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PHD THESIS

ELEMENTS OF ORTHODOX BIOETHICS AND SPIRITUALITY IN PALLIATIVE NURSING

CASE STUDY: CENTRE FOR PALLIATIVE NURSING "SAINT NETARIOS" CLUJ

– abstract -

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Bioethics is a vast and in the same time sensitive field, and the interest for this polyvalent discipline is especially increased both for the scientist (especially doctors and researchers) and for theologians, philosophers, anthropologists and sociologists. Although rather new, bioethics has already developed philosophies, generated polemics and put limits there where science created unthinkable technical possibilities.

However, bioethics did not manage to make its mark universally, because it is especially sensitive to the local ethos. Thus, bioethics differs depending on the culture in which it developed, on the geographical region (it is sometimes different within the area of the same country) and, none the less, on religion. Orthodox bioethics is very little developed, and the reasons for that matter are of different natures. However, it approaches essential problems of the beginning of life (the techniques of assisted reproduction, planning, the issue of abortion), subjects related to the ethical dilemmas that may occur during life (addictions, payed organ transplants, ecology issues) and manifests a special care for the ethical aspects regarding the end of life (the problem of sufferance, illness, death, useless treatments, brain death etc.).

For Romania the area of palliative nursing is just as new, and the services that provide such type of medicine can barely serve 5% of the patients that need it. Proposing a holistic approach, palliative nursing treat the patient complexly and completely, satisfying the medical, social, psychological and spiritual needs in an environment as homely as possible. Palliation addresses patients with chronic progressive illnesses, in various stages, right from the moment of diagnosis, in parallel with curative treatments, and especially after the end of treatment. Since the development of the services of hospitalized palliative nursing is a medical-pastoral emergency, we consider that the orthodox approach of the main bioethical aspects that emerge from such an activity is highly important and actual.

The choice of the theme is based on two personal observations. The first was that on a theoretic level there isn't any thesis that approaches problems of bioethics and spirituality in the area of palliative nursing, in an Orthodox key, most of the approaches referring only tangentially to the subjects specific to the advanced and terminal stages, and thus they do not succeed to offer to those who are interested a general view that clarifies the Orthodox position in relation to the essential moments in which the patient receives palliative services.

The second finding – originating not from academic reasons – was made in the Centre for Palliative Nursing "Saint Nectarios" from Cluj-Napoca, where I serve as a priest and coordinate the activities. There I have often found myself in situations when the medical staff or the families or even the patients asked me if certain actions, attitudes or requests are in agreement with the

Orthodox morals and what is the way to be followed by an Orthodox Christian? Thus, I have come to the idea of systematizing these thoughts in an articulated form.

As I have already mentioned, the concern for palliative nursing is rather recent in Romania. Aster 1997, Hospice “Home of Hope” in Brașov started developing a series of actions with an educative character, with the purpose to put forth among medical staff a concept that was different from what was studied in the Romanian medical schools. In time, they received a more concrete form[1], and thus we have today courses destined to doctors and nurses, providers of palliative caring, multidisciplinary teams and, none the less, to families that have patients with progressive chronical illnesses.

In the case of palliative nursing, given the small amount of specialists practicing within the field and the extraordinary high request, the attention is most often focused on assisting a large number of patients, the academic interest for such a discipline being timidly sketched in the socio-medical environment, yet. To this reality one may add the fact that palliative nursing does not exist as an independent subject, to be studied in the faculties of medicine, sociology, theology and so on, and thus there aren’t any professors qualified and interested in participating actively to the academic development of the subject. An attempt to focus the interest of those who work in palliation is The Romanian Review of Palliation, a trimestral review that has been published for more than 10 years now[2].

We must mention the fact that Romanian literature has approached subjects regarding the ill in advanced or terminal stages even though the concept of palliative nursing was not always referred to. Thus, we find studies of several theologians, doctors or priests regarding the issue of sufferance at the end of the life, either from the point of view of bioethics[3], or from that of

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[1] For details, see http://www.studiipaliative.ro where there is a rich offer of online and frequented classes. Also, here one may find information regarding the manner in which the services of palliative nursing are organized and accredited, as well as the specific legislation.

[2] The review is also available electronically, http://www.paliatia.eu, the first number dates back from January 2008 (the online version) and January 2009 (the printed version).

[3] In general, the themes approached are: the concept of brain death, euthanasia, organ transplant, utility of the treatments, the decision to stop resuscitation etc. Of all the works we mention *The Romanian Review of Bioethics*, between 2003 and 2016; the volumes *Doctors and the Church* (I-XVI) coordinated by Mircea Gelu Buta; VASILE ASTĂRĂSTOAE ET ALL., *Dileme etice la finalul vieții*, Edit. Polirom, Iași, 2013 (the volume also comprises some aspects linked directly to the palliative nursing).

Orthodox spirituality[4] and anthropology[5], or from the perspective of the medical behavior that must be followed[6].

Foreign literature is rich in studies regarding palliative nursing. The subjects approached are varied and they comprise (without limiting to) aspects regarding the general principles of palliation[7], the management of the symptoms that are very heterogeneous and versatile in terminal stages of the illness[8] or communicating bad news (especially the diagnosis and the prognostic).

Moreover, the perspectives of the palliative nursing from the point of view of a multidisciplinary team with a long practical experience in assisting terminally ill patients is also taken into account[9]. Las but not least, we find articles that gather several conclusions emphasized in the experience of the terminally ill patients[10], an aspect that is extremely important in a holistic and individualized approach in palliative nursing.

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[4] ŞTEFAN ILOAIE, *Cultura vieţii. Aspecte morale în bioetică*, Edit. Renaşterea, Cluj-Napoca, 2009; RADU PREDA, *Tradiţie şi modernitate în dezbaterea bioetică actuală: consideraţii social-teologice*, Studia Universitatis Babeş-Bolyai Bioethica, vol. 54, nr. 2, 2009, pp. 19-48; MIRCEA GELU BUTA, *Rolul credinţei în îngrijirile paleative*, Studia Universitatis Babeş-Bolyai Bioethica, vol. 54, nr. 2, 2009, pp. 77-83; MIRCEA GELU BUTA, *Spiritualitatea actului medical în fazele terminale de boală*, Studia Universitatis Babeş-Bolyai Bioethica, vol. 55, nr. 1, 2010, pp. 109-116; ŞERBAN GEORGE PAUL DRUGAŞ, *Morala vieţii şi bioetica: bioetica din perspectiva antropologiei creştine ortodoxe*, Edit. Teognost, Cluj-Napoca, 2008; MIRCEA GELU BUTA (ED.), *Medicii şi Biserica. Vol. 10: Medicină şi spiritualitate în abordarea pacientului terminal*, Edit. Renaşterea, Cluj-Napoca, 2012; IOAN C. TEŞU, „Simt boala ca iubire a lui Hristos", Edit. Doxologia, Iaşi, 2017; IOAN C. TEŞU, Teologia necazurilor, Edit. Sf. Mina, Iaşi, 2018; BENEDICT VESA, "Suffering, God's compassion and human solidarity in the experiential theology of St. Isaac the Syrian and St Thérèse of Lisieux", in *The Human condition between Suffering and God's Love. Disease therapy and palliative care*, International Symposium May 2012, Vol. 1, Alba Iulia, Reîntregirea, 2012, p. 343-357; BENEDICT VESA, "The role of the religious community in the management of the terminal diseases and the concept of „well dying" in the contemporary debate", in *Family, Philanthropy and Social Ethics. The partnership State-Church in the Social Assistance*, Alba Iulia, Reîntregirea, 2011, p. 1033-1058.

[5] Even though it does not refer directly to the aspects regarding the nursing of the ill, in order to achieve a palliative approach in an Orthodox key it is important to mention the work of PANAYOTIS NELLAS, *Omul – animal îndumnezeit. Perspective pentru o antropologie ortodoxă,* Edit. Deisis, Sibiu, 2002.

[6] MIOARA MINCU, *Medicina internă: specialităţi înrudite şi îngrijiri paliative*, Edit. Universitară „Carol Davila", Bucureşti, 2002; SABINA ANTONIU, *Nursing paliativ şi medicină paliativă*, Edit. „Gr. T. Popa", Iaşi, 2013; DESPINA MARIA BAGHIU ET ALL., *Îngrijirea paliativă la copil*, Edit. University Press, Târgu Mureş, 2004.

[7] MARIE FALLON ET ALL, *ABC of palliative care*, Edit. BMJ Books, Londra, 1998; we must mention the fact that even before 2000 there was in the West a complex work, that marked clearly the limits of palliative nursing and managed to offer a set of essential information to whoever wished to initiate such a service. Another work, more recent, is that of JASON NEGRI, *End of life issues*, Edit. Catholic Answers Press, El Cajon, 2014.

[8] SACKHEIM KIMBERLY (ED.), *Pain management and palliative care: a comprehensive guide*, Edit. Springer, New York, 2015.

[9] CHRISTINA MASON (ED.), *Journeys into palliative care: roots and reflections*, Edit. Jessica Kingsley Publishers, Londra, 2002.

[10] JULIA LAWTON, *The dying process: experiences of patients in palliative care*, Edit. Routledge, Londra, 2000.

Fortunately, there are numerous studies regarding the role of spirituality in assisting the terminally ill patients[11]. The reference to illness, the attempt to position some treatments into the category of inutility, as well as various opinions regarding the meaning (sometimes cathartic) of sufferance are subjects that can be frequently met within works of spirituality.

For some of the foreign authors, religiosity is a form of spirituality, but spirituality does not necessarily need to be religious, and thus we may also find approaches of subjects such as yoga, Reiki[12] etc. It is useful to document on this complementary therapies (sometimes, unfortunately, alternative), because besides not having the anticipated results, some of them are contrary to the Orthodox faith and involve rituals that question seriously the opportunity that they are practiced/accepted by a member of our Church.

Some studies sketch rituals characteristic to the terminal stages, depending on the religious affiliation[13], an extremely important aspect taking into account the fact that the services of palliative nursing are most often founded by the Church and around churches, and the beneficiaries are very heterogeneous from the point of view of the cult they belong to[14]. An Orthodox approach of the palliative nursing is missing, and one can only find fragments, sometimes even contrasting, incapable to offer to the person interested on the subject a general view.

The present thesis comprises 5 chapters.

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[11] Of all the works translated into Romanian it is important to mention: JOHN BRECK, Darul sacru al vieții, Edit. Patmos, Cluj-Napoca, 2001; JOHN BRECK ET ALL., *Ce este moartea?,* Edit. Patmos, Cluj-Napoca, 2003; JOHN BRECK, LYNN BRECK, *Trepte pe calea vieții: o viziune ortodoxă asupra bioeticii*, Edit. Sophia, București, 2007; TRISTRAM H. ENGELHARDT JR., *Fundamentele bioeticii creștine: perspectiva ortodoxă*, Edit. Deisis, Sibiu, 2005; GEORGIOS MANTZARIDIS, *Morala creștină. Omul și Dumnezeu. Omul și semenul. Poziționări și perspective existențiale și bioetice*, Edit. Bizantină, București, 2006.

[12] MAXIME BILLOT ET ALL., *Reiki therapy for pain, anxiety and quality of life*, BMJ Support Palliat Care., 2019 Apr 4; YONG ZENG ET ALL., *Complementary and Alternative Medicine in Hospice and Palliative Care: A Systematic Review*, J Pain Symptom Manage. 2018 Nov; 56(5):781-794.

[13] HAROLD COWARD ET ALL., *Religious understanding of a good death in hospice palliative care*, Edit. State University of New York Press, Albany, 2012.

[14] An article which presents a meta-analysis of the specialized literature, emphasizes the fact that most of the studies regarding the importance of religion in palliative nursing, with an accent on the (in)utility of certain treatments refer to Christianism, Hinduism, Islam, Buddhism - STEVEN STEINBERG, *Cultural and religious aspects of palliative care*, International journal of critical illness and injury science vol. 1(2), 2011; although it speaks about *Christianism* in general, the approach is rather the position of the Roman-Catholic Church, probably the most active Church in uttering opinions regarding the various bioethical aspects. Some other works referring to the anticipated directives, contingent treatments, coping mechanisms while facing the illness in relation to religion and personal beliefs are: CIARÁN BRADLEY, *Roman Catholic doctrine guiding end-of-life care: a summary of the recent discourse*, J Palliat Med. 2009 Apr;12(4): 373-7; Mohammad Ali Cheraghi et all., *Spiritual aspects of end-of-life care for Muslim patients: experiences from Iran*, Int J Palliat Nurs. 2005 Sep;11(9):468-74; SARAH WHITMAN, *Pain and suffering as viewed by the Hindu religion*, J Pain. 2007 Aug;8(8):607-13; STANLEY HARAKAS, *Contemporary Moral Issues Facing the Orthodox Christian*, Edit. Light and Life Publishing Co., Minneapolis, 1982.

The first chapter is dedicated to the terminological and conceptual delimitations. Because of the novelty of the areas that compose the subject of the research (bioethics and palliative nursing), it is necessary a preliminary clarification of the terms. Since they are often used interchangeably, although they have a different etymology and semantic, I chose to detail on the following concepts: ethics, morals, Christian morals, applied ethics, deontological ethics, bioethics, Orthodox bioethics. A special place was dedicated to the term of palliative nursing, presenting both the etymology and the history of its appearance.

The second chapter presents the factors that contributed decisively to the development of bioethics. I took into account the scientific research of the 20th century, which besides having a real medical success, they were carried on without respecting the rights of the participants, the latter being forbidden the access to therapies that could heal them or being promised unreal benefits. Of the most immoral studies performed in the 20th century, I mentioned the Tuskegee Study, the Willowbrook Study, the Homesburg Experiment, the experiment with cancerous cells and the Thalidomide experiment.

In order to emphasize the relation of causality between the experiments mentioned and the development of bioethics, I also included a subchapter regarding the regulations that occurred in the field of medical ethics. The Nazi experiments lead to the elaboration of the Nuremberg Code, a document that stood at the basis of the future debates on the necessity of performing scientific research on human subjects, while respecting ethical rules. The Declaration of Geneva was also essential for the development of bioethics, a document based on the Hippocratic Oath. The declaration suffered numerous changes along the years and the final variant was published in 2017. Another regulation in the field of medical ethics was the Declaration of Helsinki from 1964, elaborated by the World Medical Association which comprised besides the Nuremberg Code the stipulation that the individual’s interest outperforms the interest of the society, and the individual has the right to receive the most efficient treatment for his pathology. This declaration also suffered a series of changes, the most important being related to obtaining an informed consent in relation to the paternalist approach of the doctor-patient relationship. Another document elaborated by the National Commission for the Protection of Human Subject of Biomedical and Behavioral Research from the USA in 1979 mentioned the fact that the subjects cannot be used in research only to obtain a benefit for the society, and the existence of the informed consent is obligatory for each participant. Nonetheless, the Council for International

Organizations of Medical Sciences elaborated a series of 15 guides in 1993 (reaching 21 guides by 2002) referring to the manner of recruitment of the participants to research as well as t the possibility of involving vulnerable groups within the study.

The second subchapter regarding the factors that influenced the development of bioethics, refer to the medical discoveries from the second half of the 20th century.

One of the discoveries of the 20th century that generated numerous ethical disputes, involving also the position of the clerical authority was the first contraceptive pill, *Enovid*, initially sold as a product for various gynecological pathologies. It is interesting to observe the dynamics of this drug, which was approved by FDA as a therapeutic drug for a series of illnesses, then it was prescribed as contraceptive only for the married couples, and after 7 years it could be bought by everybody.

Another essential discovery in the history of medicine and bioethics was that of the deoxyribonucleic acid, a structure responsible for the transfer of genetic information to the descendants. Besides the multiple uses in medicine, connected especially to the manner in which certain illnesses occur and how they can be prevented, the discovery related to the name of Watson and Crick also involved less positive aspects such as *eugenics* or *cloning*. Other bioethics implications regarding the discovery of DNA are represented by the genetic testing in pediatrics, the possibility of intrauterine diagnosis of several pathologies that may lead to decisions of abortion, the possibility of modifying the embryos genetically etc.

A premiere that generated a frenzy among scientists was the first heart transplant. The procedure was performed in Cape Town, in the winter of 1967, by the South-African surgeon Christiaan Barnard. The location of the transplant was in a country that did not have a legislation regarding such procedures, which raised a series of suspicions. The concept of *brain death* was not well established yet, so the promoters of ethics came to elaborate a report regarding unconscious patients, with irreversible lesions and without any hope for survival. The report was elaborated at Harvard Medical School the next year and it stipulated the possibility of harvesting the organs if the legal representatives of that person agree.

In the same time, the techniques of intensive care develop, especially mechanic ventilation. Based on this technique, the possibility occurs to maintain vital signs even in the absence of brain activity. Given this situation, society faced the problem of redefining death. Initially it was suggested the term *"obsolete coma,"* referring to a pathological situation which was described by a flat electroencephalogram, clinically translated by the absence of reflexes of the cerebral trunk. The main problems encountered during the debates where related with the lack of a consensus regarding the definition of the "death" and the burocratic aspects that where supposed to overcome the conflict of interests. Therefore, there have been established the criteria used to define the irreversible coma and it was stated that in order to avoid any possible accusation, the transplant team should be different from the coma diagnosis team (which is still respected today). Each country has established its own diagnostic criteria, Romania being among the countries with the strictest lists in this area. The law refers to the way a complete diagnosis is made, consisting of clinical diagnosis, diagnosis of the lesion, paraclinical diagnosis and differential diagnosis.

Diagnoses of irreversible coma and brain death have raised the interest of many specialists in both science, philosophy, theology, anthropology. The reticence of organ harvesting and transplantation stems mainly from the fact that the diagnosis of brain death always raises suspicion. This attitude is not necessarily caused by the lack of moral probity of medical teams, but rather by the family's inability to accept diagnosis and the hope that there may be a solution for the patient to recover. If, in addition to this aspect- impossible to correct – there are overlapped the opinions of more or less well-known people of notoriety, then the result is an unlikely prolix situation that will dramatically decrease the chances of some people to live. We refer here especially to certain articles and interviews in the Romanian press which question the reality of the diagnosis of brain death, mentioning that patients are crying at the time of organ removal and that they are anesthetized before the operation - situations that seem contradictory to the diagnosis of death . Knowing some basic notions of anatomy and physiology can explain the so-called *hidden truths* behind transplantation process.

The third chapter of the thesis deals with the theme of palliative care. Although recently emerging in the medical landscape, the development of palliative care services is a pressing need, highlighted by the on-going incidence of oncological diseases and other progressive chronic pathologies. The preferred term is *palliative care* instead of the one of *palliative medicine,* which would suggest an excessive medication for a period of life that requires more love and less therapy. There is, in this sense, a major conceptual difference. Classic medicine wants to heal and declare its defeat around the near death that a failure counts. Palliative care recognizes the imminence of the death of a patient with incurable disease but seeks to provide comfort and support in all stages of the patient, being with the patient and family even in the last few moments. Thus, the philosophy of palliative care treats death as a natural fact, which must not be hurried, but not delayed. In addition, unlike classical medicine, palliative care addresses both the patient and family members, encouraging the latter to become actively involved in the care process. Furthermore, it offers the patient the opportunity to be active and autonomous for as long as possible. Last but not least, palliative care provides the family with support even in the event of mourning.

In order to understand the specificities of palliative care pathologies, a subchapter was reserved for the succinct description of chronic progressive, and especially oncological diseases. Several epidemiological elements, linked in particular to the incidence of these diseases and the mortality rate, are completing the picture of these pathologies while highlighting the need to develop palliative care services. Since the primary purpose of palliative care is to increase the quality of life of patients with progressive chronic diseases, we have also mentioned here the concept of quality of life that we have tried to define and present some of the internationally validated instruments to measure its level.

Another subchapter referres to several elements of forensic tanatology, highlighting the diagnostic criteria of the terminal state and the approach of death, as well as the preference of the place of death and the factors that influence it.

An important subchapter deals with the general pastoral lines of the terminally ill. Since the dying patient is an exceptional case (or, anyway, rarely encountered) in the pastoral care of a parish, the priest may encounter difficulties in correctly addressing and benefiting these persons. Even though the guidelines refer to pastoral hospitals in hospitals, they can be easily adapted to the situation where the priest is called to the home of a parishioner in his parish. In this part of the paper there were mentioned some harmful attitudes in the case of seriously ill patients. The priest should not go to the sick at home as a working visit to check out the fulfillment of certain rituals. He has to entrust the patient and the family with all the availability and together to participate in prayer. Also, the priest will not have to treat the patient as a vulnerable as he will increase the anxiety he is living anyway. On the opposite side, neither the optimistic attitude, which can induce the patient's feeling that the other person does not care or he treats the situation superficially, is not beneficial. Last but not least, pastoral tact must be manifested in the reading of prayers such as the one at the hard exit of the soul. The text of prayer can be interpreted as a rough one for those who get for the first time in contact with it. Also, the family's expectations, which sometimes can call the priest to read a prayer in the hope of healing / miracles, as a last resort, must be carefully investigated. It is a blessing and a great pastoral responsibility for the patient to leave with the Messages of Christ the Taine, which can be done even in the absence of the Eucharist or the Confession of Sacrament (where the time or the condition of the patient do not allow it). However, the act of Communion must be one desired and assumed, so that the priest will not share sick people who are unconscious or who, due to special pathologies, can not swallow. There is the risk that the family may press the priest to share the sick, as they can understand that the reception of the Holy Eucharist equates to a magical gesture that can bring healing.

It is also important to mention the ways in which spiritual assistance can be given in the event of the mourning period. Beyond the parastas ordered by the Church, the priest must visit the family (alone, if it is a parish or care team if it is a case of a hospital) and strengthen them with scriptural and patristic arguments on the one hand, and manifest their whole availability and commemoration of the holy service, on the other.

A major problem commonly encountered in staff working in high-stress medical departments is the occurrence of burnout. The problem was identified in the 1980s, and more and more causal or contributing factors have been added over time. Burnout syndrome is characterized by a state of physical and mental exhaustion, distinct from daily stress, leading to lack of motivation and low yield. Among the factors favoring palliative care include, in particular, the lack of evidence of a causal relationship between the assistance given and a certain therapeutic success. Most assisted cases end with a death rather than a cure or home discharge. The idea of classical medicine underlying the training of health professionals needs to be re-conceptualized, because it can provide a sense of activity. Thus, the patient will be valued until the last minute, and death with dignity and pain can be a primary goal of activity in a palliative care department. Communicating bad news, assisting a category of patients with multiple and wide pathologies can also lead to an increased risk of developing the syndrome. In the same category of communication is the involvement of the staff in the conspiracy of silence, through which the family or the patient requires, in complicity, to conceal the real diagnosis of the other partner of the dialogue. All these problems can be prevented through a continuous medical-spiritual education that sustains the value of every moment of life, but also of death, as a unique event that can not be considered a failure of science. Even if he can not provide healing, the staff can find joy in relieving pain, facilitating patient and family encounters, offering the opportunity to die Christian, worthy, painless and at peace.

Palliative care services under continuous hospitalization have many benefits, including the possibility that appropriate care reduces the incidence of suicide or euthanasia requests where legislation permits. The main reasons that lead patients to such situations are related to atrocious pain (which can be easily controlled with medication available), lack of sense of utility (prevented by a permanent attempt to preserve patient autonomy at least at the psychic level), adverse effects of medication (which can be prevented / countered by a careful assessment), as well as the fear of becoming a burden to the family (the existence of the centers removes this fear). Of course, we can not say that the main benefit of palliative care centers is the decrease in the incidence of suicide, but this also derives implicitly from the quality of the services provided to the patients and their families.

There are also other social benefits that palliative care centers have. Here it must be mentioned for sure the relief of emergency services, which are hardly responding to this category of patients. Then, we must mention that terminal patients are extremely dependent, which makes their families have difficulties in assisting them at home while they are active at work. The existence of these services would allow family members to continue working at the workplace, ensuring that the patient is carefully supervised and cared for. Another benefit is that people will learn to cherish every moment of life and have more confidence in a health insurance system that is able to assist the patient until the last minute. Last but not least, country-wide costs can be reduced by accessing this type of service, which - as we have seen - reduces the number of emergency requests, cancels frequent visits to family doctors, home care requests, or admissions various sections that have a curative character, with low efficiency and increased costs.

Another problem commonly encountered in palliative care is access to alternative or complementary medical services. The complexity of the disease and its incurable nature sometimes forces the patient to look for other therapeutic options in the hope of healing. Without a claim to demonstrating alternative or complementary medicine, we need to make it clear that these are particularly numerous and, in rare cases, have been proven to be effective, and sometimes even harmful, being used by people without medical training. The causes of access to this type of medicine are related both to the nature of the disease, as it has been mentioned, to the pressure of the family, the suggestions of the colleges, and the aggressiveness of promoting so many products that promise miraculous effects. I have mentioned here and what are the common features of complementary therapies and how serious they are when it becomes an alternative. Some of the most common therapies have been mentioned: acupuncture, Bowen therapy, Reiki therapy, homeopathy and Ayurveda. For an easy understanding, I outlined for each method its history, description, some evidence that supports or denies its effectiveness, as well as the potential risks for those who practice it. Orthodox spirituality must also be concerned about these aspects, since many of the alternative or complementary therapies involve aspects of spirituality and are contrary to our faith.

The fourth chapter refers to the value of the body and to the sense of suffering in Orthodoxy. The existence of anti-somathic philosophies hasve led in many cases to the denial of the body and the consideration of it as a matter, so something devoid of it. The Savior's Incarnation itself shows that the body needs to be valued, and Scripture urges not to be ignorant of the disease (cf. Eccl 38: 9). Also, the deeds of the merciful mercy that the Church recommends to His believers, demonstrate that caring for the flesh is a Christian duty. Last but not least, the criterion of the Last Judgment is the mercy we have had towards our neighbor, pity also characterized in the care of the flesh.

Regarding the sense of sufferance, there haft be mentioned that there is a difference between Western (Occidental, Catholic) thinking, which created the dolorist current and considers suffering as a cathartic role and Eastern Orthodox thinking, which did not give a certain value to suffering, given by the way a person and assume it. We can not say that human suffering has any value before God, and it is preferable to try to avoid it wherever possible.

In the same chapter we have also presented the spiritual causes of the diseases. It should be noted that these explanations do not want to surpass or in any way replace the natural / pathophysiological causes of the diseases, but, alongside them, they can offer a much more complex approach. The Holy Scripture abounds in examples that demonstrate the variety of causes of illness: the Job of Job, the blind man of the birth, the vileress of Vitezda, the sacrifice of Zechariah, the ungodly sharing, the thorns of Paul's body, the Ananias and Saphira, Elimas the sorcerer, others. Thus we encounter disease as a result of sin, disease as a way in which the healing brought was to the glory of God, illness as a result of unbelief, illness as a result of impartial sharing, disease as prophylaxis of pride, disease as a result of lie, as a result of the attempt to turn from faith and, last but not least, the disease caused by demonic possession.

The fifth chapter refers to the bioethical management of medical-pastoral decisions in the Center of Palliative Care "Saint Nectarie" in Cluj-Napoca. I recalled a brief history of this Center as well as the material and human resources it has. At the same time, the services provided and how to access them were mentioned.

A major problem that patients with incurable diseases face it is how it is communicated to them their diagnosis and prognosis. There are several attitudes about the opportunity of communicating such a diagnosis. Some authors argue that this information is not beneficial to terminal patients because there are no curative variants for which the patient can choose. In some situations, families ask for hiding the diagnosis, motivating some protection for the patient who would destabilize the diagnosis. In fact, it is about the family's inability to cope with the sick. However, knowing the diagnosis is a moral right to truth and a chance to use the time remaining as a time of repentance. The lie does not find its intrafamiliar place nor in the doctor-patient relationship, whatever the arguments.

The causes for which patients come to the doctor are multiple, but for sure the pain is the first in a hierarchy of them. Palliative care operates with a much wider concept, that of *total pain*. This concept suggests that in addition to somatic pain, patients are also experiencing states of helplessness and addiction, due to lack of control, which exacerbates main somatic pain. The incapacity of classical hospitals to fully treat the pain of oncological patients in advanced disease states not only improper knowledge of pain therapy but also an inadequate understanding and approach to the components of this type of pain. As mentioned, pain therapy is the primary focus of palliative care. No other aspect (medical, social, psychological or pastoral) will be addressed before pain therapy. In order to properly control pain, the World Health Organization has imagined an analgesia scale with three steps of medication and certain rules. I also mentioned here the main morphine-related myths, trying to show that correct and controlled administration is not at all risky. Like any drug, opioids can have side effects. The principle of the double effect, imagined by Toma de Aquino, a moral reflection framework that attempts to provide a solution when intentionally deliberate action produces besides desirable effects and negative, unintended but predictable effects is much discussed here. The principle does not provide a real solution, but can provide arguments in support of opioid use and can respond to moral accusations.

Another essential aspect of palliative care is the one of truly important elements from the end of life. At every Divine Liturgy we ask for a Christian end to our lives, without pain, unmolested and in peace. Sometimes the patient's inability to accept his fate and to understand that eternity is planted in the human soul but not to being lived on the earth, as well as the pressure of family members on the medical team, make the natural care of the end of life a therapeutical endurance which is not beneficial for any of the participants.

Among the most common medical practices unfit for the end of life, but difficult to discontinue due to family feelings, there are the hydration and nutrition. Sometimes these two are the only springs that have left the patient outside the curative treatment methods. In addition, these remain the main ways the family can take care of the sick, and they are especially careful not to let the patient die of inanimation or dehydration. We have shown, however, that in terminal conditions, excessive hydration and food are more harmful than beneficial. Conversely, the lack of water and food in terminal states creates the premises of a deserving end, with few sufferings. Keeping the doctor in the way and how he can approach the family about the opportunity to stop the work that damages the patient.

Also in the category of unnecessary treatments is chemotherapy in the last months of life. Lack of palliative care centers make clinicians unable to interrupt chemotherapy where the prognosis is poor. The inability to provide a care alternative leads to over-exploitation of available methods, even if their effectiveness has been found to be null.

Last but not least, there is the question of the opportunity of resuscitation of a terminal patient with diagnosed oncological disease. The West has different legal forms in which the patient can manifest his desire for the way he would like to be treated in a situation requiring resuscitation. The best known is the living will, a sort of medical testament that indicates the conduct of the doctor to be followed in a situation where the patient can no longer consent. In Romania, the legislation provides for the medical staff to be required to initiate resuscitation maneuvers for any deceased patient in the hospital.

There is also the issue of equity in accessing services. As places are limited, there have been several options for prioritizing admissions in the bed unit within the Center. Empirically, socio-medical surveys have been shown to be particularly subjective, and the most objective method is the first-come-first-served waiting list.

The practical part also included a study conducted over a period of 3 years at the Center of Palliative Care "Saint Nectarie" in Cluj-Napoca. This study involved the completion of questionnaires addressed to patients, carers and staff working in the institution. The questions were related to the opportunity to know the diagnosis, the usefulness of hydration and nutrition in the terminal states, the most appropriate way to prioritize admissions to the idea of fairness in the distribution of services, the opportunity to resuscitate a terminal patient, and issues related to institutions which should set up and support such centers. The results of the study were quantitatively and qualitatively interpreted, confirming a number of ideas mentioned in the theoretical part.

There have also been mentioned some particular cases that have created difficulties in the bioethical and pastoral approach. The situations have been mentioned to highlight the difficulty of applying bioethical principles imported from the West and the need for an Orthodox bioethics based on Holy Scripture and Holy Tradition on the one hand and taking into account its own case-law on the other. Here, I also mentioned a few situations regarding the attitude that we must have around a dying person, as we often regard the state of coma as equal to total unconsciousness, but the practice has shown that things are a little different.

The work ends with conclusions, where I have presented briefly, thinking on the fact that they can help to the reading as easily as possible and of a more complex picture of the bioethical situations of palliative care.