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教廷信理部

信函

《慈善的撒瑪黎雅人》

對生命處於危重和末期病患時的照顧

慈善的撒瑪黎雅人竭盡所能幫助那個受傷的人（參閱：路十30~37）。這表示耶穌基督與需要救恩的人相遇，並且祂用「安慰之油及希望之酒」照顧這人的創傷和痛苦。[1] 祂是眾靈魂和身體的醫師，在世上為神聖救恩的臨在「做忠信見證的」（默三14）那位。現今該如何具體化這個信息？如何把它詮釋為一份樂意之心，準備就緒為那個在世上生命處於末期的受苦者作陪伴，並以一種方式為他提供協助，應該尊重和促進病患者在本質上的人性尊嚴，以及他們成聖的使命，如此才是他們存在的最高價值呢？

1 羅馬經書（義大利文），按照梵蒂岡第二次大公會議的法令，由教宗保祿第六世所頒布，以及被教宗若望保祿二世修定的「通用頌謝詞第八式——耶穌善心的撒瑪黎雅人」，第404頁（Messale Romano, *riformato a norma dei decreti del Concilio Ecumenico Vaticano II, promulgato da papa Paolo VI e riveduto da papa Giovanni Paolo II*，Conferenza Episcopale Italiana – Fondazione di Religione Santi Francesco d'Assisi e Caterina da Siena，Roma 2020，Prefazio comune VIII，p. 404）。

生物醫學科技上顯著的先進發展，使診斷醫學在臨床上護理和診治病人的能力急速遞增。教會對科學研究及科技抱有希望，認為它們大有機會為生命的良善與及每一個人類存有的尊嚴作出服務。[2] 然而，醫學科技的進步儘管是珍貴的，但其本身並不能為人類生命的正確意義及價值下定義。事實上，每一項醫護上的技術發展都需要在道德的判別上成長，[3] 以避免使用科技時有所失衡和非人化地使用它們，特別是在生命病危和末期病患時。

此外，有組織的管理模式及其精密程度，以及當代在醫療分配上之複雜性，能夠把醫師與病人之間的互信關係，削弱為純粹技術性的和非人化的關係。特別在那些已頒布立法的政府，她們使協助自殺和自願安樂死等方式合法化，容許在最易受傷害的病人和體弱者身上進行，就會出現這種危險。如此的立法，越過了維護病人作自主決定的道德和法律界限。而令人擔憂的是，在患病期間的生命價值、痛苦的意義及臨終彌留時的重要性都變得黯然失色。痛苦和死亡——是每個人會經歷的，身為「人類存在」的事實——再不構成人性尊嚴的最終尺度。

2 參閱：宗座醫護人員牧靈輔助委員會（Pontifical Council for Pastoral Assistance to Health Care Workers），《新醫護人員約章》（*New Charter for Health Care Workers*）：國立天主教生命倫理中心（National Catholic Bioethics Center NCBC），費城，賓夕法尼亞州，2017年，第6條。

3 參閱：教宗本篤十六世，《在希望中得救》通諭（2007年11月30日），22：《宗座公報》99（2007），1004。「假如科技進步不配合人的道德的教育，在人內在成長中進行（參閱：弗三16；格後四16），那根本不算進步，而是對人和世界的威脅。」

關於在醫學上、照顧病人的重要性、以及我們對弱勢社群之社會責任等方面，有些挑戰正影響我們對之作出深入思考。面對這些挑戰，本信函旨在啟發牧者及信徒，就他們在醫療護理上的問題及不確定的事項而論，並且關於在病危和末期病患時的生命，他們在靈性和牧靈上的義務。為了具體實現耶穌的願望，所有人都被召叫在病人身旁作見證，並成為一個「醫治的團體」，從最弱小和最易受傷害的人開始，願全員成為一體。[4] 關於對這群人的照顧，廣泛都承認有需要在道德和實踐方面作出澄清。對於這個敏感的範疇，包含了一個人生命之中最脆弱和決定性的時期，教會「必須在教導和實踐方面保持一致。」[5]

由於某些國家把協助自殺和自願安樂死合法化，世界各地許多不同的主教團都發表了牧函及聲明，以應付合法化對醫護專業人員和病人所帶來的挑戰，特別為天主教機構裡的一群。關於為那些打算結束自己生命的人舉行聖事，於具體情況下作靈性輔導所產生的疑問，現在需要在教會方面介入，作出更清晰和更準確的回答，為了：

— 重申福音的訊息及在教會教導中表達福音的基本教義，因此對所有接觸到病危和末期病患者的人（家屬或法定監護人、醫院院牧、非常務送聖體員和牧靈工作者、醫院志工和醫護人員）以及病人本身，都能喚起他們的使命。

— 提供精確而具體的牧靈指引，可以設身處地應付這些在各地的複雜情況，並且在處理它們時，培育病人，使他們能夠親身與天主的慈愛相遇。

一、關懷近人

儘管我們盡最大的努力，當我們注視人類生命的弱點和脆弱時，很難會認出生命的深奧價值。痛苦遠遠超出人存在的界域，關於生命的意義，痛苦總是引出了無數的問題。[6] 這些迫切的問題不能僅靠人類的反省來獲得答案，因為痛苦隱含著**一個特殊奧祕的偉大地方**，這只能靠天主的啟示去揭露。[7] 對人類生命忠實的照顧，直到它自然終結為止，[8] 這個使命具體地託付給每一個醫護人員，並透過護理的程序得到實現，即使在患病和痛苦之中，這種照顧能夠讓每一個病人對自己的存在，有深刻的認識。為此，我們首先仔細斟酌特殊使命之重要性，這些使命是天主託付給每一個人、醫護人員及牧靈工作者的、也給了病人和他們的家屬。

人類對醫療服務的需求源自於人類在有限條件下生來就

4參閱：教宗方濟各，2019年3月2日對「義大利預防血癌、淋巴瘤及骨髓瘤協會」的演說（*Discorso all'Associazione italiana contro le leucemie-linfomi e myeloma-AIL*），羅馬觀察報，2019年3月3日，7。

5教宗方濟各，《愛的喜樂》宗座勸諭（2016年3月19日），3：《宗座公報》108（2016），312。

6參閱：梵蒂岡第二屆大公會議，《論教會在現代世界牧職憲章》，10：《宗座公報》58（1966），1032~1033。

7教宗若望保祿二世，《論得救恩的痛苦》牧函（1984年2月11日），4：《宗座公報》76（1984），203。

8參閱：宗座醫護人員牧靈輔助委員會，《新醫護人員約章》（*New Charter for Health Care Workers*）第144條。

是脆弱且易受傷害的。每個人的脆弱都編排在我們的本性中，如同身體與靈魂的合一：我們在物質上、時間上有其限制，然而我們還渴望無限和永恆的生命。作為本性有限的受造物，然而卻仍然渴望永恆的生命，我們要依靠物質和其他人的互相支持，同時依賴我們本有與天主那份深切的聯繫。我們的脆弱構成了關懷倫理學的基礎，特別在醫療界，向託付給我們的男與女表示關心、奉獻，跟他們一起分擔，並為他們負上責任，如此展現了這種倫理，因為當他們有需要時，我們為他們提供了物質和靈性上的幫助。

關懷的關係揭示了正義的雙重原則，即是在促進人類生命上要各得其所（*suum cuique tribuere*）以及不傷害他人（*alterum non laedere*）。耶穌把這個原則轉成金科玉律：「凡你們願意別人給你們做的，你們也要照樣給人做」（瑪七12）。這一條規律跟傳統醫學倫理的首要格言「首先不要傷害」（*primum non nocere*）產生著共鳴。

因此，關懷生命是醫師的首要責任，在醫師會見病人時，他們要據此而行。由於關懷生命在人類學和道德上有更廣闊的範圍，因此不僅在實際上可以恢復健康時，甚至在不大可能或無法治癒的情況下，也應承擔這個責任。在醫療及護理方面，必須照顧到人體的生理機能，同樣，照顧病人在心理上和靈性上的健康亦是不可推卸的責任。醫學除了借鑒了眾多科學外，它還具有「治療技巧」的重要幅度，當中必涉及種種緊密的關係，與病人、醫護人員、家屬、及一些與病人有關的社區團體成員等等。在醫學的實踐中，特別是生命處在病危和末期病患時，**治療技巧、臨床程序和日常護理**的操作是密不可分的。

事實上，慈善的撒瑪黎雅人「不僅拉近那個他發現半死的人；他為他負起責任。」[9] 他不僅用他手上的資金投放在這人身上，而且還用了他沒有的，他希望在耶里哥那裡賺得：他承諾在回程時將償還任何額外的費用。同樣地，基督邀請我們相信祂無形的恩寵，這恩寵促使我們投向超自然的慈愛，因為當我們認出每個生病的人時：「我實在告訴你們：凡你們對我這些最小兄弟中的一個所做的，就是對我做的」（瑪廿五40）。這斷言表達了普遍的道德真理：「因此我們必須對整個生命及對每一個人的生命『**表示關懷**』」，[10] 如此揭示了天主本來的無條件的愛，正是所有生命意義的來源。

為此，特別是在奉行基督價值觀的醫院和診所，重要的是要給予空間，在認出病人的**脆弱性**和**易受傷害性**的基礎上建立關係。軟弱使我們意識到我們對天主的依賴，並邀請我們作出回應，以應有的尊重對待鄰人。每一位照顧病人的（醫師、護理師、親屬、志工、牧者）都有道德責任，要懂得那個基本的而且是不可剝奪的善，就是人的位格本身。他們應該堅持自尊和尊重別人的最高標準，懷抱、維護並促進人類生命直至自然死亡

9教宗方濟各，2014年6月1日第四十八屆世界傳播日文告：《宗座公報》106（2014），114。

10教宗若望保祿二世，《生命的福音》通諭（1995年3月25日），87：《宗座公報》87（1995），500。

為止。這裡運作的是一種**默觀的目光**，[11] 注視著自己和他人的存在，是獨特且不可重現的驚歎，生命作為一種禮物應該加以歡迎和接納。這種目光是當人不妄求占有現實的生命，而是樂於接受生命的現狀，與困難和苦難同行，並在信德的光照下，在病患中願意捨棄自己，投向那位在痛苦中顯現的生命之主。

肯定的是，醫學必須接受死亡的限制作為人類狀況的一部分。當一些特定的醫療干預，它們顯然無法使末期病的病情有所進展時，死亡便會來臨。面對這個現實巨變，必須以極大的人性和對超自然的視野開放的信念與病人溝通，並要察覺到死亡所帶來的劇痛，特別是在一些試圖掩蓋死亡的文化裡。人不能視肉體生命為一個不惜所有代價都要保存的東西——這是不可能的——而是在自由地接納了身體的存在意義下生存：「惟有把人視作『合一的整體』，就是『靈魂是在身體內表達自己，而身體是由不死的精神體所形成』，這樣身體的特殊人性的意義才能把握住。」[12]

在瀕臨死亡的情況下，無法治癒並不意味必須停止醫療和護理行為。與末期病患者作負責任的溝通，應能清楚表明將會為他提供照顧直到生命的結束：「**盡可能治癒，時刻關懷**」[13]：而時刻關懷病人的責任，為「不

11參閱：教宗若望保祿二世，《百年》通諭（1991年5月1日），37：《宗座公報》83（1991），840。

12教宗若望保祿二世，《真理的光輝》通諭（1993年8月6日），50：《宗座公報》85（1993），1173。

13教宗若望保祿二世，2004年3月20日對「維持生命的治療和植物人狀態。科學進展與道德困境」（*Life sustaining treatments and vegetative state. Scientific progress and ethical dilemmas*）國際代表大會的參與者演說，7：《宗座公報》96（2004），489。

可治癒」之症提供了採取行動的評估標準：判斷為不治之症並非指對病人的照顧已可結束。默觀的目光要求一個更廣的關懷概念。援助病人的目標必須考慮到人的完整性，因此應為他們配置足夠的支援，在身體、心理、社會、家庭及宗教方面為病人提供必要的支持。那些參與照顧的人，他們生活的信德有助於病人渡真正的神學生命，即使這些並不是立即可見的。眾人——家庭、醫師、護理師及院牧——的牧靈關顧，能幫助病人聖化的恩寵中堅持不懈，並在愛德和天主的慈愛內與世長辭。當面對無法避免的疾病，人會缺乏信德，尤其在患上慢性或退化性疾病時，所連帶的對痛苦、死亡和不適的恐懼，這主要因素驅使人企圖去控制和掌管死亡的時刻，並確實通過安樂死或協助自殺來加速死亡。

二、受苦基督的生活經驗及希望的宣講

如慈善的撒瑪利亞人的形象，為醫療保健提供了嶄新的思路，那麼天主降世為人表明重現親近人的一面，就在基督受苦的生活經驗當中，當祂在十架上受著極度痛苦，以及在基督復活時得到呈現：基督經歷了各種形式的痛苦和悲傷，就在病人臨終前漫長的養病日子裡，祂的經驗引起了病人和家庭的共鳴。

不僅是先知依撒意亞，他的話宣告了基督是熟悉苦難和痛苦的人（參閱：依五三），而且當我們重溫有關祂受難的章節時，我們也認出那些對祂懷疑和輕蔑的經歷，以及祂被遺棄、感到身體疼痛和悲傷的經驗。基督的經

歷與病人產生共鳴，他們時常被視為社會的負擔；他們的問題不被理解；他們經常在情感上遭受某種形式的遺棄，並與其他人失去聯繫。

每個病人不僅需要自己的說話被別人聽見，而且他們還需要得知，跟他們談話的對話者是「知道」他們，即真正明白他們感受的孤單、被忽視和因身上的痛楚而遭受折磨。再加上，當社會把他們作為人的價值，等同於他們的生活品質，並讓他們感到是其他人的負擔時，這樣也使到病人感到痛苦。在這種情況下，將目光轉向基督，就是要投向基督，找祂幫忙；基督以祂的肉體經歷過鞭和釘的痛苦、祂被折磨祂的人嘲笑、並遭最親近祂的人遺棄和背叛。

面對疾病的挑戰，以及面對與痛苦相關在情緒上和靈性上的困難，人必須知道如何向病人說出安慰的話，這些話源自十字架上耶穌的憐憫。它充滿著希望——是真誠的希望，就像基督在十字架上一樣，祂能夠面對審判那一刻和死亡的挑戰。我們在耶穌受難日的禮儀中詠唱著「*Ave crux, spes unica*」。世間上所有疾病和苦難都集中在一起，並且重現在基督的十字架上：對於所有**肉體的痛苦**，十字架——那個可恥不堪的死亡的工具——是象徵標記；所有**心理的痛苦**，當耶穌在最黑暗的孤獨、被遺棄和背叛中死亡時表現了出來；所有**道德的痛苦**，就在無辜者被判處死亡時呈現；所有**靈性的痛苦**，展現出一個荒涼的境況，似乎是天主沉默了。

對於「留在」十字架下的母親和門徒，基督察覺到他們的痛苦驚愕，他們儘管「一直留在」也顯得無能為力並要退讓，然而所發放的親情，使降生成人的天主在似乎毫無意義的時光裡一直活著。

那麼十字架是：一個只為最弱小者預留的酷刑及執行死刑的工具，象徵地看來就像是那些折磨，把我們釘在病床上，只有預示著死亡，也使時間和它的流逝變得毫無意義。儘管如此，那些「留在」病者身邊的人不只作為表示，他們還把對病人的情感和跟病人的聯繫具體表現出來，同時亦表現他們是深度地願意去愛。在這一切中，受苦者便能明白人們的目光，它們為患病的時刻增添了意義。因為在被愛的經驗中，所有生命都為自己找到了充分的理由。受難時，基督堅信天父的愛，憑藉這份信念，祂一直被支撐著，這些在祂被釘在十架時顯然易見，而且基督也堅信自己母親的愛。天主的愛總是在人類歷史中揭示自己，幸虧天主的愛，祂永不離棄我們，儘管一切，都「留在」我們身邊。

在生命終結時，人們常常對自己留下的——他們的孩子、配偶、父母和朋友——心懷憂慮。這個人的因素永遠不能被忽略，而且需要以同理心作出回應。

出於同樣的關注，基督在臨終前想到了自己的母親，她將獨自一人處於悲傷之中，從現在開始，她必要承受這種痛苦。在若望福音的額外章節裡，基督轉向他的母親，安慰她並將她交托給心愛的門徒照顧。「女人，看，你的兒子！」（參閱：若十九26~27）生命的終結

是一段關係的時期，把自己的生命有信心的獻給天主（參閱：路廿三46），此時必得戰勝孤獨和遺棄。（參閱：瑪廿七46及谷十五34）

就這觀點來看，當我們注視基督的十字苦像，就會看見一個合唱團的景象，基督在這裡位居中心，因為他以自己的血肉概括了一生，並真正轉化了人類經驗中最黑暗的時光，那時祂默默地面對著可能要發生的絕望。信德之光使我們能夠從福音裡那些簡短的、靈活變通的描述中辨認出聖三的存在，因為基督信賴天父，亦因為聖神一直支撐著祂的母親和門徒。這樣，「他們留在」十字架之下，而且當他們「一直留在」時，把自己獻身於受苦的基督，一同參與了救贖的奧祕。

以這種方式面對死亡，儘管它會經歷痛苦的過程，然而藉著信德，死亡有機會成為一個更大的希望，因為信德使我們成為了基督救贖工程的參與者。只有在懷著希望時，痛苦才能在存在的層面上得以忍受。基督傳達給病人和受苦者的希望，是祂的同在以及祂真正的親近。希望不但是一份期盼，盼望著更大的善，而且它是一種目光，注視著充滿意義的現在。在基督徒的信仰中，基督的復活不僅揭示了永恆的生命，而且還在歷史當中顯示，最後的聖言是永遠不屬於死亡、痛苦、背叛及苦難的。基督在歷史當中復活，而在復活的奧蹟裡，證實了天父持久不渝的愛。

默觀基督受苦的生活經驗，就是要向當今的男和女宣布希望。希望為患病和死亡的時間賦予了意義。從這希望中流溢愛，這份愛克服了招致絕望的誘惑。

雖然緩和醫療是一種必不可少和無價的服務，但它本身並不足夠，除非某人會「留在」病人的床邊，見證他們獨一無二和不可重覆的價值。為信徒來說，凝視十架苦像表達信賴天主憐憫之愛。在一個時代，當獨立自主和個人主義受到讚許時，我們必須謹記，儘管每個人都生活在自己的苦難、痛苦及死亡之中，但這些經歷總會在其他人在場時，及在他們的目光下為人所知。在十字架附近，還有些是羅馬城邦的官員、有其他充滿好奇心的人、有困惑而不集中的、有漠不關心的和充滿怨恨的：他們雖然在十字架那裡，但卻不「留在」當中與被釘的基督一起。

在深切治療病房或處理慢性疾病的治療中心，有些人的出現可以純粹只為工作性質，或者某些是「留在」病人那裡的。

十字架的經驗使我們能夠面對受苦者，作為一個真正的對話者，他們跟我們談話或表達思想，或把所感受的悲痛和恐懼託付給我們。為那些照顧病人的人來說，十字架的景象提供了一種理解的方式，即使似乎是沒有甚麼可以再做時，其實仍然有很多方面是可以繼續做的。因為「一直留在」病人身邊是愛的標記，是包含希望的標記。宣講死後的生命不是一種幻象，也不僅僅是一種安慰，而是確定存在愛中心的事實，即是那個死亡不能吞噬的生命。

三、撒瑪黎雅人那「一顆看見的心」：人類生命是神聖不可侵犯的恩寵

無論身心理狀況如何，身為天主的肖象，人類始終保持原有的尊嚴。人類可以在神聖的光輝下生活和成長，因為他們受召以「天主的肖像和光榮」（格前十一7及格後三18）存在。他們的尊嚴處於這個召叫之內。天主降生成人拯救我們，祂應許我們獲得救贖，並召叫我們與祂共融相通：此處是人類尊嚴的最終基礎。[14]

教會以慈悲之心陪伴在苦難旅程中最軟弱的人，維護他們超性的生命，並引導他們獲得救恩是適當的做法。[15] 慈善的撒瑪黎雅人的教會[16] 認為「服務病人是她使命中一個不可或缺的部分。」[17] 從人與人之間的共融和精誠團結的角度來理解，教會救恩性的介入有助於克服化約主義和個人主義的趨向。[18]

「一顆看見的心」是慈善的撒瑪黎雅人這比喻的綱要。他「教導說，有必要轉化心靈的目光，因為許多時旁觀者並看不見。為什麼？因為缺乏了憐憫 [⋯]。沒有憐憫，那些觀看的人，對於所觀察到的事情，他們不會參與，而是繼續前行；相反，充滿憐憫之心的人會因此受到感動，他們會投入參與，停下來並表示關懷。」[19] 這顆心可以看到哪裡需要愛，進而以實際行動付出愛。[20] 這些眼睛在軟弱之中認出天主的召叫，能欣賞人類生命為社會中最首要的共同利益。[21] 人類的生命是至高的善，社會該承認這一點。生命是神聖不可侵犯的恩寵。[22] 而且每一個天主創造的人，都有一種超性的召叫，要與給予生命的那一位建立獨特的關係。「不可見的天主，為了祂無窮的愛情」[23] 向每個各自的人施予一個救恩的計劃，使人們可以肯定「生命永遠是一個『善』。這是出於本能的看法，也是所體驗到的事實，人受召去了解其中的深奧理由。」[24] 因此，教會時刻都樂意與所有懷著善意的人、其他教派或宗教信徒，以及非信徒合作，他們即使在痛苦和死亡的最後階段也尊重人類生命的尊嚴，並拒絕任何違反人類生命的行為。[25]

14參閱：教廷信理部，《依照天主的計劃》（*Placuit Deo*）信函（2018年2月22日），6：《宗座公報》110（2018），430。

15參閱：宗座醫護人員牧靈輔助委員會，《新醫護人員約章》（*New Charter for Health Care Workers*）第9條。

16參閱：教宗保祿六世，1965年12月7日在梵蒂岡第二屆大公會議最後的大會上發表的演說：《宗座公報》58（1966），55~56。

17宗座醫護人員牧靈輔助委員會，《新醫護人員約章》（*New Charter for Health Care Workers*）第9條。

18參閱：教廷信理部，《依照天主的計劃》（*Placuit Deo*）信函（2018年2月22日），12：《宗座公報》110（2018），433~434。

19教宗方濟各，2020年1月30日對教廷信理部全體大會的參與者演說：《羅馬觀察報》，2020年1月31日，7。

20參閱：教宗本篤十六世，《天主是愛》通諭（2005年12月25日），31：《宗座公報》98（2006），245。

21參閱：教宗本篤十六世，《在真理中實踐愛德》通諭（2009年6月29日），76：《宗座公報》101（2009），707。

22參閱：教宗若望保祿二世，《生命的福音》通諭（1995年3月25日），49：《宗座公報》87（1995），455。「生命最深刻及最真實的意義，就是說，讓自己成為一項禮物，在付出自我時得以成全。」

23梵蒂岡第二屆大公會議，《天主的啟示》憲章（1965年11月8日），2：《宗座公報》58（1966），818。

24教宗若望保祿二世，1995年3月25日，《生命的福音》通諭，34：《宗座公報》87（1995），438。

25參閱：梵蒂岡2019年10月28日《亞巴郎一神宗教就有關生命的

造物主天主恩賜了人類生命和生命的尊嚴，是寶貴的禮物應加以維護和養育，而且最終要向祂負責。

教會肯定人類生命的積極意義可以通過正確的理性而得知，並且在信德的光照下，生命有不可剝奪的尊嚴更加得到肯定和理解。[26] 這個準則既不是主觀的也不是任意的，而是建立在本性不可侵犯的尊嚴之上。生命是首要的善，因為它是享受其他一切善的基礎，包括超驗的召叫，即每個人受召去分享生活的天主祂那聖三的愛。[27]「創造者對每一個人特別愛護，『賦予他或她無限的尊嚴。』」[28] 生命不可侵犯的價值是自然道德律的一項基本原則，也是法律秩序的一個必要基礎。正如我們不能將另一個人當作我們的奴隸，即使是他們要求的；那麼，我們不可直接選擇奪取另一人類的性命，即使他們提出了這個要求。因此，為要求安樂死的病人結束生命，絕不是承認或尊重他們的自主，反而是否決病人所

問題的立場書》（*Position Paper of the Abrahamic Monotheistic Religions on matters concerning life*）：「我們反對任何形式的安樂死–那是奪取生命的直接、蓄意及有計劃的行為–以及反對醫師協助自殺——那是對犯自殺的作直接、蓄意及存心的支持——因為它們從根本上與人類生命那不可剝奪的價值相矛盾，也因此在道德上和宗教上，它們都固有地和必然地是種錯誤，並且應當絕無例外地被禁止。」

26參閱：教宗方濟各，2014年11月15日在意大利天主教醫師協會成立70周年的紀念會議上對參與者演說：《宗座公報》106（2014），976。

27參閱：宗座醫護人員牧靈輔助委員會，《新醫護人員約章》（*New Charter for Health Care Workers*）第1條；教廷信理部，2008年9月8日《位格的尊嚴》訓令，8：《宗座公報》100（2008），863。

28教宗方濟各，《願祢受讚頌》通諭（2015年5月24日），65：《宗座公報》107（2015），873。

具有自由的價值和生命的價值－－而其自由的價值現正受到痛苦和疾病的衝擊——並且排除病人在人際關係上、在領悟人存在的意義上、或在超性生命內成長等方面，有任何進一步的可能性。再者，決定死亡的時刻，這是充當天主的做法。為此，「墮胎、安樂死和惡意自殺（…）都有辱人類的文明。這些罪孽固使受之者含羞蒙辱，但尤其這玷汙的主使者，同時又極其違反天主的光榮。」[29]

四、文化上的障礙使每個人類生命的神聖價值被遮蔽

每一個人類生命都具有深奧的本質價值，當我們在探知這價值時會遇到種種障礙，其中首先能削弱我們這探知能力的，是在於「有尊嚴的死亡」這個主張。它以「生活品質」作標準來衡量生命，從功利主義的人類學觀點來看，認為「生活品質主要與經濟資產、『健康』、物質生活的美好和享受有關，而忘記了存在的其他幅度，即更深奧的，人際關係、靈性和宗教等方面。」[30] 從這個角度來看，由個人或第三者為生命價值做判斷，他們量度某種特定的心理或身體功能，計算一人擁有或缺乏它們的程度，又或者他們有時只完全計算其心理上的不適，結果只要這麼的品質符合他們可接受的程度，那個生命才被視為有價值的。根據這種觀點，一個生命如果它的品質似乎是貧乏的，便不值得繼續活下去。如此，

29梵蒂岡第二屆大公會議，《論教會在現代世界牧職憲章》（1965年12月7日），27：《宗座公報》58（1966），1047~1048。

30教宗方濟各，2014年11月15日在義大利天主教醫師協會成立70周年紀念會議上對參與者演說：《宗座公報》106（2014），976。

人類生命不再被認為有其本身的價值。

第二個障礙是對「憐憫」的錯誤理解，它遮蔽了我們認知人類生命的神聖性。[31] 面對看似「難以忍受」的痛苦，以「憐憫」的名義終止病人的生命是合理的。這所謂「富於憐憫的」安樂死，它認為死亡比受苦更好，而透過安樂死或協助病人自殺，這樣是富於憐憫的做法。事實上，人類的憐憫不在於導致死亡，而在於懷抱病人，於困難時支持他們，給他們關愛和關注，並設法為他們減輕痛苦。

第三個因素是在人際關係中日益增長的個人主義，它阻礙人認識自己以及他人的生命價值－－他人被視為一種對自己的自由的限制或威脅。這種心態源於「新白拉奇主義（*neo-pelagianism*），其中個人具有極端的獨立自主，他認為可以自救，不承認在自己的最深處，是依賴著天主和其他人（……）。另一方面，某種新唯識論（*neo-gnosticism*）提出了一種救贖的模式，這模式僅僅只有內在性，它受其自身的主觀主義所封閉」，[32] 它希望使人擺脫身體的限制，尤其是當身體脆弱和患病的時候。

31參閱：教宗方濟各，2019年9月20日對醫師及牙醫會的國家聯會演說：羅馬觀察報，2019年9月21日，8：「有些選擇並非是人自由的表達，雖然它們看來似是的，當它們包括丟棄病人這個可能性，或者當病人為了死亡而請求協助時，對他們發出了錯誤的憐憫，這樣的選擇都是草率的。」

32教廷信理部，《依照天主的計劃》（*Placuit Deo*）信函（2018年2月22日），3：《宗座公報》110（2018），428~429。參閱：教宗方濟各，《願祢受讚頌》通諭（2015年5月24日），162：《宗座公報》107（2015），912。

特別是個人主義，它是當代最隱蔽的弊病——獨享或隱私——的根源。[33] 在某些操控的環境下，個人主義變成了主題，甚至作為一種「獨享權」。憑據人的自主性和「允許－同意原則」（principle of permission-consent），在某種不適或患病的情況下，它可以擴展到人是否選擇可以繼續生存。這種「權利」是安樂死和協助自殺的基礎。這主義的基本想法是，那些察覺自己處於依賴的狀態的人，他們無法實現完滿的自主性及未能發揮互助的能力時，此時對他們作出照顧，是對他們的一種**恩惠**。如此，善的概念被簡化為一種社會協議：每個人所得到的治療及援助，是出於自主能力或社會與經濟上能夠供應他們的，亦或是權宜應急之計。結果，在面對生命最困難的時刻和決擇時，一旦欠缺了超性的愛德，也欠缺了人類的精誠團結、社會的支持，人際關係則變得貧乏且脆弱。

忽略人際關係和善的重要性，只會逐漸削弱生命的終極意義，它促使生命受到操縱，甚至透過法律使安樂死合法化，結果導致病人死亡。這樣的行為扭曲了人際關係，也引致對病人的照顧變得極漠不關心。在這種情況下，在現實中一些絕對是必須履行的基本照顧，例如為無意識狀態的末期病人餵食和補水等，都產生了毫無根據的道德困境。

33參閱：教宗本篤十六世，《在真理中實踐愛德》通諭（2009年6月29日），53：《宗座公報》101（2009），688。「一個人所經歷的最貧窮情況，莫過於被孤立。我們若細察其他形式的貧窮，包括物質上的貧窮，可知它們都是因被孤立、得不到愛或難於愛人所致。」

關於這一點，教宗方濟各曾經談到一種「用完即棄文化」[34]，其中受害者是最弱小的人，當制度不惜一切代價追求功效時，他們很可能會遭受「丟棄」。這種文化現象深深違反了人類的精誠團結，教宗若望保祿二世將其描述為「死亡文化」，它導致真正的「罪的結構」[35]，僅出於「感覺更好」這個目的，它能夠使人執行一些本身是錯誤的行為。在善與惡之間混淆的領域中，更要帶著超越的承諾並對超越保持開放，應該理解每一個人類生命都具有獨特且不可重現的價值。在這種廢棄和死亡的文化中，面對照顧末期患者的挑戰，安樂死和協助自殺成為了錯誤的解決方案。

五、教會的訓導

1. 禁止安樂死和協助自殺

教會肩負她的使命，向信徒傳達贖世主基督的恩寵和天主神聖的誡律，這些都已在自然道德律的規律中辨別了出來。關於安樂死和協助自殺，教會為了排除教會訓導當局在訓導上所有含糊不清，即使在已合法化這些行為的國家或地區，教會是有責任要介入的。

特別在發放醫療臨終協定等，例如「**不施行心肺復甦術**」（*Do Not Resuscitate Order*）或「**維持生命醫令**」（*Physician Orders for Life Sustaining Treatment*）——當中所有變更取決於國家的法律和實際情況而定——最初的想法是，這些指令作為工具，為了避免在生命末期時使用侵入性治療。如今，當病人處於最危重時期，有關保護其生命的職責方面，這些協定引起了嚴重的問題。一方面，病人所作的聲明表達要自決，使得醫護人員越來越感到束縛，這種自決剝奪了醫師捍衛生命的自由和責任，即使當時他們是能夠做的。另一方面，在某些醫療的設定底下，近來引起關注的是這些協定被廣泛濫用，以安樂死的觀點為重。結果，關於如何照顧病人的最終決定，並未諮詢病人或家屬，尤其在安樂死合法化的國家。對於提供照顧的責任，臨終法律內留有寬闊且含糊其詞的空間。

基於這些原因，教會深信有必要重申教會的最終訓導：安樂死是**一種對抗人類生命的罪行**，因為在這行為中，有人選擇直接導致另一個無辜者的死亡。安樂死的正確定義並不取決於考慮善或價值等利害關鍵，而在於適當地具體指出那個**道德對象**——是否「為了消除一切痛苦而有所作為或有所不為，這些作為或不為的本身都會導致死亡，或因有意圖執行而導致死亡。」[36]「因此安樂死的發生是在於意向和所運用的方法。」[37] 對於

34參閱：教宗方濟各，《福音的喜樂》宗座勸諭（2013年11月24日），53：《宗座公報》105（2013），1042；另見同上，2013年12月7日對「*Dignitatis Humanae Institute*」代表團演說：《宗座公報》106（2014），14~15；同上，2014年9月28日教宗與年長者會面：《宗座公報》106（2014），759~760。

35參閱：教宗若望保祿二世，《生命的福音》通諭（1995年3月25日），12：《宗座公報》87（1995），414。

36教廷信理部，《教會對安樂死的聲明》（1980年5月5日）II：《宗座公報》72（1980），546

37教宗若望保祿二世，《生命的福音》通諭（1995年3月25日），65：《宗座公報》87（1995），475；參閱：教廷信理部，《教會對安樂死的聲明》（1980年5月5日），II：《宗座公報》72（1980），546。

安樂死及其後果的道德評價，並不取決於權衡某些理據，即有些人認為可以視乎情況和病人的痛苦，使到結束病人生命成為正當的做法。生命的價值、自主權和決策能力，與生活品質本身並不在同一個水平上。

因此在任何情況下，安樂死都是本質上邪惡的行為。過去教會曾經以最終的方式確認了「安樂死是**嚴重地違反天主的法律**，因為那是故意殺人，是道德上所不容的。這個教理是基於自然道德律和形之於文字的天主聖言，為教會傳承遞達，是一般的、普遍的訓導權所講授的。安樂死所牽涉到的罪惡，（視情況）跟自殺或謀殺罪是一樣的。」[38] 在**各種形式上或物質上與安樂死的直接合作**都是對抗人類生命的嚴重罪行——「任何權威都不能合法地建議或允許這種行為。因為這是違反神律的問題，是侵犯人性尊嚴的罪，一種對抗人類生命的罪行及對人性的攻擊。」[39] 因此，安樂死是一種謀殺行為，任何目的都無法使這行為變為正當，也無法容忍以任何形式作同謀、主動或被動的協助。據此，那些批准安樂死和協助自殺法律的人成為了這嚴重罪行的幫兇，招致其他人將執行這種罪行。他們亦負有壞榜樣的罪責，因為藉著這些法律，甚至在信徒們中，他們都助長了人們對良心有所曲解。[40]

每個人的生命都具有相同的價值和尊嚴：對別人生命的尊重及對自己生命的尊重，兩者是同等的。一個人完全放肆地選擇結束自己的生命，他破壞了與天主及與別人的關係，也棄絕了自己作為一個道德的主體。而協助自殺則加劇了這一種行為的嚴重性，因為它在自己絕望中涉及另一個人。這另一人被誘導，使到他的意志離開了在屬神的望德中天主的奧祕，如此他拒絕承認生命的真正價值，並且破壞了建立人類大家庭的盟約。在自殺行為中加以協助，是在一個非法的行為上，實行了不正當的合作。這做法否定了我們與天主的超性關係以及與他人的道德關係，在這道德關係內，我們與他人團結在一起，一同分享生命的恩賜和存在的意義。

因為憂慮和絕望而要求實施安樂死[41]，「雖然在這種情形下，個人的罪過可減輕，甚或完全無罪，可是良心所做的錯誤判斷，即便是出於善意，也不能改變謀殺行為的本質，此行為本身就該受到責斥。」[42] 協助自殺也是如此。這樣的行為絕不是對病人的真正服務，而相反是幫助他死亡。

安樂死及協助自殺永遠都是錯誤的選擇：「醫務工作人員和其他醫護人員——要忠誠地履行那『常為生命服務，並且協助生命直到盡頭』的任務——不可以讓自己

38教宗若望保祿二世，《生命的福音》通諭（1995年3月25日），65：《宗座公報》87（1995），477。這是一個徹底明確的教義，教會在其中行使了她的不可錯誤性；參閱：教廷信理部，1998年6月29日《教義評論——宣信辭的總結禮規》（*Doctrinal Commentary on the Concluding Formula of the Professio Fidei*），11：《宗座公報》90（1998），550。

39教廷信理部，《教會對安樂死的聲明》（1980年5月5日），II：《宗座公報》72（1980），546。

40參閱：《天主教教理》2286條。

41參閱：《天主教教理》1735 及2282條。

42教廷信理部，《教會對安樂死的聲明》（1980年5月5日），II：《宗座公報》72（1980），546。

參與任何安樂死的行為，不論是關注團體所要求的，或更不用說是病人家屬的要求，都不可以參與。事實上，人沒有任意丟棄生命的權利，因此沒有一個醫護人員可以被逼去執行一個不存在的權利。」[43]

因此，為安樂死及協助自殺建立理論、決定落實它或實踐執行它的人來說，**安樂死及協助自殺就是失敗**。[44]

正因為這理由，如使安樂死合法化而頒布法律，或者承認自殺是合理的並鼓吹自殺，都是極其不公義的，因為兩者借助了一個錯誤的權利選擇了死亡，僅只因為是所選擇罷，便不恰當地視之為可敬的行為。[45] 此類法律沖擊了法律秩序的基礎：生命權支撐著所有其他的權利，包括行使自由。這些法律的存在深深地傷害了人際間的關係和正義，並威脅了人與人之間的相互信任。協助自殺和安樂死的合法化標誌著法律制度的退化。教宗方濟各提醒地指出「當前的社會文化背景正逐漸侵蝕人類對於何為珍貴的生命的知覺。事實上，人們越來越基於它的效能和效用為生命作出評價，以至於將不符合該標準的人視為『丟棄的生命』或『不相稱的生命』。在這種喪失了真正價值的情況下，人類必須履行的責任，即團結及人類與基督徒的友愛都未能做到。在現實上，如果一個社會，發展出針對廢棄文化的抗體；承認人類生命的無形價值；確實實踐並維護團結作為共同生活的基礎，那麼這個社會就值得享有『公民』的地位。」[46] 世界上有些國家，已經有數以萬計的人死於安樂死，其中許多人是因為他們表現心理上的痛苦或患有憂鬱。由醫師方面呈報所知，安樂死的做法經常被濫用，一些從來沒有渴求安樂死的人，他們的生命卻遭受終止。有許多個案，作出死亡的要求本身就是一個病徵，由於孤立和身體不適使得這病情更為嚴重。教會在這些困難中辨別出一個靈性淨化的機會，當人把希望專注於天主，而且只有在天主之內時，這個希望便成了真正屬神的望德。

基督徒必須向病人提供所需要的援助，讓他們離開絕望，而不要縱容一種虛價的見義勇為心態。「不可殺人」的誡命（出廿13；申五17）事實上是天主**對肯定生命而作的保證**，而這「就成了邀請人顯示關懷的愛情，保護愛惜人的生命」的召叫。[47] 因此，基督徒知道俗世生命並不是至高的價值，最終的幸福在於天上。如此，當死亡明顯臨近時，基督徒不會期望繼續肉身的生命。基督徒必須幫助臨終者擺脫絕望，並將希望寄託在天主之內。

從臨床的角度而言，使人決意要求安樂死和協助自殺的主要因素，是無法控制的痛楚，以及喪失了做人的希望和屬神的望德。這是因為照顧病人的主要照顧者，他

43宗座醫護人員牧靈輔助委員會，《新醫護人員約章》（*New Charter for Health Care Workers*）第169條。

44參閱：同上，第170條。

45參閱：教宗若望保祿二世，《生命的福音》通諭（1995年3月25日），72：《宗座公報》87（1995），484~485。

46教宗方濟各，2020年1月30日對教廷信理部全體會議的參加者演說：羅馬觀察報，2020年1月31日，7。

47教宗若望保祿二世，《真理的光輝》通諭（1993年8月6日），15：《宗座公報》85（1993），1145。

們經常未能為病人提供足夠在心理和靈性上的協助所致。[48]

經驗證明，「當然重病的人有時會要求結束自己的生命，但我們不能以為那就表示他真的希望安樂死；事實上，這常是一種渴望獲得愛和幫助的哀求。病人除了接受醫療外，還需要愛，需要在他周圍的人，父母及子女、醫師及護理師，給他本性和超性的溫暖。這不但是病人的需要，也是他應得的。」[49] 一個病人，被人和基督的臨在所包圍，這裡充滿著愛，他便能夠克服各種形式的憂鬱，他不必因為孤單而感到悲痛，他也不會被遺棄於痛苦及死亡之中。

人不僅是在生物學的一種情況下經驗痛苦，所以為了使它變得可以忍受而治療它，而是由於人是身體和靈魂的合一，當人面臨肉身生命的終結時——痛苦是人類易受傷害性的奧祕，一個難以承受的事。

因此，疼痛和痛苦難免是走進「生命盡頭」的預兆，而只有對死亡本身的意義作出重新表達，此才能享有尊嚴——讓死亡向永恆生命的界域開放，並且確認每一個人都具有超驗的命運。事實上，「痛苦是比疾病**更廣闊**，更繁複，同時更深深地植於人性的本身。」[50] 憑藉

48參閱：教宗本篤十六世，《在希望中得救》通諭（2007年11月30日），36、37：《宗座公報》99（2007），1014~1016。

49教信理部，《教會對安樂死的聲明》（1980年5月5日）II：《宗座公報》72（1980），546。

50教宗若望保祿二世，《論得救恩的痛苦》牧函（1984年2月11日），5：《宗座公報》76（1984），204。

恩寵的幫助，這種痛苦能夠像基督在十字架上所受的痛苦一樣，在神聖的愛德內活生生地展現出來。

為慢性和末期病患者提供協助的人，他們必須能夠「知道如何逗留」在那些對死亡感到極度憂慮的人身邊，要保持警醒，為「安慰」他們，當他們孤單時要跟他們在一起，要成為持久的**同在**，灌注他們希望。[51] 藉著靈魂的親密關係所發之信德和愛德，照顧者可以體驗到另一個人的痛苦，他們可以與弱小者開啓一個親切的關係，生命的界域擴展，使生命超出死亡之外，成為了一個充滿希望的臨在。

「與哭泣的一同哭泣」（羅十二15）：因為有福的人是那個會憐憫別人，會為別人哀慟垂淚的（參閱：瑪五4）。在精誠團結中彼此分享人性的狀況之下，人們也分享通往天主的旅程，結成一種盟約，使他們能夠共睹超越死亡的光，在這種關係裡，愛得以實現，痛苦也具有了意義。[52] 醫療護理服務在醫師與病人之間的治療性盟約內運作－－醫師與病人都承認生命的超值和痛苦的神祕意義，於此他們彼此結合。按照這個盟約，良好的醫療護理服務會受到重視，而能夠掃除現今流行的功利主義及個人主義。

51參閱：教宗本篤十六世，《在希望中得救》通諭（2007年11月30日），38：《宗座公報》99（2007），1016。

52閱：教宗若望保祿二世，《論得救恩的痛苦》牧函（1984年2月11日），29：《宗座公報》76（1984），244：「是『近人』的人，不能無動於衷的看到別人受苦而從一旁走過去：這是人類間休戚相關的基本，也是愛近人的基本。他必須『逗留』，『同情』，一如福音比喻中所講的撒瑪黎雅人。這比喻表達了極深的基督真理，同時也是非常的合乎人性。」

2. 拒絕採用侵入性治療的道德負任

教會訓導指出，當人臨近塵世生命的結束時，人性尊嚴使人有權利保持正當的人性及基督徒的尊嚴，盡可能安祥地死去。[53] 透過採用「侵入性治療」促成死亡或延遲死亡的來臨，會使死亡喪失了其應有的尊嚴。[54] 現今的醫學可以延遲死亡的來臨，但往往對病人沒有真正的好處。當無法避免死亡時，只要照樣給病人正常的照顧，可以依據科學與良心，拒絕採用希望極小或令人痛苦的方法來延長生命，這樣是合法的做法。[55]，但是停止為病人供應維持基本生理機能所需的治療是不合法的，只要身體是可以從中得到益處（如補水、提供營養、調節體温、相稱的維持呼吸技術、以及其他種類的輔助，以保持身內平衡及止痛）。停止為病人採用無效的治療，**絕對不得包括撤消治療性的照顧**。這樣的澄清是必不可少的。因為鑑於近年有許多法庭案件，它們導致從危重病人身上撤消照顧（並使他們提早了死亡），這些病人是處於危重關頭，但並非末期病患，卻遭判定要停止為他們提供維生照顧，這些照顧確不能改善病人的生活品質，卻是維持生命的照顧。

對於採用侵入性治療這具體情況，就此要重申表明，棄絕採用「特殊的」及／或「不相稱的」醫療方法，「並不等於自殺或安樂死；而是表示能在死亡面前接受人類的限度」[56] 或是一個經深思熟慮而作出的決定，該放棄不相稱的醫療方法，它們幾乎沒有取得積極效果的希望。棄絕採用這些希望極小及痛苦的治療來延長生命，亦可表明對臨終者意願的尊重。臨終者的意願在**預設醫療**指示中表達，然而，**無論如何要排除每一個安樂死或自殺性質的行為**。[57]

相稱原則是指對病患者的整體福祉而言。當我們運用它在各種價值（例如生命與生活品質）之間進行選擇時，如果不考慮維護人的完整性、善的生命、以及行為的真正道德對象，便會陷入道德的錯誤判斷。[58] 每一個醫療

53參閱：教廷信理部，《教會對安樂死的聲明》（1980年5月5日），IV：《宗座公報》72（1980），549~551。

54參閱：《天主教教理》2278條；宗座醫護人員牧靈輔助委員會，《新醫護人員約章》（*New Charter for Health Care Workers*）第119條；教宗若望保祿二世，《生命的福音》通諭（1995年3月25日），65：《宗座公報》87（1995），475； 教宗方濟各，2017年11月7日在世界醫師協會的歐洲區域會議上給參加者的訊息。「即使我們知道，我們總不能保證他們可以痊癒或根治，然而我們有能力並且必須時刻對生命關懷，不會縮短他們的生命，也不會徒然的阻止他們死亡」；宗座醫護人員牧靈輔助委員會，《新醫護人員約章》（*New Charter for Health Care Workers*）第149條。

55參閱：《天主教教理》 2278條；參閱：教廷信理部，《教會對安樂死的聲明》（1980年5月5日），IV：《宗座公報》72（1980），550~551；教宗若望保祿二世，《生命的福音》通諭（1995年3月25日），65：《宗座公報》87（1995），475；宗座醫護人員牧靈輔助委員會，《新醫護人員約章》（*New Charter for Health Care Workers*）第150條。

56教宗若望保祿二世，《生命的福音》通諭（1995年3月25日），65：《宗座公報》87（1995），476。

57參閱：宗座醫護人員牧靈輔助委員會，《新醫護人員約章》（*New Charter for Health Care Workers*）第150條。

58參閱：教宗若望保祿二世，《向研究負責任生殖研討會的參與者致詞》（*Discorso ai partecipanti ad un incontro di studio sulla procreazione responsabile*）（1987年6月5日）第一條：教宗若望保祿二世的教導（*Insegnamenti*）X/2，（1987），1962，「談及『在價值上或者在善上發生的衝突』，並因此需要在它們之中作出某種『平衡』，即是選擇某一種而否認另一種，在道德上是錯

行為都必須以促進人類生命為目標（這是道德行駛者所意欲的），而絕不是追求死亡。[59] 醫師從來不是僅僅的執行者，只顧執行病人或其法律代表的意願，相反他持守的權利和責任，他用良心辨別出與道德善背道而馳的行為，從而按照自己的意願，拒絕參與其中任何的過程。[60]

3. 基本照顧：營養和補充水分的需要

為病危和末期病患者提供援助，有一個基本且不可逃避的原則，就是對病人基本的生理功能作出持續性的照顧。特別是每一個人必需的基本照顧，包括為他輸送所需要的養分及液體，以維持他身體內的平衡狀態，直至明確證實所提供的已達到了目的，即已為病人補充足夠水分和營養為止。[61]

當所供應的營養和水分不再使病人受益時，因為他們的有機體無法吸收養料，或者無法進行代謝，則應中止為他們輸送。這樣做不是違法的。病人沒有因為缺乏對身體機能極其重要的水和營養而提早死亡。相反這是在大和末期病患時，對疾病自然的病情有所尊重。向一直要靠糧食的病人撤消為他們供應所需是不公義的做法，這樣做會為病人帶來極大的痛苦。嚴格來說，營養和補水並不是醫學治療法，這些治療法在於對抗一些折磨病人的病理狀況。相反，它們是照顧病人所必須履行的方式，代表在臨床上對病人作出基本的回應，亦是一個無可避免的人性回應。這種必須供應營養和補充水分的義務，有時可以用人工的方法輸送，[62] 只要這些方法不會對病人造成傷害或帶來無法忍受的痛苦。[63]

4. 緩和治療

我們對病人負有持續照顧的責任，**持續性的照顧**，並體會病人的各種需要：護理的需要、緩解疼痛以及感情和靈性上的需要。由豐富的臨床經驗中得到證明，當病人經歷最受折磨、在瀕臨死亡的痛苦、慢性病及末期病患時，緩和醫學是照顧病人的寶貴和至關鍵的工具。**緩和醫療**是人及基督徒所施予的關懷的真實表達，是富於憐憫地「留在」受苦者身邊的有形象徵。它的目標是「減輕在疾病最後階段時的痛苦，同時確保病人得到適當的人性陪伴」[64]，並且運用有尊嚴的方法，盡能力

誤的。」

59參閱：教宗若望保祿二世，1978年12月28日對意大利天主教醫師協會演說：教宗若望保祿二世的教導（*Insegnamenti*）1，（1978），438。

60參閱：宗座醫護人員牧靈輔助委員會，《新醫護人員約章》（*New Charter for Health Care Workers*）第150條。

61參閱：教廷信理部，2007年8月1日對美國天主教主教會議就有關人工營養及水分等問題作出回應，《宗座公報》99（2007），820。

62參閱：同上。

63參閱：宗座醫護人員牧靈輔助委員會，《新醫護人員約章》（*New Charter for Health Care Workers*）第152條。「營養和補充水分，即使是利用人工的方法輸送，當未能證實這些供應會造成過分的負擔，或者未能證實它們毫無益處時，都屬於對臨終者應有的基本照顧。因此，不合理中止這項照顧就等於一個真正的安樂死行為。『食物及水的供應，即使以人工方法輸送，原則上是維持生命的常規和相稱的方法。因此，是有責任必須供應食物和水，到達一個程度及維持一段時間，直到能夠顯出這做法完成了其正確目的為止，即是能夠為病人補充水分及供應養料。這樣做，可以避免由於飢餓和脫水所致的痛苦及死亡。』」

64教宗方濟各，2015年3月5日對宗座生命學院全體參加者演說：

去改善病人的生活品質及整體的幸福。我們從經驗所得，利用緩和治療大大減少了要求安樂死的人數。為此，這裡需要一個堅定的承諾，在可能的財政範圍內，將緩和治療擴大到需要這些服務的人，並在生命的末期為病人提供協助。而患上慢性病或退化性病變的病人，醫師預測病情會有複雜的發展，為病人和家屬來說，這些都是負面的而且痛苦的，在這方面，緩和醫療該作為一個綜合**護理照護方針**，全面地照顧他們。[65]

緩和醫療應包括對病人及其家人的靈性關懷。這樣的關懷激發末期病患者及家人對天主的信德與望德，幫助家人接受所愛的人離世。這是牧靈工作者及整個基督徒團體必須付出的貢獻。根據慈善撒瑪黎雅人的模範，接受克服否認，而希望勝過憂苦。[66] 尤其是當病人垂死時，病人所受的痛苦會因為病情惡化而延長。在這個階段裡，為病人找出有效的止痛方法，好使他們能夠面對疾病與死亡，而不必擔心遭受無法忍受的疼痛。如此的照顧必須加上弟兄友愛的支持，以減少病人在困難當中由於缺乏足夠的支持或理解而感到孤單。

緩和醫療無法為遭受痛苦的人提供根本的答案，它亦不能從人類的生活中徹底杜絕痛苦。[67] 考慮聲稱能為痛苦

《宗座公報》107（2015），274。參閱：教宗若望保祿二世，《生命的福音》通諭（1995年3月25日），65；《宗座公報》87（1995），476；參閱：《天主教教理》2279條。

65參閱：教宗方濟各，2015年3月5日對宗座生命學院全體參加者演說：《宗座公報》107（2015），275。

66參閱：宗座醫護人員牧靈輔助委員會，《新醫護人員約章》（*New Charter for Health Care Workers*）第147條。

67參閱：教宗若望保祿二世，《論得救恩的痛苦》牧函（1984年2

找到答案，相反會產生假希望，也會在痛苦當中造成更大的絕望。醫療科學能夠更好地理解身體上的疼痛，並能有效地配置最佳的技術資源來治療疼痛。但是，疾病末期給病人帶來極度痛苦時，他尋求的是超出純粹技術水準的照顧。「*Spe salvi facti sumus*」——聖保祿宗徒說：在希望中，在對天主超性的望德中，我們得救。（羅八24）

「希望之酒」是基督信仰在照顧病人方面的具體貢獻，是指天主戰勝世間上邪惡的方式。在遭受痛苦時，病人應該可以體驗到團結和愛，他們承擔著痛苦，給予生命一種超越死亡的意義。這些都具有重大的社會意義：「一個無法接受受苦成員的社會，無法藉『同情』分擔他們的痛苦，並默默予以支持，那些是一個殘酷而不人道的社會。」[68]

但是我們應該承認，近年來對於緩和醫療的定義有時候會有模棱兩可的涵義。在某些國家，規範著紓和治療的國家法律（Palliative Care Act）以及有關「臨終生命」的法律（End-of-Life Law：臨終生命法），連同所提供相關的紓和醫療，有時被稱為「為臨終者的醫療援助」（Medical Assistance to the Dying / MAiD）的方案，當中能包括要求安樂死和協助自殺的可能性。這樣的法律條文引起了嚴重的文化上的混淆：即是在緩和醫療內，

月11日），2：《宗座公報》76（1984），202：「痛苦看來屬於人的超越性：以某種意義說，這是人『注定』超越自己的事件之一，他以神秘的方式被召到一個超越的境界。」

68教宗本篤十六世，《在希望中得救》通諭（2007年11月30日），38：《宗座公報》99（2007），1016。

包含為自願死亡者提供綜合的醫療援助，意味著要求安樂死或協助自殺在道德上是合法的了。

此外，在這種法例管制的框架下，為減輕重症或末期病患者的痛苦，所採用的緩和治療可能包括施行一些藥物，意圖加速死亡，甚至在死亡尚未迫近時，也中止或暫停為病人補水和提供營養。事實上，這種做法等同於**導致死亡的直接作為或不作為，因此是不合法的**。這種法律和一些國家及國際性的專業團體所訂立的科學準則，正在日益廣泛傳播，對許多人構成了不負責任的社會性威脅，包括越來越多弱勢群體，他們本來只需要得到更好的照顧和安慰，但反而被引導去選擇安樂死和自殺。

5. 家庭及善終中心的角色

家庭的角色是照顧末期病患者的核心。[69] 在家庭中，除了家人的樂於幫助，亦或為其成員帶來喜樂外，人也能夠依靠當中的穩固關係而珍視自己。必要的是，被照顧的病人不會感到自己是負擔，而是能夠感受到親人的親密關係和支持。為完成這項任務，家庭需要得到幫助和足夠的資源。當政府承認家庭具有此首要的、基本的和不可替代的社會功能時，政府應該作出承擔，扶持家庭提供所必需的資源，並且建立有關體制。此外，蒙受基督感召的醫療機構應把家庭作出的人性和靈性的陪伴，納入到**關懷病人的統一照顧計劃**內。這點是不應該忽視的。

69參閱：教宗方濟各，《愛的喜樂》宗座勸諭（2016年3月19日），48：《宗座公報》108（2016），330。

僅次於家庭的**善終中心**，接納末期病人，並確保要照顧他們直至生命的最後一刻，這些中心為病人提供了重要而寶貴的服務。畢竟「基督徒對死亡及痛苦的奧祕所作出的回應，不是為提供解釋，而是一種臨在」[70] 這種臨在擔負著痛苦，陪伴著痛苦，為痛苦帶來充滿信任的希望。這些中心是社會真正人性的典範，它們是聖所，在其中痛苦充滿了意義。因此，在這裡必須要僱用合格的工作人員，應具備適當的資源，並時刻歡迎家庭的參與。「在這點上，我覺得善終院舍為緩和醫療做得相當好，在這裡有合格的醫療、心理及靈性的支援陪伴著末期病人，使他們在塵世的最後階段能夠具有尊嚴地生活，在親人的親密關係下得到安慰。我希望這些中心繼續在承諾之中，成為奉行『尊嚴療法』的場所，從而培育愛，並對生命尊重。」[71] 在這種環境，以及在天主教的設施裡，醫護人員和牧靈工作者除了在臨床上要有足夠能力可以勝任外，他們還應該實踐一個真正的信德與望德的超性生命，朝向天主，因為它是使臨終旅程得以人性化的最高形式。[72]

6. 產前及兒科醫學裡的陪伴與照顧

關於對患有晚期慢性退化疾病，或處於生命末期的初生嬰兒及兒童作照顧，我們有必要重申以下說明，了解有需要實施一流的計劃，確保兒童及其家人的福祉。

70C. Saunders，*Watch with Me : Inspiration for a life in hospice care*，Observatory House，Lancaster，UK，2005，29。

71教宗方濟各，2020年1月30日對教廷信理部全體大會的參與者演說：《羅馬觀察報》，2020年1月31日，7。

72參閱：宗座醫護人員牧靈輔助委員會，《新醫護人員約章》（*New Charter for Health Care Workers*）第148條。

從受孕開始，患有畸形或其他病變的兒童就是**幼小的病人**，現今的醫學總是能夠以尊重生命的方式協助和陪伴他們。他們的生命是神聖的、獨一無二的、不可重複並且不可侵犯的，完全就像每個成年人一樣。

胎兒有患所謂「與生命不相容」——肯定會在短時間內導致死亡——的產前病變，當缺乏可以改善他們的治療時，我們都也不應該棄之不顧，對他們不施以援助，相反地他們必須像其他任何一個病人一樣獲得陪伴，直到他們自然死亡為止。**產前的安慰關懷**有助於行走**綜合援助**之途，包括醫護人員和牧靈工作者的支持，他們與家庭持續的臨在同行。孩子是一個特別的病人，他需要具有專業醫學知識和情緒技巧的專業人士所照顧。生命正處於末期的，是最脆弱的一群的孩子，要用同理心陪伴著他，目的是為孩子的歲月賦予生命，而非為孩子的生命給予歲月。

特別是，**產前善終**中心為一些家庭提供了必要的支持，他們將要迎接一個出生就脆弱中的孩子。在這些中心，有能力勝任的醫療援助、靈性陪伴、以及其他經歷過同樣痛苦及失去子女的家庭予以支持，這些都是不可少的資源。蒙受基督感召的醫護人員，應該努力向全世界廣泛地擴展這些中心，這是一個牧靈的責任。

鑑於目前的科學知識水準，對那些註定要在出生後不久或短時間內死亡的兒童，這種援助方式顯得尤其必要。為這些兒童提供照顧，可以幫助父母處理悲傷，並把這種經驗不僅視為損失，而是父母與子女一起經歷的，是

愛的旅途中的一個時刻。

不幸地，現今的主流文化並不鼓勵這種模式。有時候，過分訴諸於產前診斷，以及對殘疾人士的仇視文化，往往促使人們選擇進行墮胎，甚至將這行為描述為一種「預防」。墮胎在於蓄意殺害無辜者的生命，因此墮胎絕不合法。把產前診斷用於篩選目的違反了位格的尊嚴，這樣做嚴重地不合法，因為它表達了優生的心態。在其他產後的個案，由於孩子已有殘疾或將來可能出現殘疾，同樣的文化亦鼓勵在剛出生時中止或不展開對他照顧。這種功利主義的做法——不人道並且嚴重不道德——無法予以贊同。

兒科照顧的基本原則，是當兒童處於生命的最後階段時，他們有權利獲得位格應有的尊重和照顧。我們要避免採用侵入性治療，同時避免不合理地堅持某些治療，以及不會故意加快病人死亡。從基督信仰的角度來看，為一個末期病患的孩子的牧靈關懷與照顧，需要讓他在聖洗和堅振內分受神聖的生命。

兒童在不治之症的末期，一些針對他所患病變的藥物或其他治療可能受到中止。主診醫師會鑒定他的病情惡化，使得這些治療沒有效用或過於猛烈，並有可能帶來更多的痛苦。但是，在這種情況下，對兒童的各種生理、心理、情緒和靈性的全人照顧絕不能停止。所謂照顧，它蘊含比療法和治癒有更豐富的意思。當一項療法對不治之症患者再沒有益處而受到中止，其他維持兒童基本生理功能的治療則必須繼續，只要兒童能夠從中獲

得益處（如補水、提供營養、調節體温、相稱的維持呼吸技術、以及其他種類的輔助，以保持身內平衡及止痛）。對於任何被認為是無效的治療，當我們有意不再過於執著地施行它們時，這份意欲**不必牽涉要為病人撤消照顧**。一直陪伴病人走到死亡那刻，這條道路必須保持開放。例行的醫療介入，如輔助呼吸等，可以用無痛的和相稱的方法為病人提供。我們對生命有正義的關注，但有些痛苦本來是可避免的，卻被人不義地強添在病人身上，為了避免混淆，使兩者無法對比出差異，因此我們必須按照病人的個人需要，為他們安排適當的照顧。

在初生嬰兒或兒童患病的艱難時期，評估他們身上的疼痛並為他們進行治理，這樣做能夠表達對他們適當的尊重，以及為他們提供適當的協助，這份尊重和協助都是在此時他們應該得到的。如今，個人化的細心照顧已受到臨床兒科醫學所認證，這種方式在父母的陪伴下持續實踐，使到照顧的服務可以落實以綜合的管理形式運作，而這種治理方針比侵入性治療更為有效。

維繫父母與子女的情感關係是照顧過程中的一個不可或缺的部分。提供照顧方面和支援父母與子女方面，他們之間的聯繫對治療不治之症或末期病患是基本要有的，因此兩者應盡可能保持聯繫。除了給予情感上的支持外，屬靈的時刻也不容忽視。親近病童的人他們的祈禱具有超性的價值，這個價值超越了並且加深了彼此的感情關係。

「兒童的最大利益」的倫理／司法概念——當它以成本效益為照顧作出計算時——我們絕不能以這個概念作為下決定的基礎，即為了消除痛苦而決定要縮短孩子的壽命，當這些決定設想有所作為或不作為，它們在本質或意圖上是安樂死的。正如之前所述，中止對病人作不相稱的治療法，這不能是中止對他們作基本照顧（包括緩解疼痛）的正當理由，我們必須陪伴這些幼小的病人，直到他們有尊嚴地自然死亡，為這些快將與天主相遇的人，我們也不要中斷給予他們屬靈的關懷。

7. 鎮痛治療及喪失知覺

在醫護人員方面，某些專科的照顧需要他們作出特別的專注，及要求他們具有專門的能力水準，使得他們可以實踐在倫理的觀點上最佳的醫務工作，對正處於疼痛中的人作出關注。

為了減輕病人的痛苦，鎮痛治療會採用可導致喪失知覺（鎮靜）的藥物。一個深層的宗教意識使病人能夠在痛苦中生活，從救贖的角度視這種生活作為對天主的特別奉獻，[73] 然而，教會仍然確認，為了保證讓生命盡可能在最大平安中，也是在病人體內的最佳條件下走到盡頭，使用鎮靜劑為照顧病人的一部分，在道德上是合法的做法。這也適用於一些會加速病人死亡的治療（末期

73參閱：碧岳十二世，1957年2月24日致詞「*Allocutio. Trois questions religieuses et morales concernant l'analgésie*」：《宗座公報》49（1957），134~136；教廷信理部，《教會對安樂死的聲明》（1980年5月5日）III：《宗座公報》72（1980），547；教宗若望保祿二世，《論得救恩的痛苦》牧函（1984年2月11日），19：《宗座公報》76（1984），226。

時的深度紓和性鎮靜劑），[74] 而總該盡可能在病人的知情同意下使用。從牧靈的角度來看，應事先為病人提供靈性的準備，好使他們可以有意識地面對死亡，視死亡與天主的相遇。[75] 因此，使用止痛劑是照顧病人的一部分，但是任何直接和故意導致病人死亡的處方都是安樂死的行為，是不可以接受的。[76] 使用鎮靜劑必須排除殺

74參閱：碧岳十二世，1958年9月9日致詞「*Allocutio. Iis qui interfuerunt Conventui internationali. Romae habito,a «Collegio Internationali Neuro–Psycho–Pharmacologico» indicto*」：《宗座公報》50（1958），694； 教廷信理部，《教會對安樂死的聲明》（1980年5月5日）III：《宗座公報》72（1980），548；《天主教教理》 2279條；宗座醫護人員牧靈輔助委員會，《新醫護人員約章》（*New Charter for Health Care Workers*）第155條。「此外，止痛藥及麻醉劑有可能使臨終者喪失知覺。這樣的藥物值得受到特別的關注。當出現無法忍受的疼痛，它對典型的治理痛症療法呈現抗性，若已臨近死亡的一刻，或假如有充份理由預料在死亡一刻會出現具體的危象時，一個嚴正的臨床指示可以包括在病人的同意下使用能導致喪失知覺的藥物。當有臨床的需要時，在疾病末期使用這深度的紓和性鎮靜劑，在道德上是可以被接受的，條件是要得到病人的同意、為家人提供適當的資訊、排除了任何安樂死的意向、並且那病人已能履行其道德，家庭及宗教義務–『在走向死亡時，人必須能滿全他們的倫理責任和家庭義務，更重要的是，他們應該能在神志完全清醒的情況下，準備自己迎接天主。』所以，『沒有嚴正的理由而剝奪臨終者的知覺，是不正確的行為。』」

75參閱：碧岳十二世，1957年2月24日致詞「*Allocutio. Trois questions religieuses et morales concernant l'analgésie*」：《宗座公報》49（1957），145；教廷信理部，《教會對安樂死的聲明》（1980年5月5日）III：《宗座公報》72（1980），548；教宗若望保祿二世，《生命的福音》通諭（1995年3月25日），65：《宗座公報》87（1995），476。

76參閱：教宗方濟各，2014年11月15日在意大利天主教醫師協會成立70周年紀念會議上對參與者演說：《宗座公報》106（2014），978。

人的意圖作為其直接之目的，即使它可能使無法避免的死亡提早發生。[77]

在兒科的設定下，當一個兒童（例如是初生嬰兒）未有能力對事情作出理解，這裡必須指出，假定該兒童能夠忍受疼痛是錯誤的想法，而在實際上，是有為他們減輕疼痛的可行方法。提供照顧者有責任盡可能減輕孩子的痛苦，當他/她能夠感受醫護人員和最重要的是其家人，他們用愛臨在於自己當中，那麼他／她便能夠在平安內自然地死亡。

8. 植物人及微意識狀態

其他相關的情況是一些持續缺乏意識的病人，所謂「植物人」或處於「微意識狀態」中的病人。對於這些能夠自主呼吸的主體本身，假如認為植物狀態或微意識狀態是一些徵象，表示病人已經不再是一個人的位格——具有人之為人所有尊嚴的，這常是全然的錯誤。[78] 相反，

77參閱：碧岳十二世，1957年2月24日致詞「*Allocutio. Trois questions religieuses et morales concernant l'analgésie*」：《宗座公報》49（1957），146；同上， 1958年9月9日致詞「*Allocutio. Iis qui interfuerunt Conventui internationali. Romae habito, a «Collegio Internationali Neuro–Psycho–Pharmacologico»*」：《宗座公報》50（1958），695；教廷信理部， 《教會對安樂死的聲明》（1980年5月5日），，III：《宗座公報》72（1980），548；《天主教教理》2279條；教宗若望保祿二世，《生命的福音》通諭（1995年3月25日），65：《宗座公報》87（1995），476；宗座醫護人員牧靈輔助委員會，《新醫護人員約章》（*New Charter for Health Care Workers*）第154條。

78參閱：教宗若望保祿二世，2004年3月20日對「維持生命的治療和植物人狀態。 科學進展與道德困境」（*Life sustaining treatments and vegetative state. Scientific progress and ethical dilemmas*）國際代

在處於這些最弱勢的狀態下，這個人必須以位格的本質價值而得到承認，並要給予他適當的照顧。病人可以在這種極度痛苦的情況下存活多年，而沒有任何康復的機會，這個事實無疑給提供照顧者帶來痛苦。

我們絕對不要忘記在這痛苦的情況下，處於這些狀態的病人是有獲得營養和補充水分的權利，甚至可以透過人工的方法輸送，當這些方法符合常規方法的原則。在某些情況下，這類措施可能會變得不相稱，因為施行它們無法得到效果，或者它們涉及一些程序，當中會為病人造成過度的負擔，這些不良後果超過對病人的任何好處。

在這些原則的啟迪之下，提供照顧者的責任不僅包括病人，而且還延伸至家庭成員或主照顧病人者，這份責任應該包括在牧靈上為他們作出足夠的陪伴。必須要為家庭提供足夠的支持，他們為這些狀態的病人承擔著長期照顧的負擔，而這種支持應設法平息他們的灰心沮喪，並幫助他們，免得他們把停止治療視為唯一的選擇。提供照顧者必須為這種情況做好充分的準備，因為家庭成員需要得到適當的支持。

9. 醫護人員和天主教醫療機構方面的良心抗辯

面對安樂死或協助自殺的合法化——即使當它們簡單地被視為另外一種醫療援助形式——都必須排除正式或直接與它們在物質上的合作。這種情況為基督徒的見證提供了具體的機會，在這裡「聽天主的命應勝過聽人的命」（宗五29）。不論是自殺或是安樂死，我們都沒有權利：法律的存在，不是為了導致死亡，而是為了保護生命和促進人類之間的共存。因此，與如此不道德的行為合作，或以言語、有所作為或不作為暗示合謀，在道德上從來都是不合法的。病人的真正權利，是要獲得以真正的人性對他作陪伴和照顧。只有如此才能維護病人的尊嚴，直到他自然死亡的那刻。「因此，即使當事人在他還是完全清醒時要求安樂死，都沒有一個醫護人員可以為一個不存在的權利作其守衛者。」[79]

因此在這點上，重申了關於與邪惡合作（即是與非法行為合作）的普遍原則：「與所有善心人士一樣，基督徒受召叫，在重大的良心責任下，不得在實際行為上正式與違反天主法律的法律合作，即使國家的法律准許他如此做。的確，從道德立場來看，正式與邪惡合作常是不正當的。當一件行為，不論以其性質或在具體情況中所表現的形式來說，若能被界定為直接參與一件反對無辜生命的行為，或是同意主犯者之不道德的意向，那就是與邪惡合作。這種合作絕不能合理化，不論是以尊重他人自由為訴求，或是訴諸於民法准許或要求合作的事實。其實每一個人都應對他個人的行為負起道德責任；此責任無一人能豁免，天主也會按照這責任親自審判每一個人（參閱：羅二6；十四12）。」[80]

表大會的參與者演說，3：《宗座公報》96（2004），487：「一個人，即使病情嚴重或身體殘疾而無法運用最高的功能，他都是一個人，永遠會是一個人，並且永遠不會成為『植物』或者『動物』。」

79宗座醫護人員牧靈輔助委員會，《新醫護人員約章》（*New Charter for Health Care Workers*）第151條。

80同上，151條；教宗若望保祿二世，《生命的福音》通諭（1995年

各國政府必須承認在醫療及保健界別具有良心抗辯的權利，當中包括運用自然道德律，特別是在為生命服務時，都會喚起良心的聲音。[81] 在某些不承認這點的國家，公民可能要面對一個責任，是為了避免一錯再錯而違抗人律，因此人要培育自己的良心。醫護人員應毫不猶豫地提出自己享有這個權利，作為對大眾共同利益的具體貢獻。

同樣，醫療機構必須抗拒強大的經濟壓力，這些壓力有時候會誘使機構接受安樂死的做法。假如這些公共機構難於找到必需的營運資金，而為它們帶來極大的負擔，那麼，整個社會必須承擔額外的責任，以確保不治之症患者不會只靠著自己或家庭的資源。所有這些都要求主教會議、地方教會以及天主教團體和機構，在那些批准作安樂死和自殺的制度裡，要採取明確及統一的立場，以維護良心抗辯的權利。

教會團體在照顧病人方面效法慈善的撒瑪黎雅人的做法，而天主教醫療機構就是這做法的具體標誌。耶穌的誡命「要醫治病人」（路十9）不僅透過向他們覆手來成全，而且還要從街上拯救病人，在病人家中為他們提供協助，並建立對病人親切友善和接納他們的特別體系。教會忠信上主的誡命，她經過幾個世紀建立了各種體系，當中為病人提供全人的服務上，醫療服務找到它特殊的運作形式。

3月25日），74：《宗座公報》87（1995），487。

81參閱：教宗方濟各，2014年11月15日在義大利天主教醫師協會成立70周年紀念會議上對參與者演說：《宗座公報》106（2014），977。

天主教醫療機構受召要忠誠地作出責無旁貸的見證－－為道德的承諾，以及為構成天主教醫療機構身分的基本人性和基督價值作見證。這見證需要他們棄絕明顯的不道德行為，並聲明他們正式地嚴格遵守教會訓導當局的教導。對於那些授意天主教醫療機構運作的宗旨和價值，任何與它們不相符的行為，在道德上都是不可接受的。而且這樣做，也損害了該機構身為「天主教」的原本身分。

當相關者要為尋求安樂死的人作轉介時，此時與其他醫院系統作出機構之間的合作，在道德上是不容許的。即使法律上採納這麼的選擇，在具體實現中，此舉在道德上也不可被接納或受到支持。的確，對允許安樂死的法律，我們可以正確說「良心沒有遵守這種法律的義務；反而有重大而明確的責任，應以良心抗辯來反對這種法律。教會從一開始，宗徒的宣講就提醒基督徒，他們有責任服從合法的政府權柄（參閱：羅十三1~7；伯前二13~14），但同時也堅定地警告：『聽天主的命應勝過聽人的命』（宗五29）。」[82]

具有良心抗辯的權利，並不是指基督徒憑私下的宗教信念而拒絕遵守這些法律，而是由於這一個不可剝奪的權利，它對整個社會的共同利益是必要的。事實上，這些法律違反了自然律，因為它們漸漸削弱人性尊嚴及人類共存的最根基礎，這是源於公義的。

82教宗若望保祿二世，《生命的福音》通諭（1995年3月25日），73：《宗座公報》87（1995），486。

10. 牧靈陪伴和聖事的支持

死亡是人類與救主天主相遇的一個決定性時刻。教會奉召於這個時刻在靈性上陪伴著信友，給予他們祈禱中「醫治的資源」並為他們舉行聖事。以靈性的輔導使基督徒好好經驗這一刻，是一個至上的愛德行為。因為「任何信徒都不應在孤獨和被忽視中死去」，[83] 這愛德擁抱病人，以人類及人性化的關係給予病人實實在在的支持，陪伴他們並使他們見到希望。

慈善撒瑪黎雅人的比喻說明了與受苦近人應有的關係，也說明了應該避免的素質—漠不關心、冷漠、偏見、害怕弄髒自己的手、完全忙於自己的事務——及應該採納的素質——關注、聆聽、理解、憐憫和謹慎。

這個要仿效撒瑪黎雅人的邀請，要以他作為榜樣——「你去，也照樣做吧！」（路十37）——是一種勸言，讓我們不要低估人類於臨在、接納、洞察、能夠參與和投入參與方面的全部潛能，這些都是親近有需要的人時要求要具備的條件，也是為病人作全人照顧時所必具的能力。

對生命處在危重和末期病患的人獻上愛與關懷，這種素質有助於消除病人那個可怕的欲望，是他非常想結束自己生命的欲望。只有憑著人性的溫暖和福音的友愛，才

83教宗本篤十六世，2008年2月25日對宗座生命學院籌備的會議的參加者演說，主題為「親近不治之症病人和臨終者：科學和道德觀點」（*Close by the incurable sick person and the dying: scientific and ethical aspects*）：《宗座公報》100（2008），171。

能展示正面積極的界域，在希望和堅信當中給予病人支持。

這樣的陪伴是緩和治療所行的道路上的一部分，當中包括病人與他們的家庭。

家庭在照顧方面一直扮演著重要的角色，因為他們的臨在可以支持病人，而且在照顧病人方面，他們的愛相當於一個必要的治療因素。的確，我們記得教宗方濟各曾經講，家庭「至現今為止，它一直是最近的『醫院』；在世界上許多地方，醫院是為特許的少數人而設，而且往往設立得很遠。其實是母親、父親、兄弟、姊妹及代父母，他們保證照顧病人，並幫助病人得到治癒。」[84]

照顧他人或為受苦者提供照顧是一項承諾，它不僅涵蓋少數人，而且是對整個基督徒團體的。聖保祿宗徒肯定地說，當一個成員受苦時，那整個團體都遭受痛苦（參閱：格前十二26），而所有的都傾向病人，為他們帶來安慰。當面對任何人類孤寂或不適的處境時，每一個人就他或她而言，都是受召要成為一個給別人帶來「安慰的僕人」。

牧靈關懷包括履行人性和基督的**同理心**（en-pathos）及**憐憫**（cum-passio）的德行，透過分享痛苦而擔負別人的痛苦，也有**安慰**（cum-solacium）之德，走進別人的孤寂世界，使他們感到被愛、被接納、得到陪伴及支持。

84教宗方濟各，2015年6月10日《公開接見》（*General Audience*）：羅馬觀察報，2015年6月11日，8。

神父受召要獻上聆聽和安慰的事工，象徵著基督和教會富於憐憫的關懷，它能夠而且必須有明確的的任務。在這個必要的使命中，極為重要的是，神父要見證這位善牧的目光，祂永不止息地陪伴著祂所有的孩子，而神父也要使真理和愛德結合於這項事實。鑑於神父在病人的生命終結時，在牧靈、人性和靈性的陪伴上都處於中心的位置，因此對於這個範疇，他的聖職培育必須為他提供更新及精確的準備。同樣重要的是，神父們也在基督的陪伴下接受培育。有些特別的情況，神父可能難以親臨於病人床前，因此醫師和醫護人員也需要這方面的培育。

成為具有人類技能的男人和女人，意味我們對受苦的近人作出關懷的方式，應該是能幫助他們與生命之主相遇，祂是唯一能夠有效地將慰藉之油和希望之酒，傾注在人類傷口上的生命之主。

每個人的位格本性上都有被關懷的權利，此時正是一個人對所信奉的宗教的最高表達。

聖事的時刻，永遠是整個牧職對關懷照顧作出承諾的高峯，這時刻先於其他照顧，並且是隨後所有一切的源頭。

教會稱懺悔聖事和病人傅油聖事為「治療的聖事」[85]，因為它們在聖體聖事內達至頂峰，這個是永生的「天路行糧 （臨終聖體）」。[86] 藉著與教會的親密關係，病人可以體驗基督的親近，祂會在旅途中陪伴自己前往天父的家（參閱：若十四6）。教會也幫助病人不要陷於絕望，[87] 特別當旅途使人筋疲力盡時，[88] 教會在望德之中支持他們。

85《天主教教理》1420條。

86參閱：Rituale Romanum，*ex decreto Sacrosancti Oecumenici Concilii Vaticani II instauratum auctoritate Pauli PP. VI promulgatum, Ordo unctionis infirmorum eorumque pastoralis curae, Editio typica, Praenotanda*, Typis Polyglottis Vaticanis, Civitate Vaticana 1972，n. 26；《天主教教理》1524條。

11. 對尋求安樂死或協助自殺的人作牧靈判別

當在明確地要求安樂死或協助自殺的人作牧靈陪伴時，這一刻有必要重申教會的訓導。關於懺悔及和好聖事，告解神父必須保證當中有一個真心的痛悔，作為獲得**赦罪的必要有效成分**，在於「心靈的痛苦與對所犯之罪的憎惡，連同不再犯罪的決心」[89] 這情況，我們發現自己面對一個人，無論其主觀意向如何，他已決定進行一個嚴重的不道德行為，並甘願堅持這一個決定。這種狀態，明顯地缺乏了為領受赦罪的懺悔聖事[90] 及領受臨終聖體[91] 的傅油聖事[92] 的正確意向。這樣的悔罪者，只有當施行人辨識得他或她願意採取具體的步伐，表明他或她在這方面已經改變了決定時，才可領受這些聖

87參閱：教宗方濟各，《願祢受讚頌》通諭（2015年5月24日），235：《宗座公報》107（2015），939。

88參閱：教宗若望保祿二世，《生命的福音》通諭（1995年3月25日），67：《宗座公報》87（1995），478~479。

89特利騰大公會議 （第14次）《論懺悔聖事的教義》第四章：《公教會之信仰與倫理教義選集》，1676。

90參閱：《天主教法典》987條。

91參閱：《天主教法典》915條及843條1項。

92參閱：《天主教法典》1007條：「固執生活在顯著的重罪中的人，勿為其施行傅油聖事。」

事。因此，一個人可能在某機構中，為接受安樂死或協助自殺已作登記，他必須在領受聖事之前，表明有意取消這項登記。必須重申的是，有必要推遲為一個人赦罪，並不表示作了判斷要歸咎於其罪過，因為那個人的罪責是可以減輕的，甚或完全無罪。[93] 神父可以為沒有意識的人**有條件的**（*sub condicione*）施行聖事，基於病人先前發出的某些信號，神父可以推測得知他或她的悔改。

在這點上，教會的立場並不意味她不接納病人，她更是必須樂意去聆聽和幫助病人，加上為聖事的本質作出更深入的解釋，好使直到最後一刻，都能為病人提供機會，使他渴望並選擇領受聖事。教會仔細地深入尋找人歸依的充分跡象，因此信徒可以合理地要求領受聖事。推遲赦罪是教會的一種醫治行為，目的並非是譴責，而是要引導罪人悔改歸依。

當人並未處於可以領受聖事的客觀條件時，必須與這人保持接近。因為這種親近是一個轉化歸依的邀請，尤其是當所請求的或要接受的安樂死，不會立刻執行或未臨近執行時。此時，仍然有可能陪伴著他，可以重燃他的希望，改變他的錯誤決定，從而使他有資格可以領受聖事。

不過，在靈性上協助這些人的，他們應避免作任何的表現，例如一直逗留直至執行安樂死那刻等。因為他們這

93參閱：教廷信理部，《教會對安樂死的聲明》（1980年5月5日）II：《宗座公報》72（1980），546。

樣做，有可能被詮釋為贊同了安樂死，如此的臨在可以暗示他們是同謀，參與了該行為。這項原則應用於特定的情況，它適用於一些院牧，他們在實行安樂死的醫療制度內服務。但是，該原則也不局限於此地，因為這些院牧絕不能成為別人的惡表，他們不可以藉著所表現的態度，成為中止人類生命的同謀而立壞榜樣。

12. 醫護人員在培育及教育上的改革

在現今的社會及文化背景下，當保護處於最危重時期的人類生命時，會面對眾多的挑戰，此時教育扮演了關鍵性的角色。家庭、學校、其他教育機構以及堂區團體必須下定決心，喚醒我們對近人及他們的痛苦的敏感度，並使我們在這方面日趨完善，正如福音裡慈善的撒瑪黎雅人所表現的敏感度一樣。[94]

醫院院牧應加強對醫護人員（包括醫師和護理人員），以及醫院志工的靈性和道德培育，使得他們作好準備，為處於末期的生命提供必要的人性和心理上的協助。在整個患病的過程中，牧靈工作者及醫護人員要為病人及其家庭，在心理和靈性上提供關懷照顧，這個必須是他們的優先任務。

我們必須向世界各地廣傳緩和治療。為此，值得為醫護人員安排一些專門培育這方面的學術課程。同樣要優先的是，關於有效的緩和治療，我們要為它的價值發放準確的全面資訊，讓人可以有尊嚴地受到陪伴，直至他自

94參閱：教宗若望保祿二世，《論得救恩的痛苦》牧函（1984年2月11日），29：《宗座公報》76（1984），244~246。

然死亡為止。蒙受基督感召的醫療機構應為醫護人員籌劃一些服務指引，其中應包括一些適當的方法，讓他們提供心理、道德及靈性的協助，作為緩和治療必不可少的部分。

人性和靈性的輔助這些要素，必須再次納入對所有醫護人員的學術培育內，以及包括在醫院的培訓計劃裡。

此外，醫護及援助機構必須安排一些心理和靈性的輔助方案，為照顧末期病患的醫護人員提供幫助。**向照顧者表示關懷**是必不可少的，使得醫護人員和醫師不會承受所有的重擔，那些是不治之症患者的痛苦及死亡的重擔（這重擔能使醫護者**精疲力盡**）。他們需要得到支持和接受一些治療節數，不僅要調整自己的價值觀和感受，而且正當他們為生命服務，在面對痛苦和死亡時會經驗到萬分悲痛，這方面也該處理。他們需要對希望有強烈的感覺，加上意識到自己的使命是一個真正的召叫，當人的存在處於痛苦和末期時，讓他們陪伴生命的奧祕和恩典。[95]

95參閱：教宗方濟各，2016年6月9日對西班牙及拉丁美洲醫師演說「憐憫是醫學最根本的靈魂」（*compassion is the very soul of medicine*）：《宗座公報》108（2016），727~728。「脆弱、痛苦和體弱生病是每個人的艱難試煉，包括醫務人員；他們被召要有耐性，要與別人一同受苦；因此，我們絕不能屈服於功能主義的誘惑下，出於錯誤的憐憫或純粹以效用或成本效益作標準，而採用了迅速且極端的解決方案。人類的生命尊嚴受到威脅；醫療專業的尊嚴面臨危機。」

結論

救贖人類的奧祕，它的方式令人驚訝，這奧祕植根於天主以愛參與在人類的痛苦當中。因此，我們可以把自己交託給天主，並在信德中把這個確定的事實，傳達給遭受痛苦及害怕痛苦和死亡的人。

基督徒的見證展示出希望永遠是可能的，即使在「用完即棄文化」裡。「慈善的撒瑪黎雅人和整個福音精神的說服力在此：每個人必須感覺到**自己受召**，在痛苦中為愛作見證。」[96]

教會從慈善的撒瑪黎雅人那裡學習到如何照顧末期病患，並同樣遵守了與生命的恩賜相關的誡命：「**請尊重、保護、珍愛和服務生命，所有人類生命！**」[97] 生命的福音是一部憐憫和慈悲的福音，它指向真實的人，是軟弱而且有罪的，它減輕他們的痛苦，讓生命的恩典支持他們，並在可能的情況下使他們的傷患得到治癒。

然而，僅僅分享病人的痛苦是不足夠的；一個人需要把自己沈浸在基督的逾越奧蹟的果實中，基督戰勝了罪惡與死亡，而人也要具有「消除別人的苦痛，猶如這是自己的苦痛一樣」[98] 的意志。人最大的苦痛，在於面對死

96教宗若望保祿二世，《論得救恩的痛苦》牧函（1984年2月11日），29：《宗座公報》76（1984），246。

97教宗若望保祿二世，《生命的福音》通諭（1995年3月25日），5：《宗座公報》87（1995），407。

98聖多瑪斯．阿奎那《神學大全》第一部，第21提問，第三條回答。

亡時失去了希望。藉著基督徒見證所宣布的，正是這個希望，要使它落實發揮效用，就必須在信德中生活，並讓希望涵蓋所有的人——家庭、護理師以及醫師。它必須運用教區和天主教醫療中心在牧靈上的資源，這些都受召在信德之中，在病人患病的所有階段，要活出**陪伴病人的義務**，特別在本信函所定義的時期，即是在生命處於危重和末期病患時更應如此。

慈善的撒瑪黎雅人把患難中那弟兄的臉放在自己的心中，他看到了弟兄的需要，供給他一切用來修補那孤寂的傷口，並讓他的心接受希望之亮光。

撒瑪黎雅人的「樂於向善」使他親近那個受傷的人，不僅只用言語或口舌，而要用具體的行動和事實（參閱：若壹三18）。他以基督為榜樣，採取了祂照顧的模式，基督巡行各處，施恩行善，治好一切。（參閱：宗十38）

耶穌治好了我們，使我們成為蒙召的男與女，要我們宣講祂醫治的力量，為我們的近人施予愛並為他們提供照顧，這些是耶穌所見證的。

那個愛和關懷別人的召叫[99] 帶來了永恆的回報，這事藉著生命之主在公審判的比喻中很清楚地表達出來：承受這國度罷！因為我患病，你們來探望了我。主啊！我們什麼時候做了這些？每次你們對這些最小的所做的，為受苦中的弟兄或姊妹而做的，就是對我做的。（參閱：瑪廿五31~46）

教宗方濟各在2020年6月25日批准了以上信函並予之准印，此信函於2020年1月29日在信理部的全體會議上通過。

部長 拉達里亞樞機

（Luis F. Card. LADARIA, S.I.）

✠祕書 莫蘭迪總主教

（Giacomo MORANDI Tit. Archbishop of Cerveteri）

羅馬，2020年7月14日發於教廷信理聖部，紀念聖嘉彌祿（Saint Camillo de Lellis）瞻禮日。

（台灣地區主教團 恭譯）

99參閱：教宗本篤十六世，《在希望中得救》通諭（2007年11月30日），39：《宗座公報》99（2007），1016。「為與別人和其他的人一起受苦，為了真理和正義受苦，為愛受苦以及為成為一個真正愛的人，這些是人類的基本因素，放棄它們將毀滅人自己。」

Congregation for the Doctrine of the Faith

Letter
Samaritanus bonus

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

Introduction

The Good Samaritan who goes out of his way to aid an injured man (cf. *Lk* 10:30-37) signifies Jesus Christ who encounters man in need of salvation and cares for his wounds and suffering with "the oil of consolation and the wine of hope".[1] He is the physician of souls and bodies, "the faithful witness" (*Rev* 3:14) of the divine salvific presence in the world. How to make this message concrete today? How to translate it into a readiness to accompany a suffering person in the terminal stages of life in this world, and to offer this assistance in a way that respects and promotes the intrinsic human dignity of persons who are ill, their vocation to holiness, and thus the highest worth of their existence?

The remarkable progressive development of biomedical technologies has exponentially enlarged the clinical proficiency of diagnostic medicine in patient care and treatment. The Church regards scientific research and technology with hope, seeing in them promising opportunities to serve the integral good of life and the dignity of every human being.[2] Nonetheless, advances in medical technology, though precious, cannot in themselves define the proper meaning and value of human life. In fact, every technical advance in healthcare calls for growth in moral discernment[3] to avoid an unbalanced and dehumanizing use of the technologies especially in the critical or terminal stages of human life.

Moreover, the organizational management and sophistication, as well as the complexity of contemporary healthcare delivery, can reduce to a purely technical and impersonal relationship the bond of trust between physician and patient. This danger arises particularly where governments have enacted legislation to legalize forms of assisted suicide and voluntary euthanasia among the most vulnerable of the sick and infirm. The ethical and legal boundaries that protect the self-determination of the sick person are transgressed by such legislation, and, to a worrying degree, the value of human life during times of illness, the meaning of suffering, and the significance of the interval preceding death are eclipsed. Pain and death do not constitute the ultimate measures of the human dignity that is proper to

1 Messale Romano, *riformato a norma dei decreti del Concilio Ecumenico Vaticano II, promulgato da papa Paolo VI e riveduto da papa Giovanni Paolo II*, Conferenza Episcopale Italiana – Fondazione di Religione Santi Francesco d'Assisi e Caterina da Siena, Roma 2020, Prefazio comune VIII, p. 404 (Eng. trans.)

2 Cf. Pontifical Council for Pastoral Assistance to Health Care Workers, New Charter for Health Care Workers, National Catholic Bioethics Center, Philadelphia, PA, 2017, n. 6.

3 Cf. Benedict XVI, Encyclical Letter *Spe salvi* (30 November 2007), 22: AAS 99 (2007), 1004. "If technical progress is not matched by corresponding progress in man's ethical formation, in man's inner growth (cf. *Eph* 3:16; 2 *Cor* 4:16), then it is not progress at all, but a threat for man and for the world".

every person by the very fact that they are "human beings".

In the face of challenges that affect the very way we think about medicine, the significance of the care of the sick, and our social responsibility toward the most vulnerable, the present letter seeks to enlighten pastors and the faithful regarding their questions and uncertainties about medical care, and their spiritual and pastoral obligations to the sick in the critical and terminal stages of life. All are called to give witness at the side of the sick person and to become a "healing community" in order to actualize concretely the desire of Jesus that, beginning with the most weak and vulnerable, all may be one flesh.[4] It is widely recognized that a moral and practical clarification regarding care of these persons is needed. In this sensitive area comprising the most delicate and decisive stages of a person's life, a "unity of teaching and practice is certainly necessary."[5]

Various Episcopal Conferences around the world have published pastoral letters and statements to address the challenges posed to healthcare professionals and patients especially in Catholic institutions by the legalization of assisted suicide and voluntary euthanasia in some countries. Regarding the celebration of the Sacraments for those who intend to bring an end to their own life, the provision of spiritual assistance in particular situations raises questions that today require a more clear and precise intervention on the part of the Church in order to:

– reaffirm the message of the Gospel and its expression in the basic doctrinal statements of the Magisterium, and thus to recall the mission of all who come into contact with the sick at critical and terminal stages (relatives or legal guardians, hospital chaplains, extraordinary ministers of the Eucharist and pastoral workers, hospital volunteers and healthcare personnel), as well as the sick themselves; and,

– provide precise and concrete pastoral guidelines to deal with these complex situations at the local level and to handle them in a way that fosters the patient's personal encounter with the merciful love of God.

I. Care For One's Neighbor

Despite our best efforts, it is hard to recognize the profound value of human life when we see it in its weakness and fragility. Far from being outside the existential horizon of the person, suffering always raises limitless questions about the meaning of life.[6] These pressing questions cannot be answered solely by human reflection, because in suffering there is concealed *the immensity of a specific mystery* that can only be disclosed by the Revelation of God.[7] In particular, the mission of faithful care of human life until its natural conclusion[8] is entrusted to every healthcare worker and is realized through programs of care that can restore, even in illness and suffering, a deep awareness of their existence to every patient. For this reason we begin with a

4 Cfr. Francesco, *Discorso* all'*Associazione italiana contro le leucemie-linfomi e mieloma (AIL)* (2 marzo 2019): L'Osservatore Romano, 3 marzo 2019, 7.

5 Francis, Apostolic Exhortation *Amoris laetitia* (19 March 2016), 3: *AAS* 108 (2016), 312.

6 Cf. Second Vatican Ecumenical Council, Pastoral Constitution *Gaudium et spes*, 10: *AAS* 58 (1966), 1032-1033.

7 Cf. John Paul II, Apostolic Letter *Salvifici doloris* (11 February 1984), 4: *AAS* 76 (1984), 203.

8 Cf. Pontifical Council for Pastoral Assistance to Healthcare Workers, *New Charter for Healthcare Workers*, n. 144.

careful consideration of the significance of the specific mission entrusted by God 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 in its finitude and limitations. Each person's vulnerability is encoded in our nature as a unity of body and soul: we are materially and temporally finite, and yet we have a longing for the infinite and a destiny that is eternal. As creatures who are by nature finite, yet nonetheless destined for eternity, we depend on material goods and on the mutual support of other persons, and also on our original, deep connection with God. Our vulnerability forms the basis for an ethics of care, especially in the medical field, which is expressed in concern, dedication, shared participation and responsibility towards the women and men entrusted to us for material and spiritual assistance in their hour of need.

The relationship of care discloses the twofold dimension of the principle of justice to promote human life (*suum cuique tribuere*) and to avoid harming another (*alterum non laedere*). Jesus transformed this principle into the golden rule "Do unto others whatever you would have them do to you" (*Mt* 7:12). This rule is echoed in the maxim *primum non nocere* of traditional medical ethics.

Care for life is therefore the first responsibility that guides the physician in the encounter with the sick. Since its anthropological and moral horizon is broader, this responsibility exists not only when the restoration to health is a realistic outcome, but even when a cure is unlikely or impossible. Medical and nursing care necessarily attends to the body's

physiological functions, as well as to the psychological and spiritual well-being of the patient who should never be forsaken. Along with the many sciences upon which it draws, medicine also possesses the key dimension of a "therapeutic art," entailing robust relationships with the patient, with healthcare workers, with relatives, and with members of communities to which the patient is linked. *Therapeutic art, clinical procedures* and ongoing care are inseparably interwoven in the practice of medicine, especially at the critical and terminal stages of life.

The Good Samaritan, in fact, "not only draws nearer to the man he finds half dead; he takes responsibility for him".[9] He invests in him, not only with the funds he has on hand but also with funds he does not have and hopes to earn in Jericho: he promises to pay any additional costs upon his return. Likewise Christ invites us to trust in his invisible grace that prompts us to the generosity of supernatural charity, as we 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). This affirmation expresses a moral truth of universal scope: "we need then to 'show care' for all life and for the life of everyone"[10] and thus to reveal the original and unconditional love of God, the source of the meaning of all life.

To that end, especially in hospitals and clinics committed to Christian values, it is vital to create space for relationships built on the recognition of the *fragility* and *vulnerability* of the

9 Francis, *Message for the 48th World Communications Day* (1 June 2014): *AAS* 106 (2014), 114.

10 John Paul II, Encyclical Letter *Evangelium vitae* (25 March 1995), 87: *AAS* 87 (1995), 500.

sick person. Weakness makes us conscious of our dependence on God and invites us to respond with the respect due to our neighbor. Every individual who cares for the sick (physician, nurse, relative, volunteer, pastor) has the moral responsibility to apprehend the fundamental and inalienable good that is the human person. They should adhere to the highest standards of self-respect and respect for others by embracing, safeguarding and promoting human life until natural death. At work here is a *contemplative gaze*[11] that beholds in one's own existence and that of others a unique and unrepeatable wonder, received and welcomed as a gift. This is the gaze of the one who does not pretend to take possession of the reality of life but welcomes it as it is, with its difficulties and sufferings, and, guided by faith, finds in illness the readiness to abandon oneself to the Lord of life who is manifest therein.

To be sure, medicine must accept the limit of death as part of the human condition. The time comes when it is clear that specific medical interventions cannot alter the course of an illness that is recognized to be terminal. It is a dramatic reality, that must be communicated to the sick person both with great humanity and with openness in faith to a supernatural horizon, aware of the anguish that death involves especially in a culture that tries to conceal it. One cannot think of physical life as something to preserve at all costs –which is impossible – but as something to live in the free acceptance of the meaning of bodily existence: "only in reference to the human person in his 'unified totality', that is as 'a soul which expresses itself in a body and a body informed by an immortal spirit', can the specifically human meaning of the body be grasped".[12]

The impossibility of a cure where death is imminent does not entail the cessation of medical and nursing activity. Responsible communication with the terminally ill person should make it clear that care will be provided until the very end: "t*o cure if possible, always to care*".[13] The obligation always to take care of the sick provides criteria to assess the actions to be undertaken in an "incurable" illness: the judgement that an illness is incurable cannot mean that care has come at an end. The contemplative gaze calls for a wider notion of care. The objective of assistance must take account of the integrity of the person, and thus deploy adequate measures to provide the necessary physical, psychological, social, familial and religious support to the sick. The living faith of the persons involved in care contributes to the authentic theologal life of the sick person, even if this is not immediately evident. 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 in the face of the inevitability of illness, especially when chronic or degenerative, fear of suffering, death, and the discomfort they entail is the main factor driving the attempt to control and manage the moment of death, and indeed to hasten it through euthanasia or assisted suicide.

II. The Living Experience of the Suffering Christ and the Proclamation of Hope

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

12 John Paul II, Encyclical Letter *Veritatis splendor* (6 August 1993), 50: *AAS* 85 (1993), 1173.

13 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.

If the figure of the Good Samaritan throws new light on the provision of healthcare, the nearness of the God made man is manifest in the living experience of Christ's suffering, of his agony on the Cross and his Resurrection: his experience of multiple forms of pain and anguish resonates with the sick and their families during the long days of infirmity that precede the end of life.

Not only do the words of the prophet Isaiah proclaim Christ as one familiar with suffering and pain (cf. Is 53), but, as we re-read the pages about his suffering, we also recognize the experience of incredulity and scorn, abandonment, and physical pain and anguish. Christ's experience resonates with the sick who are often seen as a burden to society; their questions are not understood; they often undergo forms of affective desertion and the loss of connection with others.

Every sick person has the need not only to be heard, but to understand that their interlocutor "knows" what it means to feel alone, neglected, and tormented by the prospect of physical pain. Added to this is the suffering caused when society equates their value as persons to their quality of life and makes them feel like a burden to others. In this situation, to turn one's gaze to Christ is to turn to him who experienced in his flesh the pain of the lashes and nails, the derision of those who scourged him, and the abandonment and the betrayal of those closest to him.

In the face of the challenge of illness and the emotional and spiritual difficulties associated with pain, one must necessarily know how to speak a word of comfort drawn from the compassion of Jesus on the Cross. It is full of hope - a sincere hope, like Christ's on the Cross, capable of facing the moment of trial and the challenge of death. *Ave crux, spes unica*, we sing in the Good Friday liturgy. In the Cross of Christ are concentrated and recapitulated all the sickness and suffering of the world: all the *physical suffering*, of which the Cross, that instrument of an infamous and shameful death, is the symbol; all the *psychological suffering*, expressed in the death of Jesus in the darkest of solitude, abandonment and betrayal; all the *moral suffering*, manifested in the condemnation to death of one who is innocent; all the *spiritual suffering*, displayed in a desolation that seems like the very silence of God.

Christ is aware of the painful shock of his Mother and his disciples who "remain" under the Cross and who, though "remaining", appear impotent and resigned, and yet provide the affective intimacy that allows the God made man to live through hours that seem meaningless.

Then there is the Cross: an instrument of torture and execution reserved only for the lowest, that symbolically looks just like those afflictions that nail us to a bed, that portend only death, and that render meaningless time and its flow. Still, those who "remain" near the sick not only betoken but also embody affections, connections, along with a profound readiness to love. In all this, the suffering person can discern the human gaze that lends meaning to the time of illness. For, in the experience of being loved, all of life finds its justification. During his passion Christ was always sustained by his confident trust in the Father's love, so evident in the hours of the Cross, and also in his Mother's love. The Love of God always makes itself known in the history of men and women, thanks to the love of the one who never deserts us, who "remains," despite everything, at our side.

At the end of life, people often harbor worries about those they leave behind: about their children, spouses, parents, and friends. This human element can never be neglected and requires a sympathetic response.

With the same concern, Christ before his death thinks of his Mother who will remain alone within a sorrow that she will have to bear from now on. In the spare account of the Gospel of John, Christ turns to his Mother to reassure her and to entrust her to the care of the beloved disciple: "Woman, behold your son" (cf. *Jn* 19: 26-27). The end of life is a time of relationships, a time when loneliness and abandonment must be defeated (cf. *Mt* 27:46 and *Mk* 15:34) in the confident offering of one's life to God (cf. *Lk* 23:46).

In this perspective, to gaze at the crucifix is to behold a choral scene, where Christ is at the center because he recapitulates in his own flesh and truly transfigures the darkest hours of the human experience, those in which he silently faces the possibility of despair. The light of faith enables us to discern the trinitarian presence in the brief, supple description provided by the Gospels, because Christ trusts in the Father thanks to the Holy Spirit who sustains his Mother and his disciples. In this way "they remain" and in their "remaining" at the foot of the Cross, they participate, with their human dedication to the Suffering One, in the mystery of Redemption.

In this manner, although marked by a painful passing, death can become the occasion of a greater hope that, thanks to faith, makes us participants in the redeeming work of Christ. Pain is existentially bearable only where there is hope. The hope that Christ communicates to the sick and the suffering is that of his presence, of his true nearness. Hope is not only the expectation of a greater good, but is a gaze on the present full of significance. In the Christian faith, the event of the Resurrection not only reveals eternal life, but it makes manifest that in history the last word never belongs to death, pain, betrayal, and suffering. Christ rises in history, and in the mystery of the Resurrection the abiding love of the Father is confirmed.

To contemplate the living experience of Christ's suffering is to proclaim to men and women of today a hope that imparts meaning to the time of sickness and death. From this hope springs the love that overcomes the temptation to despair.

While essential and invaluable, palliative care in itself is not enough unless there is someone who "remains" at the bedside of the sick to bear witness to their unique and unrepeatable value. For the believer, to look upon the Crucified means to trust in the compassionate love of God. In a time when autonomy and individualism are acclaimed, it must be remembered that, while it is true that everyone lives their own suffering, their own pain and their own death, these experiences always transpire in the presence of others and under their gaze. Nearby the Cross there are also the functionaries of the Roman state, there are the curious, there are the distracted, there are the indifferent and the resentful: they are at the Cross, but they do not "remain" with the Crucified.

In intensive care units or centers for chronic illness care, one can be present merely as a functionary, or as someone who "remains" with the sick.

The experience of the Cross enables us to be present to the suffering person as a genuine interlocutor with whom to speak

a word or express a thought, or entrust the anguish and fear one feels. To 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.

III. The Samaritan's "heart that sees": human life is a sacred and inviolable gift

Whatever their physical or psychological condition, human persons always retain their original dignity as created in the image of God. They can live and grow in the divine splendor because they are called to exist in "the image and glory of God" (1 *Cor*11:7; 2 *Cor* 3:18). Their dignity lies in this vocation. God became man to save us, and he promises us salvation and calls us to communion with Him: here lies the ultimate foundation of human dignity.[14]

It is proper for the Church to accompany with mercy the weakest in their journey of suffering, to preserve them the theologal life, and to guide them to salvation.[15] The Church of the Good Samaritan[16] regards "the service to the sick as an integral part of its mission".[17] When understood in the perspective of communion and solidarity among human persons, the Church's salvific mediation helps to surmount reductionist and individualistic tendencies.[18]

"A heart that sees" is central to the program of the Good Samaritan. He "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 […] Without compassion, people who look do not get involved with what they observe, and they keep going; instead people who have a compassionate heart are touched and engaged, they stop and show care".[19] This heart sees where love is needed and acts accordingly.[20]These eyes identify in weakness God's call to appreciate that human life is the primary common good of society.[21] Human life is a highest good, and society is called to acknowledge this. Life is a sacred and inviolable gift[22] and every human person, created by God, has a transcendent vocation to a unique relationship with the One who gives life. "The invisible God out of the abundance

14 Cf. Congregation for the Doctrine of the Faith, Letter *Placuit Deo* (22 February 2018), 6: *AAS* 110 (2018), 430.

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

16 Cf. Paul VI, *Address during the last general meeting of the Second Vatican Council* (7 December 1965): *AAS* 58 (1966), 55-56.

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

18 Cf. Congregaton for the Doctrine of the Faith, Letter *Placuit Deo* (22 February 2018), 12: AAS 110 (2018), 433-434.

19 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.)

20 Cf. Benedict XVI, Encyclical Letter *Deus caritas est* (25 December 2005), 31: *AAS* 98 (2006), 245.

21 Cf. Benedict XVI, Encyclical Letter *Caritas in veritate* (29 June 2009), 76: *AAS* 101 (2009), 707.

22 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 ".

of his love"[23] offers to each and every human person a plan of salvation that allows the affirmation that: "Life is always a good. This is an instinctive perception and a fact of experience, and man is called to grasp the profound reason why this is so".[24] For this reason, the Church is always happy to collaborate with all people of good will, with believers of other confessions or religions as well as non-believers, who respect the dignity of human life, even in the last stages of suffering and death, and reject any action contrary to human life.[25] God the Creator 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 positive meaning of human life is something already knowable by right reason, and in the light of faith is confirmed and understood in its inalienable dignity.[26] This criterion is neither subjective nor arbitrary but is founded on a natural inviolable dignity. Life is the first good because it is the basis for the enjoyment of every other good

23 Second Vatican Ecumenical Council, Dogmatic Constitution *Dei Verbum* (8 November 1965), 2: AAS 58 (1966), 818.

24 John Paul II, Encyclical Letter *Evangelium vitae* (25 March 1995), 34: *AAS* 87 (1995), 438.

25 Cf. *Position Paper of the Abrahamic Monotheistic Religions on matters concerning life*, Vatican City, 28 October 2019: " We oppose any form of euthanasia – that is the direct, deliberate and intentional act of taking life – as well as physician assisted suicide – that is the direct, deliberate and intentional support of committing suicide – because they fundamentally contradict the inalienable value of human life, and therefore are inherently and consequentially morally and religiously wrong, and should be forbidden wihout exceptions".

26 Cf. Francis, *Address to Participants in the Commemorative Conference of the Italian Catholic Physicians' Association on the occassion of its 70th Anniversary of foundation* (15 November 2014): *AAS* 106 (2014), 976.

including the transcendent vocation to share the trinitarian love of the living God to which every human being is called:[27] "The special love of the Creator for each human being 'confers upon him or her an infinite dignity'.[28] The uninfringeable 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. Therefore, to end the life of a sick person who requests euthanasia is by no means to acknowledge and respect their autonomy, but on the contrary to disavow the value of both their freedom, now under the sway of suffering and illness, and of their life by excluding any further possibility of human relationship, of sensing the meaning of their existence, or of growth in the theologal life. Moreover, it is to take the place of God in deciding the moment of death. For this reason, "abortion, euthanasia and wilful self-destruction (…) poison human society, but they do more harm to those who practice them than those who suffer from the injury. Moreover, they are a supreme dishonor to the Creator".[29]

IV. The Cultural Obstacles that Obscure the Sacred Value of Every Human Life

27 Cf. Pontifical Council for Pastoral Assistance to Health Care Workers, *New Charter for Health Care Workers*, n. 1; Congregation for the Doctrine of the Faith, Instruction *Dignitas personae* (8 September 2008), 8: AAS 100 (2008), 863.

28 Francis, Encyclical Letter *Laudato si'* (24 May 2015), 65: *AAS* 107 (2015), 873.

29 Second Vatican Ecumenical Council, Pastoral Constitution *Gaudium et spes* (7 December 1965), 27: *AAS* 58 (1966), 1047-1048.

Among the obstacles that diminish our sense of the profound 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," which a utilitarian anthropological perspective sees in terms "primarily related to economic means, to 'well-being,' to the beauty and enjoyment of physical life, forgetting the other, more profound, interpersonal, spiritual and religious dimensions of existence".[30] In this perspective, life is viewed as worthwhile only if it has, in the judgment of the individual or of third parties, an acceptable degree of quality as measured by the possession or lack of particular psychological or physical functions, or sometimes simply by the presence of psychological discomfort. According to this view, a life whose quality seems poor does not deserve to continue. Human life is thus 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"[31]. In the face of seemingly "unbearable" suffering, the termination of a patient's life is justified in the name of "compassion". This so-called "compassionate" euthanasia holds that it is better to die than to suffer, and that it would be compassionate to help a patient to die by means of euthanasia or assisted suicide. In reality, human compassion consists not in causing death, but in embracing the sick, in supporting them in their difficulties, in offering them affection, attention, and the means to alleviate the suffering.

A third factor that hinders the recognition of the value of one's own life and the lives of others is a growing individualism within interpersonal relationships, where the other is viewed as a limitation or a threat to one's freedom. At the root of this attitude is "a neo-pelagianism in which the individual, radically autonomous, presumes to save himself, without recognizing that, at the deepest level of being, he depends on God and others [...]. On the other hand, a certain neo-gnosticism, puts forward a model of salvation that is merely interior, closed off in its own subjectivism",[32] that wishes to free the person from the limitations of the body, especially when it is fragile and ill.

Individualism, in particular, is at the root of what is regarded as the most hidden malady of our time: solitude or privacy.[33] It is thematized in some regulatory contexts even as a "right to solitude", beginning with the autonomy of the person and the "principle of permission-consent" which can, in certain conditions of discomfort or sickness, be extended to the choice of whether or not to continue living. This "right" underlies euthanasia and assisted suicide. The basic idea is that those who

30 Francis, *Address to Participants in the Commemorative Conference of the Italian Catholic Physicians' Association on the occassion of its 70th Anniversary of foundation* (15 November 2014): *AAS* 106 (2014), 976.

31 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".

32 Congregation for the Doctrine of the Faith, Lettera *Placuit Deo* (22 February 2018), 3: *AAS* 110 (2018), 428-429; Cf. Francis, Encyclical Letter *Laudato si'* (24 May 2015), 162: *AAS* 107 (2015), 912.

33 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".

find themselves in a state of dependence and unable to realize a perfect autonomy and reciprocity, come to be cared for as a *favor* to them. The concept of the good is thus reduced to a social accord: each one receives the treatment and assistance that autonomy or social and economic utility make possible or expedient. As a result, interpersonal relationships are impoverished, becoming fragile in the absence of supernatural charity, and of that human solidarity and social support necessary to face the most difficult moments and decisions of life.

This way of thinking about human relationships and the significance of the good cannot but undermine the very meaning of life, facilitating its manipulation, even through laws that legalize euthanistic practices, resulting in the death of the sick. Such actions deform relationships and induce a grave insensibility toward the care of the sick person. In such circumstances, baseless moral dilemmas arise regarding what are in reality simply mandatory elements of basic care, such as feeding and hydration of terminally ill persons who are not conscious.

In this connection, Pope Francis has spoken of a "throw-away culture"[34] where the victims are the weakest human beings, who are likely to be "discarded" when the system aims for efficiency at all costs. This cultural phenomenon, which is deeply contrary to solidarity, John Paul II described as a "culture

34 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.

of death" that gives rise to real "structures of sin"[35] that can lead to the performance of actions wrong in themselves for the sole purpose of "feeling better" in carrying them out. A confusion between good and evil materializes in an area where every personal life should instead be understood to possess a unique and unrepeatable value with a promise of and openness to the transcendent. In this culture of waste and death, euthanasia and assisted suicide emerge as erroneous solutions to the challenge of the care of terminal patients.

V. The Teaching of the Magisterium

1. *The prohibition of euthanasia and assisted suicide*

With her mission to transmit to the faithful the grace of the Redeemer and the holy law of God already discernible in the precepts of the natural moral law, the Church is obliged to intervene in order to exclude once again all ambiguity in the teaching of the Magisterium concerning euthanasia and assisted suicide, even where these practices have been legalized.

In particular, the dissemination of medical end-of-life protocols such as the *Do Not Resuscitate Order* or the *Physician Orders for Life Sustaining Treatment* – with all of their variations depending on national laws and contexts – were initially thought of as instruments to avoid aggressive medical treatment in the terminal phases of life. Today these protocols cause serious problems regarding the duty to protect the life of patients in the most critical stages of sickness. On the one hand, medical staff feel increasingly bound by the self-determination expressed in

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

patient declarations that deprive physicians of their freedom and duty to safeguard life even where they could do so. On the other hand, in some healthcare settings, concerns have recently arisen about the widely reported abuse of such protocols viewed in a euthanistic perspective with the result that neither patients nor families are consulted in final decisions about care. This happens above all in the countries where, with the legalization of euthanasia, wide margins of ambiguity are left open in end-of-life law regarding the meaning of obligations to provide care.

For these reasons, the Church is convinced of the 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. The correct definition of euthanasia depends, not on a consideration of the goods or values at stake, but on the moral object properly specified by the choice of "an action or an omission which of itself or by intention causes death, in order that all pain may in this way be eliminated".[36] "Euthanasia's terms of reference, therefore, are to be found in the intention of the will and in the methods used".[37] The moral evaluation of euthanasia, and its consequences does not depend on a balance of principles that the situation and the pain of the patient could, according to some, justify the termination of the sick person. Values of life, autonomy, and decision-making ability are not on the same level as the quality of life as such.

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

37 John Paul II, Encyclical Letter *Evangelium vitae* (25 March 1995), 65: *AAS* 87 (1995), 475; cf. Congregation For The Doctrine Of The Faith, Declaration *Iura et bona* (5 maggio 1980), II: *AAS* 72 (1980), 546.

Euthanasia, therefore, is an intrinsically evil act, in every situation or circumstance. In the past the Church has already affirmed in a definitive way "that euthanasia is *a grave violation of the Law of God*, since it is the deliberate and morally unacceptable killing of a human person. This doctrine is based upon the natural law and upon the written Word of God, is transmitted by the Church's Tradition and taught by the ordinary and universal Magisterium. Depending on the circumstances, this practice involves the malice proper to suicide or murder".[38] *Any formal or immediate material cooperation* in such an act is a grave sin against human life: "No authority can legitimately recommend or permit such an action. For it is a question of the violation of the divine law, an offense against the dignity of the human person, a crime against life, and an attack on humanity".[39] Therefore, euthanasia is an act of homicide that no end can justify and that does not tolerate any form of complicity or active or passive collaboration. Those who approve laws of euthanasia and assisted suicide, therefore, become accomplices of a grave sin that others will execute. They are also guilty of scandal because by such laws they contribute to the distortion of conscience, even among the faithful.[40]

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

38 John Paul II, Encyclical Letter *Evangelium vitae* (25 March 1995), 65: *AAS* 87 (1995), 477. It is a definitively proposed doctrine in which the Church commits her infallibility: cf. Congregation For The Doctrine of the Faith, *Doctrinal Commentary on the Concluding Formula of the Professio Fidei* (29 June 1998), 11: *AAS* 90 (1998), 550.

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

40 Cf. *Catechism of the Catholic Church*, 2286.

one's own life. One who choses with full liberty to take one's own life breaks one's relationship with God and with others, and renounces oneself as a moral subject. Assisted suicide aggravates the gravity of this act because it implicates another in one's own despair. Another person is led to turn his will from the mystery of God in the theological virtue of hope and thus to repudiate the authentic value of life and to break the covenant that establishes the human family. Assisting in a suicide is an unjustified collaboration in an unlawful act that contradicts the theologal relationship with God and the moral relationship that unites us with others who share the gift of life and the meaning of existence.

When a request for euthanasia rises from anguish and despair,[41] "although in these cases the guilt of the individual may be reduced, or completely absent, nevertheless the error of judgment into which the conscience falls, perhaps in good faith, does not change the nature of this act of killing, which will always be in itself something to be rejected".[42] The same applies to assisted suicide. Such actions are never a real service to the patient, but a help to die.

Euthanasia and assisted suicide are always the wrong choice: "the medical personnel and the other health care workers – faithful to the task 'always to be at the service of life and to assist it up until the very end' – cannot give themselves to any euthanistic practice, neither at the request of the interested party, and much less that of the family. In fact, since there is no right to dispose of one's life arbitrarily, no health care worker can be compelled to execute a non-existent right".[43]

This is why *euthanasia and assisted suicide are a defeat* for those who theorize about them, who decide upon them, or who practice them.[44]

For this reason, it is gravely unjust to enact laws that legalize euthanasia or justify and support suicide, invoking the false right to choose a death improperly characterized as respectable only because it is chosen.[45] Such laws strike at the foundation of the legal order: the right to life sustains all other rights, including the exercise of freedom. The existence of such laws deeply wound human relations and justice, and threaten the mutual trust among human beings. The legitimation of assisted suicide and euthanasia is a sign of the degradation of legal systems. Pope Francis recalls that "the current socio-cultural context is gradually eroding the awareness of what makes human life precious. In fact, it 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. In this situation of the loss of authentic values, the mandatory obligations of solidarity and of human and Christian fraternity also fail. In reality, a society deserves the status of 'civil' if it develops antibodies against the culture of waste; if it recognizes the intangible value of human life; if solidarity is factually practiced and safeguarded as a foundation for living together".[46] In some countries of the world, tens of thousands

41 Cf. *Catechism of the Catholic Church*, 1735 and 2282.

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

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

44 Cf. *Ibid*., 170.

45 Cf. John Paul II, Encyclical Letter *Evangelium vitae* (25 March 1995), 72: *AAS* 87 (1995), 484-485.

46 Francis, *Address to the Participants of the Plenary Session*

of people have already died by euthanasia, and many of them because they displayed psychological suffering or depression. Physicians themselves report that abuses frequently occur when the lives of persons who would never have desired euthanasia are terminated. The request for death is in many cases itself a symptom of disease, aggravated by isolation and discomfort. The Church discerns in these difficulties an occasion for a spiritual purification that allows hope to become truly theological when it is focused on God and only on God.

Rather than indulging in a spurious condescension, the Christian must offer to the sick the help they need to shake off their despair. The commandment "do not kill" (*Ex* 20:13; *Dt* 5:17) is in fact a *yes to life* which God guarantees, and it "becomes a call to attentive love which protects and promotes the life of one's neighbor".[47] The Christian therefore knows that earthly life is not the supreme value. Ultimate happiness is in heaven. Thus the Christian will not expect physical life to continue when death is evidently near. The Christian must help the dying to break free from despair and to place their hope in God.

From a clinical perspective, the factors that largely determine requests for euthanasia and assisted suicide are unmanaged pain, and the loss of human and theological hope, provoked by the often inadequate psychological and spiritual human assistance provided by those who care for the sick.[48]

of the Congregation for the Doctrine of the Faith (30 January 2020): *L'Osservatore Romano*, 31 gennaio 2020, 7. (Eng. trans.)

47 John Paul II, Encyclical Letter *Veritatis splendor* (6 August 1993), 15: *AAS* 85 (1993), 1145.

48 Cf. Benedict XVI, Encyclical Letter *Spe salvi* (30 November 2007), 36, 37: *AAS* 99 (2007), 1014-1016.

Experience confirms that "the pleas of gravely ill people who sometimes ask for death are not to be understood as implying a true desire for euthanasia; in fact, it is almost always a case of an anguished plea for help and love. What a sick person needs, besides medical care, is love, the human and supernatural warmth with which sick persons can and ought to be surrounded by all those close to him or her, parents and children, doctors and nurses".[49] A sick person, surrounded by a loving human and Christian presence, can overcome all forms of depression and need not succumb to the anguish of loneliness and abandonment to suffering and death.

One experiences pain not just as a biological fact to be managed in order to make it bearable, but as the mystery of human vulnerability in the face of the end of physical life—a difficult event to endure, given that the unity of the body and the soul is essential to the human person.

Therefore, the "end of life", inevitably presaged by pain and suffering, can be faced with dignity only by the re-signification of the event of death itself—by opening it to the horizon of eternal life and affirming the transcendent destiny of each person. In fact, "suffering is something which is *still wider* than sickness, more complex, and at the same time still more deeply rooted in humanity itself".[50] With the help of grace this suffering can, like the suffering of Christ on the Cross, be animated from within with divine charity.

Those who assist persons with chronic illnesses or in the

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

50 John Paul II, Apostolic Letter *Salvifici doloris* (11 February 1984), 5: *AAS* 76 (1984), 204.

terminal stages of life must be able to "know how to stay", to keep vigil, with those who suffer the anguish of death, "to console" them, to be with them in their loneliness, to be an *abiding with* that can instil hope.[51] By means of the faith and charity expressed in the intimacy of the soul, the caregiver can experience the pain of another, can be open to a personal relationship with the weak that expands the horizons of life beyond death, and thus can become a presence full of hope.

"Weep with those who weep" (*Rm* 12:15): for blessed is the one whose compassion includes shedding tears with others (cf. *Mt* 5:4). Love is made possible and suffering given meaning in relationships where persons share in solidarity the human condition and the journey to God, and are joined in a covenant[52] that enables them to glimpse the light beyond death. Medical care occurs within the therapeutic covenant between the physician and the patient who are united in the recognition of the transcendent value of life and the mystical meaning of suffering. In the light of this covenant, good medical care can be valued, while the utilitarian and individualistic vision that prevails today can be dispelled.

2. *The moral obligation to exclude aggressive medical treatment*

51 Cf. Benedict XVI, Encyclical Letter *Spe salvi* (30 November 2007), 38: *AAS* 99 (2007), 1016.

52 Cf. John Paul II, Apostolic Letter *Salvifici doloris* (11 February 1984), 29: *AAS* 76 (1984), 244: "the person who is 'a neighbor' cannot indifferently pass by the suffering of another: this in the name of fundamental human solidarity, still more in the name of love of neighbor. He must 'stop,' 'sympathize,' just like the Samaritan of the Gospel parable. The parable in itself expresses *a deeply christian truth*, but one that at the same time is very universally human."

The Magisterium of the Church recalls 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 and with one's proper human and Christian dignity intact.[53]To precipitate death or delay it through "aggressive medical treatments" deprives death of its due dignity.[54] Medicine today can artificially delay death, often without real benefit to the patient. When death is imminent, and without interruption of the normal care the patient requires in such cases, it is lawful according to science and conscience to renounce treatments that provide only a precarious or painful extension of life.[55] 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, thermoregulation, proportionate respiratory support, and the

53 Cf. Congregation for the Doctrine of the Faith, Declaration *Iura et bona* (5 May 1980), IV: *AAS* 72 (1980), 549-551.

54 Cf. *Catechism of the Catholic Church*, 2278; Pontifical Council for Pastoral Assistance to Health Care Workers, *The Charter for Health Care Workers*, Vatican City, 1995, n. 119; John Paul II, Encyclical Letter *Evangelium vitae* (25 March 1995), 65: *AAS*87 (1995), 475; Francis, *Message to the participants in the European regional meeting of the World Medical Association* (7 November 2017). "And even if we know that we cannot always guarantee healing or a cure, we can and must always care for the living, without ourselves shortening their life, but also without futilely resisting their death"; Pontifical Council for Pastoral Assistance to Health Care Workers, *New Charter for Health Care Workers*, n. 149.

55 Cf. *Catechism of the Catholic Church*, 2278; Congregation For The Doctrine Of The Faith, Declaration *Iura et bona* (5 May 1980), IV: *AAS* 72 (1980), 550-551; John Paul II, Encyclical Letter *Evangelium vitae* (25 March 1995), 65: *AAS* 87 (1995), 475; Pontifical Council for Pastoral Assistance to Health Care Workers, *New Charter for Health Care Workers*, n. 150.

other types of assistance needed to maintain bodily homeostasis and manage systemic and organic pain). The suspension of futile treatments *must not involve the withdrawal of therapeutic care*. This clarification is now indispensable in light of the numerous court cases in recent years that have led to the withdrawal of care from – and to the early death of–critically but not terminally ill patients, for whom it was decided to suspend life-sustaining care which would not improve the quality of life.

In the specific case of aggressive medical treatment, it should be repeated that the renunciation of extraordinary and/or disproportionate means "is not the equivalent of suicide or euthanasia; it rather expresses acceptance of the human condition in the face of death"[56] or a deliberate decision to waive disproportionate medical treatments which have little hope of positive results. The renunciation of treatments that would only provide a precarious and painful prolongation of life can also mean respect for the will of the dying person as expressed in advanced directives for treatment, e*xcluding however every act of a euthanistic or suicidal nature*.[57]

The principle of proportionality refers to the overall well-being of the sick person. To choose among values (for example, life versus quality of life) involves an erroneous moral judgment when it excludes from consideration the safeguarding of personal integrity, the good life, and the true moral object of the act undertaken.[58] Every medical action must always have as

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

57 Cf. Pontifical Council for Pastoral Assistance to Health Care Workers, *New Charter for Health Care Workers*, n. 150.

58 Cfr. Giovanni Paolo II, *Discorso ai partecipanti ad un incontro di studio sulla procreazione responsabile* (5 giugno 1987), n. 1: *Insegnamenti di Giovanni Paolo II* X/2 (1987), 1962: "To speak of a 'conflict of values or goods' and of the consequent need to perform some sort of 'balance' of them, choosing one and refuting the other, is not morally correct" (Eng. trans).

59 Cf. John Paul II, *Address to the Italian Catholic Doctors Association* (28 December 1978): *Insegnamenti di Giovanni Paolo II*, I (1978), 438.

60 Cf. Pontifical Council for Pastoral Assistance to Health Care Workers, *New Charter for Health Care Workers*, n. 150.

61 Cf. Congregation For The Doctrine Of The Faith, *Responses to certain questions of the United States Conference of Catholic Bishops concerning artificial nutrition and hydration* (1 August 2007): *AAS* 99 (2007), 820.

its object—intended by the moral agent—the promotion of life and never the pursuit of death.[59] The physician is never a mere executor of the will of patients or their legal representatives, but retains the right and obligation to withdraw at will from any course of action contrary to the moral good discerned by conscience.[60]

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, insofar as and until this demonstrably attains the purpose of providing hydration and nutrition for the patient.[61]

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 the deprivation of the hydration and nutrition vital for bodily function, but nonetheless respects the natural course of the critical or terminal illness. The withdrawal of this 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 in a proper sense, which is intended to counteract the pathology that afflicts the patient. They are instead forms of obligatory care of the patient, representing both a primary clinical and an unavoidable human response to the sick person. Obligatory nutrition and hydration can at times be administered artificially,[62] provided that it does not cause harm or intolerable suffering to the patient.[63]

4. *Palliative care*

Continuity of care is part of the enduring responsibility to appreciate the needs of the sick person: care needs, pain relief, and affective and spiritual needs. As demonstrated by vast clinical experience, palliative medicine constitutes a precious and crucial instrument in the care of patients during the most painful, agonizing, chronic and terminal stages of

62 Cf. *Ibid*.

63 Cf. Pontifical Council for Pastoral Assistance to Health Care Workers, *New Charter for Health Care Workers*, n. 152: "Nutrition and hydration, even if administered artificially, are classified as basic care owed to the dying person when they do not prove to be too burdensome or without any benefit. The unjustified discontinuation thereof can be tantamount to a real act of euthanasia: 'The administration of food and water even by artificial means is, in principle, an ordinary and proportionate means of preserving life. It is therefore obligatory to the extent which, and for as long as, it is shown to accomplish its proper finality, which is hydration and nourishment of the patient. In this way, suffering and death by starvation and dehydration are prevented'".

illness. *Palliative care* is an authentic expression of the human and Christian activity of providing 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 to ensure the patient appropriate human accompaniment"[64] improving quality of life and overall well-being as much as possible and in a dignified manner. Experience teaches us that the employment of palliative care reduces considerably the number of persons who request euthanasia. To this end, a resolute commitment is desirable to extend palliative treatments to those who need them, within the limits of what is fiscally possible, and to assist them in the terminal stages of life, but as an *integrated approach to the care* of existing chronic or degenerative pathologies involving a complex prognosis that is unfavorable and painful for the patient and family.[65]

Palliative care should include spiritual assistance for patients and their families. Such assistance inspires faith and hope in God in the terminally ill as well as their families whom it helps to accept the death of their loved one. It is an essential contribution that is offered by pastoral workers and the whole Christian community. According to the model of the Good Samaritan, acceptance overcomes denial, and hope prevails over anguish,[66] particularly when, as the end draws near,

64 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.

65 Cf. Francis, *Address to participants in the plenary of the Pontifical Academy for Life* (5 March 2015): *AAS* 107 (2015), 275.

66 Cf. Pontifical Council for Pastoral Assistance to Health Care

suffering is protracted by a worsening pathology. In this phase, the identification of an effective pain relief therapy allows the patient to face the sickness and death without the fear of undergoing intolerable pain. Such care must be accompanied by a fraternal support to reduce the loneliness that patients feel when they are insufficiently supported or understood in their difficulties.

Palliative care cannot provide a fundamental answer to suffering or eradicate it from people's lives.[67] To claim otherwise is to generate a false hope, and cause even greater despair in the midst of suffering. Medical science can understand physical pain better and can deploy the best technical resources to treat it. But terminal illness causes a profound suffering in the sick person, who seeks a level of care beyond the purely technical. *Spe salvi facti sumus*: in hope, theological hope, directed toward God, we have been saved, says Saint Paul (*Rm* 8:24).

"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 evil in the world. In times of suffering, the human person should be able to experience a solidarity and a love that takes on the suffering, offering a sense of life that extends beyond death. All of this has a great social importance: "A society unable to accept the suffering of its members and incapable of helping to share their suffering, and to bear it inwardly through 'com-passion' is a cruel and inhuman society".[68]

Workers, *New Charter for Health Care Workers*, n. 147.

67 Cf. John Paul II, Apostolic Letter *Salvifici doloris* (11 February 1984), 2: *AAS* 76 (1984), 202: "Suffering seems to belong to man's transcendence: it is one of those points in which man in a certain sense 'destined' to go beyond himself, and he is called to this in a mysterious way".

68 Benedict XVI, Encyclical Letter *Spe salvi* (30 November 2007), 38: *AAS* 99 (2007), 1016.

It should be recognized, however, that the definition of palliative care has in recent years taken on a sometimes equivocal connotation. In some countries, national laws regulating palliative care (*Palliative Care Act*) as well as the laws on the "end of life" (*End-of-Life Law*) provide, along with palliative treatments, something called Medical Assistance to the Dying (MAiD) that can include the possibility of requesting euthanasia and assisted suicide. Such legal provisions are a cause of grave cultural confusion: by including under palliative care the provision of integrated medical assistance for a voluntary death, they imply that it would be morally lawful to request euthanasia or assisted suicide.

In addition, palliative interventions to reduce the suffering of gravely or terminally ill patients in these regulatory contexts can involve the administration of medications that intend to hasten death, as well as the suspension or interruption of hydration and nutrition even when death is not imminent. In fact, such practices are equivalent to *a direct action or omission to bring about death and are therefore unlawful*. The growing diffusion of such legislation and of scientific guidelines of national and international professional societies, constitutes a socially irresponsible threat to many people, including a growing number of vulnerable persons who needed only to be better cared for and comforted but are instead being led to choose euthanasia and suicide.

5. *The role of the family and hospice*

The role of the family is central to the care of the terminally

ill patient.[69] In the family a person can count on strong relationships, valued in themselves apart from their helpfulness or the joy they bring. It is essential that the sick under care do not feel themselves to be a burden, but can sense the intimacy and support of their loved ones. The family needs help and adequate resources to fulfil this mission. Recognizing the family's primary, fundamental and irreplaceable social function, governments should undertake to provide the necessary resources and structures to support it. In addition, Christian-inspired health care facilities should not neglect but instead integrate the family's human and spiritual accompaniment in *a unified program of care for the sick person*.

Next to the family, *hospice centers* which welcome the terminally sick and ensure their care until the last moment of life 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"[70] that shoulders the pain, accompanies it, and opens it to a trusting hope. These centers are an example of genuine humanity in society, sanctuaries where suffering is full of meaning. For this reason, they must be staffed by qualified personnel, possess the proper resources, and always be open to families. "In this regard, I think about how well *hospice* does for palliative care, where terminally ill people are accompanied with qualified medical, psychological and spiritual support, so that they can live with dignity, comforted by the closeness of loved ones, in the final phase of their earthly life. I hope that these centers continue

69 Cf. Francis, Apsotolic Exhortation *Amoris laetitia* (19 March 2016), 48: *AAS* 108 (2016), 330.

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

to be places where the 'therapy of dignity' is practiced with commitment, thus nurturing love and respect for life."[71] In these settings, as well as in Catholic facilities, healthcare workers and pastoral staff, in addition to being clinically competent, should also be practicing an authentic theologal life of faith and hope that is directed towards God, for this constitutes the highest form of the humanization of dying.[72]

6. *Accompaniment and care in prenatal and pediatric medicine*

Regarding the care of neo-natal infants and children suffering from terminal chronic-degenerative diseases, or are in the terminal stages of life itself, it is necessary to reaffirm what follows, aware of the need for first-rate programs that ensure the well-being of the children and their families.

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 so-called pre-natal pathologies "incompatible with life" – that will surely end in death within a short period of time – and in the absence of fetal or neo-natal therapies capable of improving their health, should not be left without assistance, but must be accompanied like any

71 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.)

72 Cf. Pontifical Council for Pastoral Assistance to Health Care Workers, *New Charter for Health Care Workers*, n. 148.

other patient until they reach natural death. *Prenatal comfort carefavors* a path of *integrated assistance* involving the support of medical staff and pastoral care workers alongside the constant presence of the family. The child is a special patient and requires the care of a professional with expert medical knowledge and affective skills. The empathetic accompaniment of a child, who is among the most frail, 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. In these centers, competent medical assistance, spiritual accompaniment, and the support of other families, who have undergone the same experience of pain and loss, constitute an essential resource. It is the pastoral duty of the Christian-inspired healthcare workers to make efforts to expand the accessibility of these centers throughout the world.

These forms of assistance are particularly necessary for those children who, given the current state of scientific knowledge, are destined to die soon after birth or within a short period of time. Providing care for these children helps the parents to handle their grief and to regard this experience not just as a loss, but as a moment in the journey of love which they have travelled together with their child.

Unfortunately the dominant culture today does not encourage this approach. The sometimes obsessive recourse to prenatal diagnosis, along with the emergence of a culture unfriendly to disability, often prompts the choice of abortion, going so far as to portray it as a kind of "prevention." Abortion consists in the deliberate killing of an innocent human life and as such it 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. In other cases, after birth, the same culture encourages the suspension or non-initiation of care for the child as soon as it is born because a disability is present or may develop in the future. This utilitarian approach—inhumane and gravely immoral—cannot be countenanced.

The fundamental principle of pediatric care is that children in the final stages of life have the right to the respect and care due to persons. To be avoided are both aggressive medical treatment and unreasonable tenacity, as well as intentional hastening of their death. From a Christian perspective, the pastoral care of a terminally ill child demands participation in the divine life in Baptism and in Confirmation.

It may happen that pharmacological or other therapies, designed to combat the pathology from which a child suffers, are suspended during the terminal stage of an incurable disease. The attending physician may determine that the child's deteriorated clinical condition renders these therapies either futile or extreme, and possibly the cause of added suffering. Nonetheless, in such situations the integral care of the child, in its various physiological, psychological, affective, and spiritual dimensions, must never cease. Care means more than therapy and healing. When a therapy is suspended because it no longer benefits an incurable patient, treatments that support the essential physiological functions of the child must continue insofar as the organism can benefit from them (hydration, nutrition, thermoregulation, proportionate respiratory support, and other types of assistance needed to maintain bodily homeostasis

and manage systemic and organic pain). The desire to abstain from any overly tenacious administration of treatments deemed ineffective *should not entail the withdrawal of care*.The path of accompaniment until the moment of death must remain open. Routine interventions, like respiratory assistance, can be provided painlessly and proportionately. Thus appropriate care must be customized to the personal needs of the patient, to avoid that a just concern for life does not contrast with an unjust imposition of pain that could be avoided.

Evaluation and management of the physical pain of a newborn or a child show the proper respect and assistance they deserve during the difficult stages of their illness. The tender personalized care that is attested today in clinical pediatric medicine, sustained by the presence of the parents, makes possible an integrated management of care that is more effective than invasive treatments.

Maintaining the emotional bond between the parent and the child is an integral part of the process of care. The connection between caregiving and parent-child assistance that is fundamental to the treatment of incurable or terminal pathologies should be favored as much as possible. In addition to emotional support, the spiritual moment must not be overlooked. The prayer of the people close to the sick child has a supernatural value that surpasses and deepens the affective relationship.

The ethical/juridical concept of "the best interest of the child" – when used in the cost-benefit calculations of care– can in no way form the foundation for decisions to shorten life in order to prevent suffering if these decisions envision actions or omissions that are euthanistic by nature or intention. As already mentioned, the suspension of disproportionate therapies cannot justify the suspension of the basic care, including pain relief, necessary to accompany these little patients to a dignified natural death, nor to the interruption of that spiritual care offered for one who will soon meet God.

7. *Analgesic therapy and loss of consciousness*

Some specialized care requires, on the part of the healthcare workers, a particular attention and competence to attain the best medical practice from an ethical point of view, with attention to people in their concrete situations of pain.

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 through the lens of redemption as a special offering to God,[73] the Church nonetheless affirms the moral licitness of sedation as part of patient care in order to ensure that the end of life arrives with the greatest possible peace and in the best internal conditions. This holds also for treatments that hasten the moment of death (deep palliative sedation in the terminal stage),[74] always, to the extent possible, with the

73 Cfr. Pio XII, *Allocutio. Trois questions religieuses et morales concernant l'analgésie* (24 febbraio 1957): *AAS* 49 (1957) 134-136; Congregation for the Doctrine of the Faith, Declaration *Iura et bona* (5 May 1980), III: *AAS* 72 (1980), 547; John Paul II, Apostolic Letter *Salvifici doloris* (11 February 1984), 19: *AAS* 76 (1984), 226.

74 Cfr. Pio XII, *Allocutio. Iis qui interfuerunt Conventui internationali. Romae habito, a «Collegio Internationali Neuro-Psycho-Pharmacologico» indicto* (9 settembre 1958): *AAS* 50 (1958), 694; Congregation for the Doctrine of the Faith, Declaration *Iura et bona* (5 May 1980), III: *AAS* 72 (1980), 548; *Catechism of the Catholic Church*, 2779; Pontifical Council for Pastoral Assistance to Health Care

patient's informed consent. From a pastoral point of view, prior spiritual preparation of the patients should be provided in order that they may consciously approach death as an encounter with God.[75] The use of analgesics is, therefore, part of the care of the patient, but any administration that directly and intentionally causes death is a euthanistic practice and is unacceptable.[76] The sedation must exclude, as its direct purpose, the intention to kill, even though it may accelerate the inevitable onset of death.[77]

In pediatric settings, when a child (for example, a new-born) is unable to understand, it must be stated that it would be a mistake to suppose that the child can tolerate the pain, when in fact there are ways to alleviate it. Caregivers are obliged to alleviate the child's suffering as much as possible, so that he or she can reach a natural death peacefully, while being able to experience the loving presence of the medical staff and above all the family.

8. *The vegetative state and the state of minimal consciousness*

Other relevant situations are that of the patient with the persistent lack of consciousness, the so-called "vegetative state" or that of the patient in the state of "minimal consciousness". It is always completely false to assume that the vegetative state, 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[78]. On the contrary, in these states of greatest

Workers, *New Charter for Health Care Workers*, n. 155 "Moreover there is the possibility of painkillers and narcotics causing a loss of consciousness in the dying person. Such usage deserves particular consideration. In the presence of unbearable pain that is resistant to typical pain-management therapies, if the moment of death is near or if there are good reasons for anticipating a particular crisis at the moment of death, a serious clinical indication may involve, with the sick person's consent, the administration of drugs that cause the loss of consciousness. This deep palliative sedation in the terminal phase, when clinically motivated, can be morally acceptable provided that it is done with the patient's consent, appropriate information is given to the family members, that any intention of euthanasia is ruled out, and that the patient has been able to perform his moral, familial and religious duties: 'As they approach death people ought to be able to satisfy their moral and family duties, and above all they ought to be able to prepare in a fully conscious way for their definitive meeting with God'. Therefore,' it is not right to deprive the dying person of consciousness without a serious reason'".

75 Cfr. Pio XII, *Allocutio. Trois questions religieuses et morales concernant l'analgésie* (24 febbraio 1957): *AAS* 49 (1957) 145; Congregation for the Doctrine of the Faith, Declaration *Iura et bona* (5 May 1980), III: *AAS* 72 (1980), 548; John Paul II, Encyclical Letter *Evangelium vitae* (25 March 1995), 65: *AAS* 87 (1995), 476.

76 Cf. Francis, *Address to Participants in the Commemorative Conference of the Italian Catholic Physicians' Association on the occassion of its 70th Anniversary of foundation* (15 November 2014): *AAS* 106 (2014), 978.

77 Cfr. Pio XII, *Allocutio. Trois questions religieuses et morales concernant l'analgésie* (24 febbraio 1957): *AAS* 49 (1957), 146; Id., *Allocutio. Iis qui interfuerunt Conventui internationali. Romae habito, a «Collegio Internationali Neuro-Psycho-Pharmacologico»* (9 settembre 1958): *AAS* 50 (1958), 695; Congregation for the Doctrine of the Faith, Declaration *Iura et bona*, III: *AAS* 72 (1980), 548; *Catechism of the Catholic Church*, 2279; John Paul II, Encyclical Letter *Evangelium vitae* (25 March 1995), 65: *AAS* 87 (1995), 476; Pontifical Council for Pastoral Assistance to Health Care Workers, *New Charter for Health Care Workers*, n. 154.

78 Cf. John Paul II, *Address to the participants in the International Congress "Life sustaining treatments and vegeative state. Scientific progress and ethical dilemmas"* (20 March 2004), 3: *AAS* 96 (2004), 487: "A man, even if seriously ill or disabled in the exercise of his

weakness, the person must be acknowledged in their intrinsic value and assisted with suitable care. The fact that the sick person can remain for years in this anguishing situation without any prospect of recovery undoubtedly entails suffering for the caregivers.

One must never forget in such painful situations that the patient in these states has the right to nutrition and hydration, even administered by artificial methods that accord with the principle of ordinary means. In some cases, such measures can become disproportionate, because their administration is ineffective, or involves procedures that create an excessive burden with negative results that exceed any benefits to the patient.

In the light of these principles, the obligation of caregivers includes not just the patient, but extends to the family or to the person responsible for the patient's care, and should be comprised of adequate pastoral accompaniment. Adequate support must be provided to the families 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. Caregivers must be sufficiently prepared for such situations, as family members need to be properly supported.

9. *Conscientious objections on the part of healthcare workers and of Catholic healthcare institutions*

In the face of the legalization of euthanasia or assisted suicide – even when viewed simply as another form of medical assistance – formal or immediate 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

highest functions, is and always will be a man, and he will never become a 'vegetable' or an 'animal'".

to euthanasia: laws exist, not to cause death, but to protect life and to facilitate co-existence among human beings. It is therefore never morally lawful to collaborate with such immoral actions or to imply collusion in word, action or omission. The one authentic right is that the sick person be accompanied and cared for with genuine humanity. Only in this way can the patient's dignity be preserved until the moment of natural death. "No health care worker, therefore, can become the defender of a non-existing right, even if euthanasia were requested by the subject in question when he was fully conscious".[79]

In this regard, the general principles regarding cooperation with evil, that is, with unlawful actions, are thus reaffirmed: "Christians, like all people of good will, are called, with a grave obligation of conscience, not to lend their formal collaboration to those practices which, although allowed by civil legislation, are in contrast with the Law of God. In fact, from the moral point of view, it is never licit to formally cooperate in evil. This cooperation occurs when the action taken, either by its very nature or by the configuration it is assuming in a concrete context, qualifies as direct participation in an act against innocent human life, or as sharing the immoral intention of the principal agent. This cooperation can never be justified neither by invoking respect for the freedom of others, nor by relying on the fact that civil law provides for it and requires it: for the acts that each person personally performs, there is, in fact, a moral responsibility that no one can ever escape and on which each one will be judged by God himself (cf. *Rm* 2:6; 14:12)".[80]

Governments must acknowledge the right to conscientious objection in

79 Pontifical Council for Pastoral Assistance to Health Care Workers, *New Charter for Health Care Workers*, n. 151.

80 *Ibid*., n. 151; John Paul II, Encyclical Letter *Evangelium vitae* (25 March 1995), 74: *AAS* 87 (1995), 487.

the medical and healthcare field, where the principles of the natural moral law are involved and especially where in the service to life the voice of conscience is daily invoked.[81]Where this is not recognized, one may be confronted with the obligation to disobey human law, in order to avoid adding one wrong to another, thereby conditioning one's conscience. Healthcare workers should not hesitate to ask for this right as a specific contribution to the common good.

Likewise, healthcare institutions must resist the strong economic pressures that may sometimes induce them to accept the practice of euthanasia. If the difficulty in finding necessary operating funds creates an enormous burden for these public institutions, then the whole society must accept an additional liability in order to ensure that the incurably ill are not left to their own or their families' resources. All of this requires that episcopal conferences and local churches, as well as Catholic communities and institutions, adopt a clear and unified position to safeguard the right of conscientious objection in regulatory contexts where euthanasia and suicide are sanctioned.

Catholic healthcare institutions constitute a concrete sign of the way in which the ecclesial community takes care of the sick following the example of the Good Samaritan. The command of Jesus to "cure the sick," (*Lk* 10:9) is fulfilled not only by laying hands on them, but also by rescuing them from the streets, assisting them in their own homes, and creating special structures of hospitality and welcome. Faithful to the command of the Lord, the Church through the centuries has created various structures where medical care finds its specific form in the context of integral service to the sick person.

81 Cf. Francis, *Address to Participants in the Commemorative Conference of the Italian Catholic Physicians' Association on the occasion of its 70th Anniversary of foundation* (15 November 2014): *AAS* 106 (2014), 977.

Catholic healthcare institutions are called to witness faithfully to the inalienable commitment to ethics and to the fundamental human and Christian values that constitute their identity. This witness requires that they abstain from plainly immoral conduct and that they affirm their formal adherence to the teachings of the ecclesial Magisterium. Any action that does not correspond to the purpose and values which inspire Catholic healthcare institutions is not morally acceptable and endangers the identification of the institution itself as "Catholic."

Institutional collaboration with other hospital systems is not morally permissible when it involves referrals for persons who request euthanasia. Such choices cannot be morally accepted or supported in their concrete realization, even if they are legally admissible. Indeed, it can rightly be said of laws that permit euthanasia that "not only do they create no obligation for the conscience, but instead there is a grave and clear obligation to oppose them by conscientious objection. From the very beginnings of the Church, the apostolic preaching reminded Christians of their duty to obey legitimately constituted public authorities (cf. *Rm* 13:1-7; 1 *Pt* 2:13-14), but at the same time firmly warned that 'we must obey God rather than men' (*Acts* 5:29)".[82]

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. They are in fact laws contrary to natural law because they undermine the very foundations of human dignity and human coexistence rooted in justice.

10. *Pastoral accompaniment and the support of the sacraments*

Death is a decisive moment in the human person's encounter with God

82 John Paul II, Encyclical Letter *Evangelium vitae* (25 March 1995), 73: *AAS* 87 (1995), 486.

the Savior. The Church is called to accompany spiritually the faithful in the situation, offering them the "healing resources" of prayer and the sacraments. Helping the Christian to experience this moment with spiritual assistance is a supreme act of charity. Because "no believer should die in loneliness and neglect",[83] it encompasses the patient with the solid support of human, and humanizing, relationships to accompany them and open them to hope.

The parable of the Good Samaritan shows what the relationship with the suffering neighbor should be, what qualities should be avoided – indifference, apathy, bias, fear of soiling one's hands, totally occupied with one's own affairs – and what qualities should be embraced – attention, listening, understanding, compassion, and discretion.

The invitation to imitate the Samaritan's example— "Go and do likewise" (*Lk* 10:37)—is an admonition not to underestimate the full human potential of presence, of availability, of welcoming, of discernment, and of involvement, which nearness to one in need demands and which is essential to the integral care of the sick.

The quality of love and care for persons in critical and terminal stages of life contributes to assuaging the terrible, desperate desire to end one's life. Only human warmth and evangelical fraternity can reveal a positive horizon of support to the sick person in hope and confident trust.

Such accompaniment is part of the path defined by palliative care that includes the patients and their families.

83 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.

The family has always played an important role in care, because their presence sustains the patient, and their love represents an essential therapeutic factor in the care of the sick person. Indeed, recalls Pope Francis, the family "has always been the nearest 'hospital' still today, in so many parts of the world, a hospital is for the privileged few, and is often far away. It is the mother, the father, brother, sisters and godparents who guarantee care and help one to heal".[84]

Taking care of others, or providing care for the suffering of others, is a commitment that embraces not just a few but the entire Christian community. Saint Paul affirms that when one member suffers, it is the whole body that suffers (cf. 1 *Cor*12:26) and all bend to the sick to bring them relief. Everyone, for his or her part, is called to be a "servant of consolation" in the face of any human situation of desolation or discomfort.

Pastoral accompaniment involves the exercise of the human and Christian virtues of *empathy (en-pathos)*, of *compassion(cum-passio)*, of bearing another's suffering by sharing it, and of the *consolation (cum-solacium)*, of entering into the solitude of others to make them feel loved, accepted, accompanied, and sustained.

The ministry of listening and of consolation that the priest is called to offer, which symbolizes the compassionate solicitude of Christ and the Church, can and must have a decisive role. In this essential mission it is extremely important to bear witness to and unite truth and charity with which the gaze of the Good Shepherd never ceases to accompany all of His children. 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 priestly formation provide an updated

84 Francis, *General Audience*, (10 June 2015): L'Osservatore Romano, 11 giugno 2015, 8.

and precise preparation in this area. It is also important that priests be formed in this Christian accompaniment. Since there may be particular circumstances that make it difficult for a priest to be present at the bedside, physicians and healthcare workers need this formation as well.

Being men and women skilled in humanity means that 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, in an efficacious manner, the oil of consolation and the wine of hope onto human wounds.

Every person has the natural right to be cared for, which at this time is the highest expression of the religion that one professes.

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

The Church calls Penance and the Anointing of the Sick sacraments "of healing"[85], for they culminate in the Eucharist which is the "viaticum" for eternal life.[86] 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,[87] by supporting them in hope especially when the

85 *Catechism of the Catholic Church*, 1420.

86 Cfr. Rituale Romanum, *ex decreto Sacrosancti Oecumenici Concilii Vaticani II instauratum auctoritate Pauli PP. VI promulgatum, Ordo unctionis infirmorum eorumque pastoralis curae, Editio typica, Praenotanda*, Typis Polyglottis Vaticanis, Civitate Vaticana 1972, n. 26; *Catechism of the Catholic Church*, 1524.

87 Cf. Francis, Encyclical Letter *Laudato si'* (24 May 2015), 235: *AAS* 107 (2015), 939.

journey becomes exhausting.[88]

11. *Pastoral discernment towards those who request Euthanasia or Assisted Suicide*

The pastoral accompaniment of those who expressly ask for euthanasia or assisted suicide today presents a singular moment when a reaffirmation of the teaching of the Church is necessary. With respect to the Sacrament of Penance and Reconciliation, the confessor must be assured of the presence of the true contrition necessary for the validity of absolution which consists in "**sorrow of mind and a detestation for sin committed, with the purpose of not sinning for the future**".[89] In this situation, we find ourselves before a person who, whatever their subjective dispositions may be, has decided upon a gravely immoral act and willingly persists in this decision. Such a state involves a manifest absence of the proper disposition for the reception of the Sacraments of Penance, with absolution,[90] and Anointing,[91] with Viaticum.[92] 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 in this regard. Thus a person who may be registered in an association to receive euthanasia or assisted suicide must manifest the intention of cancelling such a registration before receiving the sacraments. It must be recalled that the necessity to postpone absolution does not imply a judgment on the imputability of guilt, since personal responsibility could

88 Cf. John Paul II, Encyclical Letter *Evangelium vitae* (25 March 1995), 67: *AAS* 87 (1995), 478-479.

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

90 Cf. *Code of Canon Law*, can. 987.

91 Cf. *Code of Canon Law*, can. 1007: "The anointing of the sick is not to be conferred upon those who persevere obstinately in manifest grave sin".

92 Cf. *Code of Canon Law*, can. 915 and can. 843 § 1.

be diminished or non-existent.[93] The priest could administer the sacraments to an unconscious person sub *condicione* if, on the basis of some signal given by the patient beforehand, he can presume his or her repentance.

The position of the Church here does not imply a non-acceptance of the sick person. It must be accompanied by a willingness to listen and to help, together with a deeper explanation of the nature of the sacrament, in order to provide the opportunity to desire and choose the sacrament up to the last moment. The Church is careful to look deeply for adequate signs of conversion, so that the faithful can reasonably ask for the reception of 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 a person who may not be in the objective condition to receive the sacraments, for this nearness is an invitation to conversion, especially when euthanasia, requested or accepted, will not take place immediately or imminently. Here it remains possible to accompany the person whose hope may be revived and whose erroneous decision may be modified, 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 this act. This principle applies in a particular way, but is not limited to, chaplains in the healthcare systems where euthanasia is practiced, for they must not give scandal by behaving in a manner that makes them complicit in the termination of human life.

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

12. *The reform of the education and formation of the healthcare workers*

In today's social and cultural context, 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 neighbour and their suffering manifested by the Good Samaritan of the Gospel.[94]

Hospital chaplains should intensify the spiritual and moral formation of the healthcare workers, including physicians and nursing staff, as well as hospital volunteers, in order to prepare them to provide the human and psychological 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 for the pastoral and healthcare workers.

Palliative treatments must be disseminated throughout the world. To this end, it would be desirable to organize academic courses of study for the specialized formation of healthcare workers. Also a priority is the dissemination of accurate general information on the value of effective palliative treatments for a dignified accompaniment of the person until a natural death. Christian-inspired healthcare institutions should arrange for guidelines for the healthcare workers 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 of all healthcare workers as well as in hospital training programs.

94 Cf. John Paul II, Apostolic Letter *Salvifici doloris* (11 February 1984), 29: *AAS* 76 (1984), 244-246.

In addition, healthcare and assistance organizations must arrange for models of psychological and spiritual aid to healthcare workers who care for the terminally ill. *To show care for those who care* is essential so that healthcare workers and physicians do not bear all of the weight of the suffering and of the death of incurable patients (which can result in *burn out* for them). They need support and therapeutic sessions to process not only their values and feelings, but also the anguish they experience as they confront suffering and death in the context of their service to life. They need a profound sense of hope, along with the awareness that their own mission is a true vocation to accompany the mystery of life and grace in the painful and terminal stages of existence.[95]

Conclusion

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

Christian witness demonstrates that hope is always possible, even within a "throwaway culture". "The eloquence of the parable of the Good Samaritan and of the whole Gospel is especially this: every individual must feel as if called personally to bear witness to love in suffering".[96]

95 Cf. Francis, *Address to the doctors in Spain and Latin America: compassion is the very soul of medicine* (9 June 2016): *AAS* 108 (2016), 727-728. "Frailty, pain and infirmity are a difficult trial for everyone, including medical staff; they call for patience, for suffering-with; therefore, we must not give in to the functionalist temptation to apply rapid and drastic solutions moved by false compassion or by mere criteria of efficiency or cost-effectiveness. The dignity of human life is at stake; the dignity of the medical vocation is at stake".

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

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*!".[97] 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, with the will "to dispel the misery of another, as if it were his own".[98] The greatest misery consists in the loss of hope in the face of death. This hope is proclaimed by the Christian witness, which, to be effective, must be lived in faith and encompass everyone—families, nurses, and physicians. It must engage the pastoral resources of the diocese and of Catholic healthcare centers, which are called to live with faith *the duty to accompany* the sick in all of the stages of illness, and in particular in the critical and terminal stages of life as defined in this letter.

The Good Samaritan, who puts the face of his brother in difficulty at the center of his heart, and sees his need, offers him whatever is required to repair his wound of desolation and to open his heart to the luminous beams of hope.

The Samaritan's "willing the good" draws him near to the injured man not just with words or conversation, but with concrete actions and in truth (cf. 1 *Jn* 3:18). It takes the form of care in the example of Christ who went about doing good and healing all (cf. *Acts* 10:38).

Healed by Jesus, we become men and women called to proclaim

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

98 Saint Thomas Aquinas, *Summa Theologiae*, I, q. 21, a. 3.

his healing power to love and provide the care for our neighbors to which He bore witness.

That the vocation to the love and care of another[99] brings with it the rewards of eternity is made explicit by the Lord of life 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).

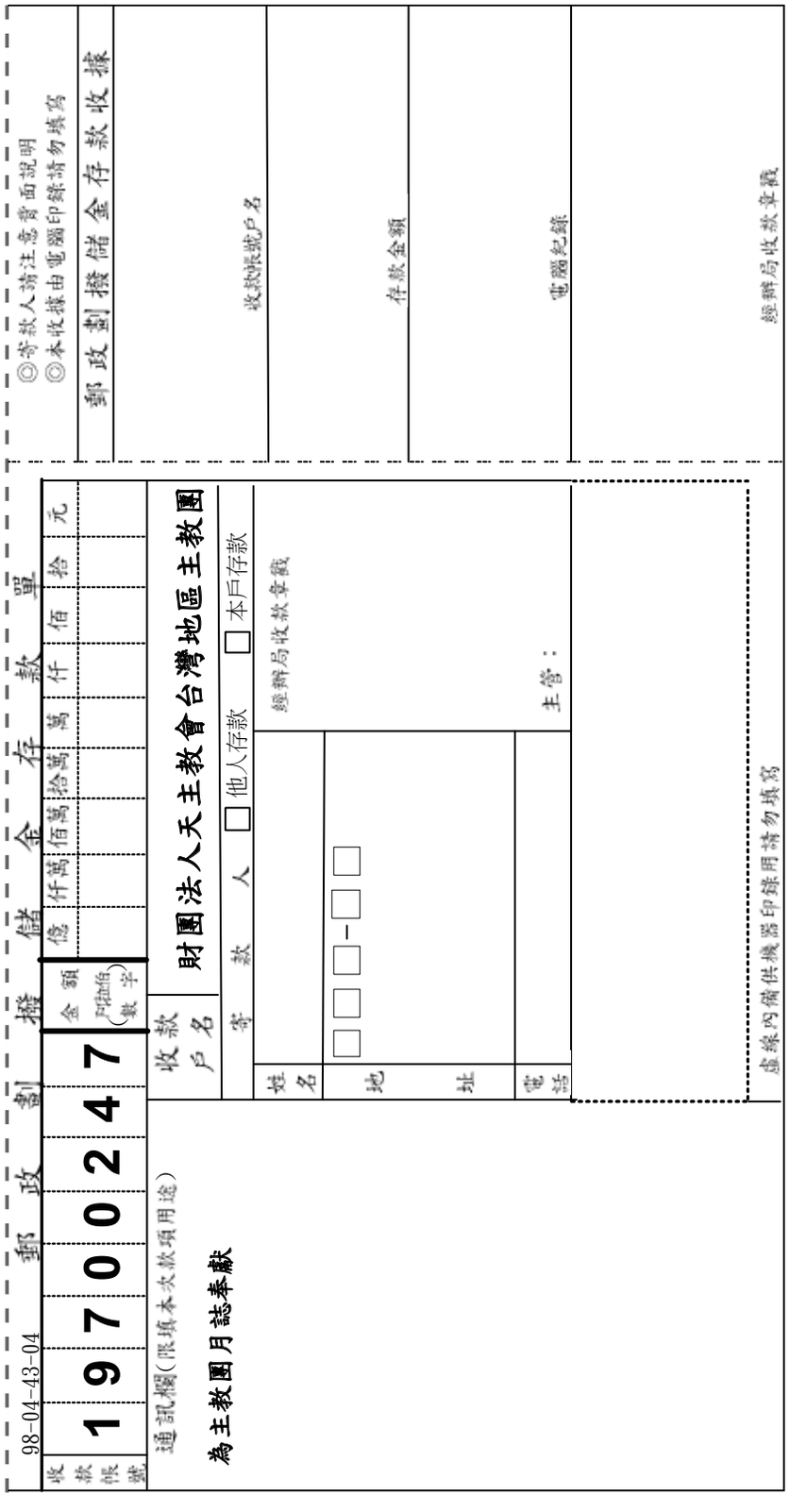
The Sovereign Pontiff Francis, on 25 June 2020, approved the present Letter, adopted in the Plenary Session of this Congregation, the 29th of January 2020, and ordered its publication.

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.

Luis F. Card. LADARIA, S.I.
Prefect

✠ Giacomo MORANDI
Archbishop tit. of Cerveteri
Secretary

99 Cf. Benedict XVI, Encyclical Letter *Spe salvi* (30 November 2007), 39: *AAS* 99 (2007), 1016. “To suffer with the other and for others; to suffer for the sake of truth and justice; to suffer out of love and in order to become a person who truly loves – these are fundamental elements of humanity, and to abandon them would destroy man himself”.



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