain directives of a euthanistic nature.

It is important to keep in mind that such documents -- even if conceived in the past (in the '70s) and for plausible reasons of today (freedom of religion, avoiding

³² SGRECCIA E., *Manuale di Bioetica*, vol. I, 4th edition, Milano, Vita e Pensiero 2007, pp. 873-919.

³³ See, for example, article 9 of the Convention of Oviedo.

³⁴ BONDOLFI A., *Living will*, in “Nuovo Dizionario di Bioetica”, ed. LEONE-PRIVITERA, pp. 640-642; CATTORINI P. – PICOZZI M., *Le direttive anticipate del malato*, Milano 1999; EUSEBI L., *Omissione dell'intervento terapeutico ed eutanasia*, in “Archivio penale”, 37, (1985), pp. 508-540; FIORI A., *I medici ed il testamento biologico*, *Medicina e Morale*, 2007/4 pp. 683-690; COMITATO DI BIOETICA, *Informazione e consenso all'atto medico*, 20 June 1992; POST S., *Encyclopedia of Bioethics*, 3rd ed., Vol. 5, New York, Thomson 2004.

excessive treatments of a therapeutically obstinate nature, organ donations, etc.), after the suggestion given by the “Manifesto of Euthanasia” -- often bear an impression oriented towards limiting treatments and in favor of euthanasia: As they will have to be acknowledged eventually by a law of Parliament, it is foreseeable that in this venue, euthanasia may be sought to be introduced surreptitiously by means of this type of document.

5 – *Communication of truth after an unfavorable diagnosis*

In this our reflection, we are keeping in mind the hypothetical journey of observation, diagnosis, therapy, and palliative care as it often occurs in patients with tumors or dying of AIDS. The matter of unexpected deaths does not allow for many problems to be put forward or to adopt the strategies that we are bringing to light.

Concerning sudden death, for which the Church has taught us to pray that we be spared it so that we might be allowed a time of preparation, always has value to the degree we have spoken above, concerning the preparation from a distance that comes to be realized when an individual is on the path of human and Christian maturity, and when life has transpired thus, it also makes easier the problems that are put upon us when two conditions verify themselves in front of a patient: *incurability* and *terminality*. The person deals here with a stretch of the journey that is brief enough and whose result is death.³⁵

In this situation of proximity to death, the most relevant problem concerning communication with the patient is that of the *means of communicating*.

Obviously, it is necessary to keep in mind that when patients arrive at a *hospice*, after the diagnosis of incurability has been made, not everyone departs from the same level of information but, also when information has been offered, the fact of

³⁵ RUFFATTO M.T. – BONETTI M., *La comunicazione della verità al malato in fase avanzata* in BONETTI M. – RUFFATTO M.T., *Il dolore narrato: La comunicazione al malato neoplastico*, op. cit., pp. 31-43; CATURELLI A., *Il morente e l'agonia nella filosofia moderna e nella riflessione metafisica*, in SGRECCIA E. – SPAGNOLO A.G. – DI PIETRO M.L. (ed.), *L'assistenza al morente*, op. cit., pp. 181-196; GRISEZ G., *Death in Theological Reflection*, in VIAL CORREA J.D.D. – SGRECCIA E. (ed.), *The Dignity of the Dying Person*, Vatican City, Libreria Editrice Vaticana, 2000, pp. 142-170; ANCONA L., *Psychological and Spiritual Assistance: The Truth when Faced with Death*, in VIAL CORREA J.D.D. – SGRECCIA E. (ed.), *The Dignity of the Dying Person*, op. cit., pp. 265-287; and again in the same volume: RAVASI G., “*It is the Lord Who Gives Life and Death*” *Towards a Theology of Death*, p.287; BIZZOTTO M., *Concealment of Death*, pp. 31-53; SANDRIN L., *Psychological Effects of the Refusal of Death*, pp. 53-63; KÜBLER-ROSS E., *La morte e il morire*, Assisi, Cittadella 1982 (orig. title: *On Death and Dying*, New York, MacMillan 1969).

approaching death puts into action emotional and spiritual conditions that require particular attention. In this light, I wish to remain for a moment on the theme of how to obtain acceptance of the truth in the patient, and also eventually an ultimate spiritual maturation if possible.

We focus ourselves, instead, upon how to carry out communication in this ultimate stage of the journey. In this point of view, the observations of Kübler-Ross preserve their relevance, whose work L. Ancona confirms, “remains a milestone in the history of medicine and of medical psychology.”³⁶

Kübler-Ross, in her systematic observations over several years of this type of patient, highlights the psychoemotive dimension that influences patients who find themselves in conditions of a death that not only is certain, but near and close by, with which the patient knows he must come to grips.

According to the research of Kübler-Ross, these patients go through determined psychological phases that may vary in their duration and also in their order of succession, but which present themselves recurrently.

These phases are noticed nearly in all people who are involved in providing psychological assistance to the gravely ill: *Denial* (It is not possible: there must be a mistake, I have never felt better than now!), *anger* (because it is happening to me), *negotiation* (reduction of negative aspects, researching positive symptoms), *depression*, and *acceptance*.

It is necessary that the doctor consider his communication strategy in this emotive situation, which has been enacted by the patient in order to defend himself. The desire to live and to die in peace becomes mixed in the patient. Death is lived mostly in a complex emotional heightening of sentiments, fears, and reactions that render difficult holding onto any thought of hope.

Kübler-Ross speaks of this occurrence as the final moment of growth.³⁷

The same scholar affirms and gives further evidence that the work of accompanying the dying brings maturity and courage also to those who stay near the sick person: The dying person is a master of life, even though it may seem that she does

³⁶ ANCONA L., *Psychological and Spiritual Assistance: The Truth when Faced with Death*, in “The Dignity of the Dying Person,” op. cit., pp. 265-287.

³⁷ KÜBLER-ROSS E. *La morte e il morire*, op. cit. p. 269: “H. (a doctor who was dedicated to the dying) was equally impressed by the intuition and awareness that the incurably ill had and of the courage that they demonstrated in the face of death, which nearly always took place in peace.

not exhibit much trust in the contribution of religious faith and declares to have met few persons who are truly religious and likewise even fewer atheists: Her strength lies in guiding personnel and the sick to confront death and to know how to accept it. The validity of her work, in my modest opinion, stands in knowing how to intuit and to describe the emotional states of the patient as well as the methodology of following them in dialogue in order to maintain availability in openness to the same dialogue.

However, from the point of view of the contents of the dialogue, the work seems insufficient to me. It lacks “a metaphysical reflection on dying”³⁸ as well as an announcement of death as being key at the salvific and eschatological levels.³⁹

Alberto Caturelli observes that it is not enough to speak of death as a fact, but it is necessary to speak of it as *an act*, as a human act. Such an act, which concentrates above all upon the throes of death, comes to be considered in its profound importance: Man starts to die from the moment in which he begins his intrauterine life, and all terrenal life with its multiple acts and choices is marked – whether he thinks of it or not – by this going towards death; in a certain sense man is always dying, but the *throes of death indicate the culminating moment* of this walk and the irreversible moment. Doctors note the fact, but the dying person lives the act of his conscience: The dying notices the silence surrounding him, observes and feels his physical deteriorating, and sees the time that he lacks.

As our academic Caturelli writes, “This interior center incommensurably outside of any verification is the area of struggle (death throes) and from the pure *Moment* without past and without subsequent future; in the *Moment* there does not exist any subsequent length of time. At this point, the doctor (who in his professional life has worked only to seek to postpone that Moment) will be bound to confirm (almost definitively outside of the event that he is contemplating) that the problem of life still remains enigmatic [...]; empirical science and its means keep themselves exterior to the struggle and final fracture. It is limited only, according to a criterion of death always

³⁸ CATURELLI A., *Il morente e l'agonia nella filosofia moderna e nella riflessione metafisica*, in *L'assistenza al morente*, ed. SGRECCIA E. – SPAGNOLO A.G. – DI PIETRO M.L., op. cit., pp. 181-196.

³⁹ FORTE B., *La visione cattolica*, in the volume of: SGRECCIA E. – SPAGNOLO A.G. – DI PIETRO M.L., *L'assistenza al morente*, op. cit., pp. 258-273.

discussed, to discover the mere *fact* of the cessation of life, but it must be silent in the midst of the act of dying.”⁴⁰

Caturelli, recalling St. Augustine and the philosopher Sciacca, speaks philosophically of that moment that escapes the doctor, the moment that escapes the past and is not bound to earthly future, a present that I live in the conscience and which has no more space (*praesens autem nullum habet spatium*) and thus *transcends* time and space, entering into becoming part of eternity.⁴¹

It is a present that is not identical with that of the animal world, because *man knows dying* with a spiritual conscience and lives the moment of dying within space. The meaning of the pangs of death at this moment is the opening to eternity, and the time that is missing takes its meaning from this transcendence. The throes of death are the moment of transcendence; it is the victory over immanence. Caturelli also writes, “In the pangs of death, <<being about to die>> is the wait for the indivisible Moment, qualitative and not measurable: The final present or present end that *contains all of the interior time of the dying person* within the precise instant in which he no longer is. It is there, in that instant impossible to capture, that time and eternity touch one another.

This is the most solemn and sacred Moment that we should contemplate with concentration and love. In that Moment is contained all of the time of the dying that, in one sole *act*, can *see* the totality of his life.⁴²

For the believer, this act conveys within the Passover of Christ the totality of personal life from terrenal immanence to the transcendence of eternity: It is an act both conclusive and initial: The new birth.

Agony destroys connections with other human subjects because death is separation, but the I that lives this Instant of rupture inaugurates an experiential human relationship with a Thou who during earthly life has remained hidden: It is the meeting with the Divine Thou. While the doctors give themselves over to working to prolong life or to mitigate suffering while relatives take his hands and pray for him, he is on the threshold of the Absolute Presence, and the duration of the meeting will be “presential”, the presence of eternity.

⁴⁰ CATURELLI A., *Il morente nella filosofia moderna . . .*, op. cit., p. 183.

⁴¹ ST. AUGUSTINE, *De immortalitate animo*, I-VI.

⁴² CATURELLI A., *Il morente nella filosofia moderna . . .*, op. cit., p. 193.

It is in this philosophical and religious vision that faith in the Paschal Mystery bears its light and its strength. The Christian knows well that in the paschal event of Christ, we have been redeemed and inserted into the death and resurrection of Jesus, “as sin came into the world through man, and death through sin, so also death spread to all men because all men sinned (Rm 5:12). The act of supreme abandonment, dying, guides the person to the threshold of the more profound separation from the Origin of life, and for this reason to a greater laceration.”⁴³

Solitude remains the unmistakable price of the supreme hour that for us may be passed and lived with Jesus who has lived in solitude, expiating human sin that is separation from God: “My soul is very sorrowful, even to death; remain here and watch with Me...My God, My God, why hast Thou forsaken me” (Mt. 26:38; 27:46).

“Abandonment,” continues Mons. Bruno Forte, “can unite together then in a new and no less mysterious way with communion: The Abandoned is he who abandons himself, accepting in the obedience of love the will of Him who abandons him.”⁴⁴

“My Father, if this cup cannot pass unless I drink it, Thy will be done (Mt. 26:42)”; “Father, into Thy hands I commend my spirit (Lk. 23:46).” To die in God becomes in this way a paschal event through which the person, commended to supreme abandonment by the Father, accepts with Christ and through Him to live death as a supreme offering of himself, in an act of infinite poverty⁴⁵ and total obedience: To die is to abandon oneself in the bosom of the Trinity.” The same act of abandonment that has produced, through the work of the Holy Spirit, the resurrection of Jesus crucified and abandoned to death, gives the resurrection to those who have died in Christ: “If there is no resurrection from the dead, then Christ has not been raised... For if the dead are not raised, then Christ has not been raised. If Christ has not been raised, your faith is futile and you are still in your sins... In fact, Christ has been raised, the first fruits of those who have fallen asleep” (1 Cor. 15: 13-17, 20). It is within the horizon of this certainty where our hope lies, and where the act of offering that awaits all of us in the moment of agony finds its support.

⁴³ FORTE B., *La visione cattolica*, p. 261.

⁴⁴ Idem.

⁴⁵ Ibidem, p. 282.

Conclusion

The great “inquiry” that must enlighten and strengthen the consciences of men is the announcement of the Death and Resurrection of Jesus, which open access to a life full of eternity. Eschatology founds and illumines all of the content of faith concerning Creation, the Resurrection, the work of the Church, and the destiny of each man called to faith: It presents to us the absolute supremacy of the destination to life and to the eternal joy in the divine design; “The final destiny of man and of history coincides with the infinite charity that is the origin of it: *God desires all men to be saved and to come to the knowledge of the truth.* (1 Tim. 2:4). There will be hell only for him who will have desired it in a free and reflected manner, constructing his life away from God.”⁴⁶

Let us leave it to theologians to reflect upon the condition of “intermediate eschatology” between the moment of encounter with the Divine Thou after death and the final resurrection of the body. We know that the death and resurrection of Jesus saves and enlivens the final moment of the earthly existence of each believer who entrusts himself to Him, with certainty of the fullness of life and love: “The native land of the entire universe within the Trinity, the whole world as the homeland of God ‘who is all in all’ is not a dream that flees from the present. Rather, it is the horizon that stimulates commitment and gives to each being the taste of dignity, at the same time great and dramatic, that has been given to him.”⁴⁷

In the project finalized on the part of God, “quod est ultimum in executione est primum in intentione”: Eschatology realizes itself at the end, but it is set principally as intention and project. That is to say, eschatology concerning the meaning of life, pain, and death comes to be explained primarily in catechesis, and only at that time are we in harmony with the finalism of the project of God.

+ Mons. Elio Sgreccia

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⁴⁶ FORTE B., *La visione cattolica*, op. cit., p. 270.

⁴⁷ *Ibidem*, p. 274.