

Letter
of the Congregation for the
Doctrine of the Faith

Samaritanus bonus

on the care of persons in the
critical and terminal phases of life

COMPENDIUM



United States Conference of Catholic Bishops
Secretariat of Pro-Life Activities

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In 2020, the Vatican's Congregation for the Doctrine of the Faith released the letter Samaritanus bonus, "on the care of persons in the critical and terminal phases of life." The letter reaffirms the Church's teaching on care for those who are critically ill or dying and offers additional pastoral guidance for increasingly complex situations at the end of life. What follows are summaries of each section of Samaritanus bonus, prepared by the U.S. Conference of Catholic Bishops' Secretariat of Pro-Life Activities to serve as a resource on and introduction to this letter.

INTRODUCTION

The Good Samaritan who goes out of his way to aid an injured man (cf. Lk 10:30-37) symbolizes Jesus, who encounters man in need of salvation and cares for his wounds and sufferings. For Christ is the physician of souls and bodies. But how are we to make this message concrete today? And how do we translate the example of the Good Samaritan into a readiness to accompany those suffering in the terminal stages of their earthly life?

The remarkable advancement of medical technologies has greatly improved patient care, and the Church looks with hope at the opportunity for such developments to serve the integral good of life and the dignity of every human being. However, every advancement in healthcare requires moral discernment in order to avoid an unbalanced and dehumanizing use of such technologies, especially in critical stages of human life.

The complexity of modern healthcare systems can reduce the bond of trust between physician and patient to a technical and impersonal relationship. The danger of such a relationship is particularly acute where governments have legalized assisted suicide and euthanasia. The value of human life, the meaning of suffering, and the significance of the season preceding death are all eclipsed.

In the face of such challenges, this letter seeks to enlighten pastors and the faithful regarding their obligations to the sick in the critical and terminal stages of life. *For all are called to give witness at the side of the sick person and fulfill Jesus' desire that all may be one flesh.* In the most delicate and decisive stages of a person's life, a moral and practical clarification regarding care of these persons is needed and necessary.

While various Episcopal Conferences have issued letters and statements to address these challenges, questions regarding the celebration of the Sacraments for those who intend to end their own life require a clear and precise intervention on the part of the Church in order to: (1) reaffirm the message of the Gospel and the doctrinal teaching of the Magisterium, recalling the mission of all who come in contact with the sick; and (2) provide precise and concrete guidelines for handling complex situations that foster the patient's personal encounter with the merciful love of God.

SECTION I

CARE FOR ONE'S NEIGHBOR

Despite our best efforts, it can be hard to recognize the profound value of human life when we see its weakness and fragility. While the mystery of suffering raises limitless questions about the meaning of life, the faithful care of human life until its natural end is entrusted to every person, healthcare professional, and pastoral worker, as well as to patients and their families.

The need for medical care is born in the vulnerability of the human condition. As a unity of body and soul, each person is temporally *finite*, with a longing for the *infinite*, and a destiny that is *eternal*. Our human vulnerability forms an *ethics of care* which is expressed in concern, dedication, participation, and responsibility towards those entrusted to us during their hour of need.

The relationship of care reveals the twofold dimension of the principle of justice: to promote human life and to avoid harming another. As Jesus taught, “Do unto others whatever you would have them do to you” (*Mt 7:12*).

Care for life is therefore the first responsibility that guides physicians in their encounter with the sick. This responsibility exists not only when the restoration of health is realistic, but even when a cure is impossible. Care must attend to the physiological, psychological, and spiritual well-being of a patient. Medicine possesses a “therapeutic art” entailing robust relationships with the patient, medical professionals, relatives, and the community. *Therapeutic art, clinical procedures, and ongoing care* are inseparably interwoven in the practice of medicine.

The Good Samaritan takes responsibility for the man he finds half dead, investing in him not only with the funds he has, but also with the funds he hopes to earn. Likewise, Christ invites us to such supernatural charity and to identify with everyone

who is ill: “Amen, I say to you, whatever you did for one of these least brothers of mine, you did for me” (*Mt 25:40*).

Relationships built on the recognition of the *fragility* and *vulnerability* of the sick person are vital. Weakness makes us conscious of our dependence on God. Every individual who cares for the sick has the moral responsibility to recognize the inalienable good that is the human person and adhere to the highest standards of respect by safeguarding human life until natural death. At work here is a *contemplative gaze*¹ that beholds the existence of oneself and others as unique and unrepeatable wonders—received and welcomed as a *gift*. This is the gaze of the one who, guided by faith, finds in illness the readiness to abandon oneself to the Lord.

Medicine must therefore accept the limit of death as part of the human condition. When an illness is recognized to be terminal, this dramatic reality must be communicated to the sick person both with great humanity and with openness in faith to a supernatural horizon.

However, the impossibility of a cure where death is imminent does not entail the cessation of medical care. Communication with the terminally ill patient must make it clear that care will be provided until the very end: “*to cure if possible, always to care.*”² Adequate care must provide necessary physical, psychological, social, familial, and religious support to the sick. The pastoral care of all—family, doctors, nurses, and chaplains—can help the patient to persevere in sanctifying grace and to die in charity and the love of God. Where faith is absent, fear of suffering and death is the main driver in attempts to control and hasten death through euthanasia or assisted suicide.

SECTION II

THE LIVING EXPERIENCE OF THE SUFFERING CHRIST AND THE PROCLAMATION OF HOPE

The nearness of God is evidenced in the living experience of Christ's suffering, agony on the Cross, and Resurrection: his experience of pain and anguish resonate with the sick and their families during the challenging days that precede life's end. Not only is Christ familiar with physical pain, but the words of the prophet Isaiah (cf. *Is 53*) recount his experience of incredulity, scorn, and abandonment. Christ's experience resonates with the sick who are often seen as a burden to society.

Every sick person has the need to be heard and to understand that Christ "knows" what it means to feel alone, neglected, and tormented by the prospect of physical pain. Their suffering is compounded when society equates their value to their quality of life, making them feel like a burden to others. In such situations, to turn one's gaze to Christ is to turn to him who experienced the pain of the lashes and nails and the betrayal of those closest to him.

In the Cross of Christ are concentrated all the sickness and suffering of the world: all *physical suffering*, of which the Cross is a symbol; all *psychological suffering*, expressed by Jesus' death in the darkest solitude and betrayal; all *moral suffering*, manifested by the condemnation of one who is innocent; and all *spiritual suffering*, displayed in a desolation that seems like the silence of God.

Yet the presence of Mary his mother and his disciples who "remain" under the Cross provide the intimacy that allow Jesus to live through hours that seem meaningless.

The Cross itself symbolically looks like those afflictions that nail us to a bed. Those who lovingly "remain" near the sick allow the suffering person to experience the human gaze, which lends meaning to a time of illness. *For, in the experience of being loved, all of life finds its justification.* Christ was sustained

in his passion by the love of his Father and his Mother. To gaze at the crucifix is to behold a scene in which Christ truly transfigures the darkest hours of the human experience. Those who "remain" at the foot of the Cross participate in the mystery of Redemption.

In this manner, death can become the occasion of greater hope. The hope that Christ communicates to those suffering is that of his presence, of his true nearness. The Resurrection proves that the last word never belongs to death, pain, or suffering. Christ rises *in* history, and in the Resurrection the abiding love of the Father is confirmed. To contemplate Christ's suffering is to proclaim a hope that imparts meaning to the time of sickness and death. And from this hope springs the love that overcomes the temptation to despair.

While palliative care³ is essential and invaluable, it cannot take the place of someone who "remains" at the bedside of the sick to bear witness to their unique and unrepeatable value. It is not enough to be merely "nearby" as the soldiers and spectators were at the Cross, distracted, indifferent, or resentful.

For those who care for the sick, the scene of the Cross provides a way of understanding that *even when it seems that there is nothing more to do, there remains much to do*, because "remaining" by the side of the sick is a sign of love and of the hope that it contains. The proclamation of life after death is not an illusion nor merely a consolation, but a certainty lodged at the center of love that death cannot devour.

SECTION III

THE SAMARITAN'S "HEART THAT SEES": HUMAN LIFE IS A SACRED AND INVIOLEABLE GIFT

Whatever their physical or psychological condition, human persons always retain their original dignity as created in the image of God. The ultimate foundation of human dignity lies in the reality that God became man to save us and calls us to communion with him. It is proper for the Church to accompany with mercy the weakest in their journey of suffering and guide them to salvation. The Church therefore regards "the service to the sick as an integral part of its mission."⁴

In the example of the Good Samaritan we find "a heart that sees." His example "teaches that it is necessary to convert the gaze of the heart, because many times the beholder does not see. Why? Because compassion is lacking."⁵ The heart of the Good Samaritan sees where love is needed and acts accordingly.

Life is a sacred and inviolable gift⁶ and every human person, created by God, has a vocation to a unique relationship with the One who gives life. God offers life and its dignity to man as a precious gift to safeguard and nurture, and ultimately to be accountable to Him.

The Church affirms that the dignity of human life is something knowable by right reason. Life is the first and highest good because it is the basis for the enjoyment of every other good.

The unfringeable value of life is a fundamental principle of the natural moral law and an essential foundation of the legal order. Just as we cannot make another person our slave, even if they ask to

be, so we cannot directly choose to take the life of another, even if they request it. To end the life of a sick person who requests euthanasia is by no means to respect their autonomy, but, on the contrary, to deny the value of their freedom—now under the influence of illness—and their life by excluding any further possibility of sensing the meaning of their existence. Moreover, it is to take the place of God in deciding the moment of death.

SECTION IV

THE CULTURAL OBSTACLES THAT OBSCURE THE SACRED VALUE OF EVERY HUMAN LIFE

Among the obstacles that diminish our sense of the intrinsic value of every human life, the first lies in the notion of “dignified death” as measured by the standard of the “quality of life.” In this utilitarian perspective, life is judged as worthwhile only if it has an acceptable degree of quality, as measured by the possession or lack of particular psychological or physical functions. In this view, a life whose quality seems poor does not deserve to continue. *Human life is no longer recognized as a value in itself.*

A second obstacle that obscures our recognition of the sacredness of human life is a false understanding of “compassion.”⁷ So-called “compassionate” euthanasia holds that it is better to die than to suffer. In reality, human compassion consists not in causing death, but in embracing the sick, surrounding them in their difficulties, in offering them affection, attention, and the means to alleviate the suffering.

A third obstacle is a growing individualism within interpersonal relationships, where the other is viewed as a limitation or a threat to one’s freedom. Individualism, in particular, is at the root of what is regarded as the most hidden malady of our time: solitude or privacy.⁸ Those who find themselves in a state of dependence and unable to realize a perfect autonomy or reciprocity, come to be cared for as a “favor” to them. Interpersonal relationships are impoverished, absent of that charity and human solidarity necessary to face the most difficult moments and decisions of life.

This way of thinking undermines the very meaning of life, facilitating its manipulation, even through laws that legalize euthanistic practices, resulting in the death of the sick. In such circumstances, baseless moral dilemmas arise regarding what are in reality mandatory elements of basic care, such as feeding and hydration of terminally ill persons who are not conscious.

Pope Francis has spoken of a “throw-away culture”⁹ where victims are the weakest human beings, “discarded” when the system aims for efficiency at all costs. John Paul II described this phenomenon as a “culture of death,”¹⁰ in which a confusion between good and evil materializes. In this culture of waste and death, euthanasia and assisted suicide emerge as erroneous solutions to the challenge of the care of terminally ill patients.

SECTION V

THE TEACHING OF THE MAGISTERIUM

1

The prohibition of euthanasia and assisted suicide

With her mission to transmit the grace of the Redeemer and the holy law of God, the Church is obliged to exclude all ambiguity in the teaching of the Magisterium concerning euthanasia and assisted suicide. Today medical end-of-life protocols, such as various *Do Not Resuscitate Orders*, cause serious problems regarding the duty to protect the life of patients in the most critical stages of sickness. On one hand, medical staff feel increasingly bound by patient self-determination declarations. They can feel deprived of their freedom and duty to safeguard life, even where they could do so. On the other hand, widely reported abuse of such protocols result in final decisions about care in which neither patients nor families are consulted. The legalization of euthanasia has created wide margins of ambiguity regarding obligations to provide care.

For these reasons, the Church finds it a necessity to reaffirm as definitive teaching that euthanasia is a *crime against human life* because, in this act, one chooses directly to cause the death of another innocent human being. Euthanasia is defined as “an action or an omission which of itself or by intention causes death, in order that all pain may in this way be eliminated.”¹¹

Euthanasia, therefore, is an intrinsically evil act, *in every situation or circumstance*. Any formal or immediate material cooperation in such an act is a grave sin against human life. Euthanasia is an act of homicide that no end can justify and that does not tolerate any form of complicity or collaboration. Those who approve laws of euthanasia or assisted suicide become accomplices in grave sin.

Each life has the same value and dignity for everyone: the respect of the life of another is the same as the respect owed to one’s own life. One who

chooses with full liberty to take one’s own life breaks his or her relationship with God and others. Assisted suicide increases the gravity of this act because it leads another to turn from hope and break the covenant that establishes the human family.

When a request for euthanasia or assisted suicide rises from despair, although “the guilt of the individual may be reduced, or completely absent, nevertheless the error of judgment ... does not change the nature of this act of killing.”¹² Such actions are never a real service to the patient, but a help to die.

Euthanasia and assisted suicide are always the wrong choice. Medical and health care professionals cannot support or participate in any euthanistic practice, neither at the request of the patient, and much less that of the family.¹³

For this reason, it is gravely unjust to enact laws that legalize euthanasia or justify or support suicide. The existence of such laws deeply wound human relations and justice, threatening the mutual trust among human beings. They also strike at the foundation of the legal order, as the right to life sustains all other rights.

Pope Francis recalls that our awareness of what makes human life precious is gradually eroding as human life “is increasingly valued on the basis of its efficiency and utility, to the point of considering as ‘discarded lives’ or ‘unworthy lives’ those who do not meet this criterion.”¹⁴

In some countries, tens of thousands have already died by euthanasia. Physicians themselves report that abuses frequently occur when the lives of persons who would never have desired euthanasia are terminated. Likewise, the request for death is in many cases a *symptom* of disease, aggravated by isolation and discomfort.

Rather than condemning those looking to hasten death, the Christian must offer to the sick the help they need to shake off their despair. Earthly life is not the supreme value; ultimate happiness is in heaven. The Christian must help the dying to place their hope in God.

From a clinical perspective, the factors that largely determine requests for euthanasia are unmanaged pain and loss of hope, often provoked by inadequate psychological and spiritual human assistance. Requests for death should not be understood as “a true desire for euthanasia; in fact, it is almost always a case of an anguished plea for help and love.”¹⁵

The “end of life,” inevitably accompanied by pain and suffering, can be faced with dignity only by seeing in the event of death the horizon of eternal life and affirming the transcendent destiny of each person. Those who assist persons with chronic illnesses or in the terminal stages of life must know how to keep vigil with those suffering, to console them and instill hope.

“Weep with those who weep” (*Rm* 12:15). Love is made possible and suffering given meaning in relationships where persons share in solidarity the human condition and the journey to God. When physicians and patients are united in the recognition of the value of life and the mystical meaning of suffering, good medical care can be valued, while today’s utilitarian and individualistic outlook is dispelled.

2

The moral obligation to exclude aggressive medical treatment

The Church affirms that when one approaches the end of earthly existence, the dignity of the human person entails the right to die with the greatest possible serenity. To hasten death or delay it through “aggressive medical treatments” deprives death of its due dignity. Medicine today can artificially delay death, often without real benefit to the patient. When death is imminent, it is lawful to forego treatments that provide only a precarious or painful extension of life. It is not lawful to suspend treatments that are required to maintain essential physiological functions, as long as the body can

benefit from them (such as hydration, nutrition, and thermoregulation). The suspension of futile treatments *must not involve the withdrawal of therapeutic care*.

The renunciation of extraordinary and/or disproportionate means of care “is not the equivalent of suicide or euthanasia; it rather expresses acceptance of the human condition in the face of death.”¹⁶ The principle of proportionality refers to the overall well-being of the sick person. Every medical action must always have as its object the promotion of life and never the pursuit of death.

3

Basic care: the requirement of nutrition and hydration

A fundamental and inescapable principle of the assistance of the critically or terminally ill person is the *continuity of care* for the essential physiological functions. In particular, required basic care for each person includes the administration of the nourishment and fluids needed to maintain bodily homeostasis.

When the provision of nutrition and hydration no longer benefits the patient, because the patient’s organism either cannot absorb them or cannot metabolize them, their administration should be suspended. In this way, one does not unlawfully hasten death through deprivation, but nonetheless respects the natural course of the illness. The withdrawal of sustenance is an unjust action that can cause great suffering to the one who has to endure it. Nutrition and hydration do not constitute medical therapy, but are instead forms of obligatory care. These can at times be administered artificially, provided that it does not cause harm or intolerable suffering to the patient.

4

Palliative care

Palliative medicine is a precious and crucial instrument in the care of patients during the most painful, agonizing, chronic and terminal stages of illness. Palliative care is an authentic expression of

human and Christian care—the tangible symbol of the compassionate “remaining” at the side of the suffering person. Its goal is “to alleviate suffering in the final stages of illness and at the same time ensure the patient appropriate human accompaniment,”¹⁷ improving quality of life and overall well-being as much as possible. Experience shows that the employment of palliative care considerably reduces the number of people who request euthanasia.

Palliative care should include spiritual assistance for patients and their families. Such assistance inspires faith and hope in God in the terminally ill and their families. As the end draws near, effective pain relief therapy allows the patient to face worsening sickness and death without the fear of undergoing intolerable pain.

Palliative care cannot provide a complete answer to suffering or eradicate it from people’s lives entirely. To claim otherwise is to generate false hope, and cause even greater despair in the midst of suffering. While medical science can deploy the best resources to treat physical pain, the sick person seeks a level of care beyond the purely technical. “The wine of hope” is the specific contribution of the Christian faith in the care of the sick and refers to the way in which God overcomes suffering in the world.

It should also be recognized that, recently, the definition of palliative care has sometimes taken on a misleading connotation. In some countries, laws regulating palliative care provide Medical Assistance to the Dying (MAiD), which can include euthanasia and assisted suicide. Such legal provisions cause grave confusion by implying that it would be morally lawful to request euthanasia or assisted suicide as part of palliative care.

Inappropriate palliative interventions in these regulatory contexts can also involve medications that intend to hasten death, as well as the suspension of hydration and nutrition, even when death is not imminent. Such practices are equivalent to a *direct action or omission to bring about death and are therefore unlawful*. The growth of such legislation constitutes a threat to many vulnerable people who need only to be better cared for, but are instead being led to choose euthanasia.

5

The role of the family and hospice

The role of the family is central to the care of terminally ill patients. In the family a person is valued in themselves. It is essential that the sick do not feel themselves to be a burden, and families need help to fulfil this mission. Recognizing the primary, fundamental and irreplaceable role of the family, governments should provide the necessary resources and structures to support it. Christian-inspired health care facilities should integrate the family’s accompaniment in *a unified program of care for the sick person*.

Hospice centers, which welcome the terminally sick and ensure their care until the last moment of life, likewise provide an important and valuable service. After all, “the Christian response to the mystery of death and suffering is to provide not an explanation but a Presence”¹⁸ that shoulders the pain and opens it to a trusting hope. These centers are an example of genuine humanity, sanctuaries where suffering is full of meaning. They must be staffed by qualified personnel, possess the proper resources, and always be open to families. In these settings, healthcare workers and pastoral staff, in addition to being clinically competent, should also be practicing an authentic life of faith and hope that is directed towards God.

6

Accompaniment and care in prenatal and pediatric medicine

Beginning at conception, children suffering from malformation or other pathologies are *little patients* whom medicine today can always assist and accompany in a manner respectful of life. Their life is sacred, unique, unrepeatable, and inviolable, *exactly like that of every adult person*.

Children suffering from prenatal pathologies, which will end in death in a short period of time, must be accompanied like any other patient until they reach natural death. *Prenatal comfort care* favors a path of *integrated assistance* involving the support of medical staff and pastoral care workers alongside the constant presence of the family. The empathetic

accompaniment of a child in the terminal stages of life aims to *give life to the years of a child and not years to the child's life*.

Prenatal Hospice Centers, in particular, provide an essential support to families who welcome the birth of a child in a fragile condition. Medical assistance, spiritual accompaniment, and the support of families who have undergone the same experience constitute an essential resource. Efforts to expand the accessibility of these centers is a pastoral duty. Providing such care helps the parents to regard their experience not just as a loss, but as a moment in the journey of love which they have traveled with their child.

Unfortunately, the dominant culture today does not encourage this approach. An obsessive recourse to prenatal diagnosis, coupled with a culture unfriendly to disability, often prompts the choice of abortion. Abortion consists in the deliberate killing of an innocent human life and as such is never lawful. The use of prenatal diagnosis for selective purposes is contrary to the dignity of the person and gravely unlawful because it expresses a eugenic mentality. After birth, the suspension or non-initiation of care due to disability is also inhumane and gravely immoral.

The fundamental principle of pediatric care for children in the final stages of life is the respect and care due to all persons, avoiding both unreasonably aggressive medical treatment as well as the hastening of death. Pastoral care also demands participation in the divine life through Baptism and Confirmation.

The integral care of the child, in its various physiological, psychological, affective, and spiritual dimensions, must never cease. The suspension of disproportionate therapies *should not entail the withdrawal of basic care*—including pain relief, hydration, nutrition, thermoregulation, and so forth.

The path of accompaniment until the moment of death must remain open, with appropriate care customized to the personal needs of the patient. Evaluation and management of the physical pain of the child show the proper respect they deserve. Likewise, maintaining the emotional bond between the parents and the child is an integral part of the

process of care. The prayer of the people close to the sick child has a supernatural value and must not be overlooked.

Any cost-benefit calculations of care can in no way form the foundations for decisions to shorten life in order to prevent suffering if such decisions envision actions or omissions euthanistic in nature or intention.

7

Analgesic therapy and loss of consciousness

To mitigate a patient's pain, analgesic therapy employs pharmaceutical drugs that can induce loss of consciousness (sedation). While a deep religious sense can make it possible for a patient to live with pain as a special offering to God, the Church nonetheless affirms the lawfulness of sedation as part of patient care in order to ensure the end of life arrives with the greatest possible peace. Prior spiritual preparation of the patients should be provided in order that they may consciously approach death as an encounter with God. However, the use of analgesics that directly or intentionally cause death is euthanistic and therefore unacceptable. Sedation must exclude, as its direct purpose, the intention to kill, even though it may accelerate the inevitable onset of death.

In pediatric settings, caregivers are obliged to alleviate the child's pain and suffering as much as possible, so that he or she can reach natural death peacefully.

8

The vegetative state and the state of minimal consciousness

It is always completely false to assume that the vegetative state, persistent lack of consciousness, and the state of minimal consciousness, in subjects who can breathe autonomously, are signs that the patient has ceased to be a human person with all of the dignity belonging to persons as such. On the contrary, *in these states of greatest weakness, the person must be acknowledged in their intrinsic value and assisted with suitable care*.

The patient in these states has the right to nutrition and hydration, even administered by artificial methods. However, in some cases, such measures can become disproportionate, due to ineffectiveness or an excessive burden that exceeds any benefits to the patient.

Adequate support must be provided to those who bear the burden of long-term care for persons in these states. The support should seek to allay their discouragement and help them to avoid seeing the cessation of treatment as their only option.

9

Conscientious objections on the part of healthcare workers and of Catholic healthcare institutions

In the face of legalized euthanasia or assisted suicide, formal or material cooperation must be excluded. Such situations offer specific occasions for Christian witness where “we must obey God rather than men” (*Acts 5:29*). There is no right to suicide nor to euthanasia; *laws exist, not to cause death, but to protect life*. It is therefore never morally lawful to collaborate with such immoral actions. The one authentic right is that the sick person be accompanied and cared for with genuine humanity.

In this regard, Christians must not collaborate with practices, such as euthanasia and assisted suicide, that are contrary to the Law of God. Formal collaboration occurs when there is direct participation in an act against human life or by sharing in the intention of such an act. Such cooperation with evil can never be justified, neither by citing respect for the freedom of others nor by the allowance in civil legislation.

Governments must acknowledge the right to conscientious objection in the medical and healthcare field. Where this is not recognized, one may be obligated to disobey human law. Healthcare workers should not hesitate to ask for this right. Likewise, healthcare institutions must resist the strong economic pressures to accept euthanasia. All of this requires episcopal conferences and local churches, with Catholic communities and institutions, to adopt a clear and unified position to safeguard the right of conscientious objection.

Catholic healthcare institutions are a concrete sign of the way in which the ecclesial community takes care of the sick following the example of the Good Samaritan. They are called to witness faithfully to the fundamental human and Christian values that constitute their identity. This witness requires that they abstain from immoral conduct and affirm their adherence to the teachings of the Magisterium. Any action that does not correspond to these values endangers the identification of the institution itself as “Catholic.” Furthermore, institutional collaboration with other hospital systems is not permissible when it involves referrals for persons who request euthanasia.

The right to conscientious objection does not mean that Christians reject these laws in virtue of private religious conviction, but by reason of an inalienable right essential to the common good of the whole society. Euthanistic laws undermine the very foundations of human dignity.

10

Pastoral accompaniment and the support of the sacraments

Death is a decisive moment in the human person’s encounter with God the Savior. The Church is called to accompany spiritually the faithful in this situation with prayer and the sacraments. Helping the Christian to experience this moment is a supreme act of charity, for “no believer should die in loneliness and neglect.”¹⁹

The parable of the Good Samaritan shows what the relationship with the suffering neighbor should be: avoiding the qualities of indifference, apathy, bias, fear of soiling one’s hands, and occupation with one’s own affairs. And rather embracing the qualities of attention, listening, understanding, compassion, and discretion.

The invitation to imitate the Samaritan’s example—“*Go and do likewise*” (*Lk 10:37*)—cautions us not to underestimate the full human potential of presence, availability, welcoming, and involvement. The quality of love and care helps alleviate the terrible desire to end one’s own life. Such accompaniment is part of the path defined by palliative care that

includes the patients and their families.

Providing care for the suffering of others is a commitment that embraces the entire Christian community. Saint Paul affirms that when one member suffers, it is the whole body that suffers (cf. *1 Cor* 12:26). Pastoral accompaniment involves the exercise of the virtues of *empathy*, of *compassion*, of bearing another's suffering by sharing it, and of the *consolation* of entering into the solitude of others to make them feel loved, accepted, and sustained.

The ministry offered by the priest can and must have a decisive role. Given the centrality of the priest in the pastoral, human and spiritual accompaniment of the sick at life's end, it is necessary that his formation provide precise preparation in this area. Since there may be circumstances that make it difficult for a priest to be present at the bedside, physicians and healthcare workers also need this formation.

Our way of caring for our suffering neighbor should favor their encounter with the Lord of life, who is the only one who can pour the oil of consolation and the wine of hope onto human wounds.

The sacramental moment is the culmination of the entire commitment to care and the source of all that follows.

The Church calls Penance and the Anointing of the Sick sacraments "of healing"²⁰, for they culminate in the Eucharist. Through the closeness of the Church, the sick person experiences the nearness of Christ who accompanies them on their journey to his Father's house (cf. *Jn* 14:6) and helps the sick to not fall into despair, by supporting them especially when the journey becomes exhausting.

11

Pastoral discernment towards those who request Euthanasia or Assisted Suicide

The pastoral accompaniment of those who ask for euthanasia or assisted suicide presents a moment when the reaffirmation of Church teaching is necessary. With respect to the Sacrament of Penance and Reconciliation, the confessor must be assured of the true contrition *necessary for the validity of*

absolution: "sorrow of mind and a detestation for sin committed, with the purpose of not sinning for the future"²¹. A person who has decided upon a gravely immoral act and willingly persists in this decision lacks the proper disposition for the reception of the Sacraments of Penance, with absolution, and Anointing, with Viaticum. Such a penitent can receive these sacraments only when the minister discerns his or her readiness to take concrete steps that indicate he or she has modified their decision.

The position of the Church here does not imply a non-acceptance of the sick person. The Church is careful to look deeply for adequate signs of conversion, so that the faithful can reasonably ask for the sacraments. *To delay absolution is a medicinal act of the Church, intended not to condemn, but to lead the sinner to conversion.*

It is necessary to remain close to the person unable to receive the sacraments, for this nearness is an invitation to conversion, especially when euthanasia will not take place immediately. It remains possible to accompany the person whose decision may be revised, thus opening the way to admission to the sacraments.

Nevertheless, those who spiritually assist these persons should avoid any gesture, such as remaining until the euthanasia is performed, that could be interpreted as approval of this action. Such a presence could imply complicity in the termination of human life.

12

The reform of the education and formation of healthcare workers

Today, with so many challenges to the protection of human life in its most critical stages, education has a critical role to play. Families, schools, other educational institutions and parochial communities must work with determination to awaken and refine that sensitivity toward our neighbor and their suffering manifested by the Good Samaritan of the Gospel.

Hospital chaplains should intensify the spiritual and moral formation of healthcare workers, including physicians, nursing staff, and volunteers, in order

to prepare them to provide the assistance necessary in the terminal stages of life. The psychological and spiritual care of patients and their families during the whole course of the illness must be a priority.

Palliative treatments must be disseminated throughout the world. To this end, it is desirable to organize academic courses for the specialized formation of healthcare workers. Also a priority is the dissemination of accurate information on the value of palliative treatments for a dignified accompaniment of the person until natural death. Christian-inspired healthcare institutions should provide guidelines for personnel that include suitable methods for providing psychological, moral, and spiritual assistance as essential components of palliative care. Human and spiritual assistance must again factor into academic formation as well as in hospital training programs.

In addition, healthcare organizations must arrange for models of psychological and spiritual aid to workers who care for the terminally ill. *To show care for those who care* is essential so that they do not bear all of the weight of the suffering and death of incurable patients. They need support and therapeutic sessions to process their values and feelings, and the anguish they experience as they confront suffering and death in their service to life. They need a profound sense of hope, along with the awareness that their own mission is a true vocation to the mystery of life and grace in the painful and terminal stages of existence.

CONCLUSION

The mystery of the Redemption of the human person is rooted in the loving involvement of God with human suffering. That is why we can entrust ourselves to God and convey this certainty to the person who is suffering or fearful of pain and death.

Hope is always possible. “Every individual must feel as if called personally to bear witness to love in suffering.”²² The Church learns from the Good Samaritan how to care for the terminally ill, and likewise obeys the commandment linked to the gift of life: “*respect, defend, love and serve life, every human life!*”²³ The gospel of life is a gospel of compassion and mercy directed to actual persons, weak and sinful, to relieve their suffering, to support them in the life of grace, and if possible to heal them from their wounds.

It is not enough, however, to share their pain; one needs to immerse oneself in the fruits of the Paschal Mystery of Christ who conquers sin and death. To be effective, the Christian witness of hope must be lived in faith and encompass everyone—families, nurses, and physicians. It must engage the resources of the diocese and of Catholic healthcare centers, called to *the duty to accompany* the sick, particularly in the critical and terminal stages of life.

The Good Samaritan, who puts the face of his brother in difficulty at the center of his heart, offers him whatever is required to repair his wound of desolation and to open his heart to the luminous beams of hope. Healed by Jesus, we become men and women called to proclaim his healing power and provide care for our neighbors.

The vocation to the love and care of another brings with it the rewards of eternity as made explicit by the Lord in the parable of the final judgment: *inherit the kingdom, for I was sick and you visited me. When did we do this, Lord? Every time you did it for the least ones, for a suffering brother or sister, you did it for me* (cf. Mt 25: 31-46).

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The Sovereign Pontiff Francis, on 25 June 2020, approved the present Letter, adopted in the Plenary Session of this Congregation, the 29th of January 2020, and ordered its publication.

Rome, from the Offices of the Congregation for the Doctrine of the Faith, the 14th of July 2020, liturgical memorial of Saint Camille de Lellis.

NOTES

1 Cf John Paul II, Encyclical Letter *Centesimus annus* (1 May 1991), 37: AAS 83 (1991), 840.

2 John Paul II, *Address to the participants in the International Congress “Life sustaining treatments and vegetative state. Scientific progress and ethical dilemmas”* (20 March 2004), 7: AAS 96 (2004), 489.

3 Palliative care is specialized medical care for people with serious illness, focusing on relief from symptoms and stress while they are still seeking curative treatment. Patients are candidates for palliative care whenever they are facing a serious illness. Care may pursue both curative and comfort goals that can be carried out over months, years, and decades. These goals may change with the progression of the disease or condition. Palliative care is holistic because it is provided by a team of physicians, nurses, social workers, chaplains, and other professionals who focus on physical pain and symptom management, as well as psychosocial and spiritual needs. The palliative care team works in service of the patient to coordinate all aspects of care, communication and decision making, as well as clarification and adjustment of the goals of care over time, all while also offering support to the family.

4 Pontifical Council for Pastoral Assistance to Health Care Workers, *New Charter for Health Care Workers*, n. 9.

5 Francis, *Address to the participants of the Plenary Session of the Congregation for the Doctrine of the Faith* (30 January 2020): *L’Osservatore Romano*, 31 gennaio 2020, 7. (Eng. trans.)

6 Cf John Paul II, Encyclical Letter *Evangelium vitae* (25 March 1995), 49: AAS 87 (1995), 455. “the deepest and most authentic meaning of life: namely, that of being a gift which is fully realized in the giving of self”.

7 Cf Francis *Address to the National Federation of the Orders of Doctors and Dental Surgeons* (20 September 2019): *L’Osservatore Romano*, 21 settembre 2019, 8: “These are hasty ways of dealing with choices that are not, as they might seem, an expression of the person’s freedom, when they include the discarding of the patient as a possibility, or false compassion in the face of the request to be helped to anticipate death”.

8 Cf Benedict XVI, Encyclical Letter *Caritas in veritate* (29 June 2009), 53: AAS 101 (2009), 688. “One of the deepest forms of poverty a person can experience is isolation. If we look closely at other kinds of poverty, including material forms, we see that they are born of isolation, from not being loved or from difficulties in being able to love”.

9 Cf Francis, Apostolic Exhortation *Evangelii gaudium* (24 November 2013), 53: AAS 105 (2013), 1042; See also: Id., *Address to a delegation from the Dignitatis Humanae Institute* (7 December 2013): AAS 106 (2014) 14-15; Id., *Meeting of the Pope with the Elderly* (28 September 2014): AAS 106 (2014) 759-760.

10 Cf John Paul II, Encyclical Letter *Evangelium vitae* (25 March 1995), 12: AAS 87 (1995), 414.

11 Congregation for the Doctrine of the Faith, Declaration *Iura et bona* (5 May 1980), II: AAS 72 (1980), 546.

12 Congregation for the Doctrine of the Faith, Declaration *Iura et bona* (5 May 1980), II: AAS 72 (1980), 546.

13 Pontifical Council for Pastoral Assistance to Health Care Workers, *New Charter for Health Care Workers*, n. 169.

14 Francis, *Address to the Participants of the Plenary Session of the Congregation for the Doctrine of the Faith* (30 January 2020): *L’Osservatore Romano*, 31 gennaio 2020, 7. (Eng. trans.)

15 Congregation for the Doctrine of the Faith, Declaration *Iura et bona* (5 May 1980), II: AAS 72 (1980), 546.

16 John Paul II, Encyclical Letter *Evangelium vitae* (25 March 1995), 65: AAS 87 (1995), 476.

17 Francis, *Address to participants in the plenary of the Pontifical Academy for Life* (5 March 2015): AAS 107 (2015), 274, with reference to: John Paul II, Encyclical Letter *Evangelium vitae* (25 March 1995), 65: AAS 87 (1995), 476. Cf. *Catechism of the Catholic Church*, 2279.

18 C. Saunders, *Watch with Me: Inspiration for a life in hospice care*, Observatory House, Lancaster, UK, 2005, 29.

19 Benedict XVI, *Address to the participants in the Congress organized by the Pontifical Academy for Life on the theme “Close by the incurable sick person and the dying: scientific and ethical aspects”* (25 February 2008): AAS 100 (2008), 171.

20 *Catechism of the Catholic Church*, 1420.

21 Council of Trent, Sess. XIV, *De sacramento penitentiae*, chap. 4: DH 1676.

22 John Paul II, Apostolic Letter *Salvifici doloris* (11 February 1984), 29: AAS 76 (1984), 246.

23 John Paul II, Encyclical Letter *Evangelium vitae* (25 March 1995), 5: AAS 87 (1995), 407.

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