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Conscientious objection and euthanasia

Xavier Symons

Should doctors be allowed to conscientiously object to euthanasia? Voluntary euthanasia for patients with terminal illness is now legal in dozens of jurisdictions. A significant portion of doctors, however, believe that euthanasia is not part of medicine; opposition is especially high amongst palliative care specialists[1] — the doctors who are closest to terminally ill patients. Some doctors wonder whether euthanasia will have a counterproductive impact on suicide prevention and social reform. Respect for reasonable disagreement is a basic tenet of liberal democracies; it is difficult to see why this principle ought not apply in the medical profession. We do well to consider the place of respectful disagreement among the medical fraternity and whether liberal societies ought to protect physicians' right to conscientious objection.

In this issue

● Xavier Symons' essay first appeared on the website *of the American Philosophical Association* in May. Xavier, who is currently undertaking a Post-Fellowship in the Human Flourishing Program at Harvard University, has been appointed to the position of Director of the Plunkett Centre.

● The Australian Catholic Bishops' Conference has published a document called ***'To Witness and to Accompany with Christian Hope'***. It is offered as a 'service' to those who are called to attend to the spiritual and pastoral needs of patients who access or seek to access services that are designed to terminate a person's life. We republish it here in full, under a Creative Commons Licence according to which we give credit to the author and make no commercial use, nor adaptations of, the work.

[1] L Sheahan, "Exploring the interface between 'physician-assisted death' and palliative care: cross-sectional data from Australasian palliative care specialists" *Internal Medicine Journal* *Vol 46, Issue 4* p 443-451 13 Jan 2016

Conscientious objection and healthcare

Conscientious objection refers to the right of healthcare professionals to opt out of participation in the provision of medical interventions to which they have an ethical or religious objection. As a rule, healthcare professionals have responsibilities to provide treatments that are safe, legal, clinically indicated, and desired by patients. Good medical practice is not just a matter of professional expertise but also respect for the rights of patients. Indeed, patient autonomy has become a preeminent medical principle governing the interactions between care teams and patients. Thus, Julian Savulescu and Udo Schuklenk – prominent critics of conscientious objection – assert that:[2]

> *"[i]f a service a doctor is requested to perform is a medical practice, is legal, consistent with distributive justice, requested by the patient or their appointed surrogate, and is plausibly in their interests, the doctor must ensure the patient has access to it."*

Physician discretion, however, remains a cornerstone of good medical practice. Doctors can and should be allowed to withhold treatment where such treatment is deemed to be inimical to patient wellbeing. The point is not just one of clinical appropriateness. Doctors ought to be allowed to act in accordance with their best judgment about what constitutes good medical care, and this judgement involves ethical as well as technical considerations.

Conscientious objection is often described with reference to neuralgic social issues such as abortion, euthanasia, sterilizations, and the provision of emergency contraceptives. But in theory a doctor could have a conscientious objection to any medical procedure. Conscientious objection is not uncommon in critical care[3], for example, where clinicians are having to regularly make complex, value-laden treatment decisions about seriously ill patients. Doctors might also object to utilizing new treatments for which there is limited evidence, such as analgesic medicinal cannabis,[4] or where the treatment might only make a patient feel worse, as may be the case with cosmetic surgery.[5] In the last analysis, conscientious objection is one manifestation of the prudential judgement that a physician must make about the best interests of their patients.

Conscientious objection is not an absolute right. Conscientious objection pertains to procedures rather than to classes of patients. It should not be used to justify racist, sexist, homophobic beliefs or religious prejudice. Appeals to conscience ought to be justified with reference to ethical reasoning or faith commitments. Appeals to conscience should be distinguished from mere laziness or a dislike for discharging one's professional duties.

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[2] Doctors Have no Right to Refuse Medical Assistance in Dying, Abortion or Contraception Julian Savulescu and Udo Schuklenk *Bioethics Volume 31, Issue 3* p. 162-170, September 2016

[3] Dominic Wilkinson, "Conscientious Non-objection in Intensive Care" *Cambridge Quarterly of Healthcare Ethics Vol 26 Issue 1* CUP **:** 09 December 2016

[4] Filip Gedin, **"**Cannabis is no better than a placebo for treating pain – new research" , *The Conversation,*)November 29**, 2022**

[5] Francesca Minerva, "Cosmetic surgery and conscientious objection", *Journal of Medical Ethics Vol 43 Issue 4* April 2017

Conscientious objection guidelines typically advise conscientious objectors to ensure that patients can access the medical service in question in a safe and timely fashion (see, for example the Australian Medical Association [6]). But these provisions ought not amount to a violation of the integrity of conscientiously objecting physicians. This would defeat the purpose of attempting to accommodate conscientious objection.

Voluntary Euthanasia

Voluntary euthanasia refers to the intentional and consensual ending of a patient's life either by or with the assistance of a medical professional. Strictly speaking, euthanasia – where a doctor ends the patient's life – ought to be distinguished from assisted suicide – where the patient themselves ends their own life.

Euthanasia is legal in several jurisdictions around the world, including in the Netherlands, Belgium, Luxembourg, Canada, Columbia, Spain, New Zealand, and in every Australian state. Assisted suicide is legal in several US states. Typically access to euthanasia and assisted suicide is confined to patients with a terminal illness, but in some jurisdictions eligibility criteria are more expansive. Both Belgium and the Netherlands allow euthanasia for psychiatric reasons and also permit euthanasia for minors. Canada recently expanded access to euthanasia to include patients with chronic illness as well as patients with mental illness. (The implementation of euthanasia for mental illness has been paused due to concerns that the Canadian healthcare system is not yet prepared to handle such requests.)[7]

Physician objections to euthanasia

Many doctors are opposed to the intentional killing of other human beings, even where this is done under the auspices of liberal medical norms. Life is the most basic of human goods and the sanctity of life is a fundamental civilizing principle even for liberal societies. Euthanasia violates this principle by sanctioning the killing of patients.

Many doctors argue that euthanasia does not belong in medicine. It is not uncommon to hear doctors invoking the first precept of the Hippocratic Oath, *primum non nocere* (do no harm), as an argument against physician participation in euthanasia. Palliative care physicians[8] argue that the refractory pain that is the supposed target of euthanasia legislation can in fact be alleviated with appropriate analgesics. In any case, it is a basic dictum of palliative care that death is a natural part of life that ought not be hastened nor inappropriately prolonged.

Physicians also raise more specific concerns about the regulation of euthanasia. Some argue that euthanasia is unsafe and will lead to wrongful deaths. Many are concerned that patients are not being adequately assessed for depression or that patients with complex mental illnesses are utilizing euthanasia on account of a lack of appropriate social support. Others have warned

[6] Australian Medical Association Conscientious Objection - Position Statement 2019

[7] Karandeep Sonu Gaind, "Canada delays expanding medical assistance in dying to include mental illness, but it's still a policy built on quicksand", *The Conversation,* December 2022

[8] Daniel Sulmasy et al Non-faith-based arguments against physician-assisted suicide and euthanasia *Lincacre Quarterly Vol 83 (3)* p246-257, August 2016

of *suicide contagion* as a result of euthanasia – a concern for which there is at least some evidence.[9]

The permissibility of conscientious objection to euthanasia

What is important is not so much whether one finds these arguments ultimately persuasive. What matters is whether they are *reasonable*. The notion of *reasonableness* and its close cousin *reasonable disagreement* have been the subject of much contention within philosophical circles in recent decades. Such philosophical speculation need not concern us here. What matters is whether it is reasonable for a doctor to hold concerns about the risks and potential harms inherent in state sanctioned voluntary euthanasia. I believe the answer is *yes*. There is at least some evidence to suggest that euthanasia has been poorly regulated in jurisdictions where it is legal. In the Netherlands, for example, data suggests[10] that upwards of 20% of euthanasia cases go unreported. Experts have also raised concerns[11] that "evaluating patients' [euthanasia] requests requires complicated judgements in implementing criteria that are intentionally open-ended, evolving and fraught with acknowledged interpretive difficulties". In Canada, family members[12] of euthanised patients have raised concerns about the way that doctors appear to 'approve of' situations of depression and social isolation.

And whatever one thinks of the ethics of physician assistance in suicide, it is undeniable that medicine's participation in euthanasia constitutes a seismic shift – a movement away from a view of medicine as oriented toward the goals of health and wellbeing and a movement toward the view that medicine is ancillary to the realisation of patient preferences regardless of whether these preferences are conducive to health and wellbeing. Indeed, the medical good *just is* what the patient wants in this new era of liberal medical norms. One might argue that euthanasia is healthcare and that a right to access healthcare is fundamental. But considered on its own it is hard to see how this argument is anything more than question begging.

Some theorists express concern at the religious character of some instances of conscientious objection. It could be argued that religion has no place in healthcare and that objections based on religious belief ought not be permitted. But the distinction between what we might call 'ethical' and 'religious' objections is tenuous at best. It seems that many doctors hold views that have both an ethical and religious dimension, and it is not easy to separate these two elements. If anything, it seems that arguments across the spectrum in the euthanasia debate – even those in favour of euthanasia – have a quasi-religious character, particularly where they are motivated by a concern for human dignity.

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[9] Michael Cook Does *legalising assisted suicide really decrease non-assisted suicide? Bioedge.org* November 2022

10 Bergje D Onwuteaka-Philisen et al, "Trends in end-of-life practices before and after the enactment of the euthanasia law in the Netherlands from 1990 to 2010: a repeated cross-sectional survey" *The Lancet Volume 380 Issue 9845 p 908-915* September 2012

[11] David Gibbes Miller, Scott Y H Kim, "Euthanasia and physician-assisted suicide not meeting due care criteria in the Netherlands: a qualitative review of review committee judgements" *BMJ Open Vol 7 Issue 10* , Oct 2017

[12] Christopher Lyon, "Witnessing my father's medically assisted death in Canada" *christopherlyon.substack.com* November 2022

The regulation of conscientious objection

Conscientious objection to euthanasia is tightly regulated in some jurisdictions. In Ontario, Canada, for example, doctors with a conscientious objection are obliged to provide an 'effective referral'[13] to patients seeking access to euthanasia. Institutional conscientious objection – i.e., the non-participation of whole institutions in the provision of euthanasia – is also difficult in Canada and in some cases hospices have had their contracts revoked[14] based on their opposition to euthanasia. In the Australian state of Queensland institutional conscientious objection is highly restricted and faith-based healthcare providers[15] cannot prevent doctors from accessing their facilities to assess patients for euthanasia eligibility.

We need to think carefully about how we regulate conscientious objection to euthanasia. Conscientious objectors may be thought by some to be bad faith actors. I would argue that the major concerns that motivate conscientious objection to euthanasia are in fact reasonable and worthy of our respect. Institutions are not the same as individual healthcare practitioners but analogous arguments can be made for their right to conscientious objection.

Conclusion

The accommodation of conscientious objection in healthcare reflects a mature understanding of moral disagreement in society. Euthanasia is no exception. Euthanasia constitutes a fundamental shift in the ethical orientation of end-of-life care and has proved difficult to regulate. Considering this, individual physicians and institutions ought to be allowed to opt out of the provision of euthanasia. Doctors and institutions with a conscientious objection should not be subject to punitive measures. Authentic liberalism in healthcare requires that we respect the values of doctors and institutions in addition to promoting patient interests.

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[13] College of Physicians and Surgeons of Ontario Medical Assistance in Dying www.cpso.on.ca April 2021

[14] Delta hospice reopens after bitter fight over medically assisted death | CBC News April 2021

[15] Lydia Lynch, "Churches denied a say in patient deaths" *The Australian* September 2021

To Witness and to Accompany with Christian Hope

Australian Catholic Bishops' Conference

"Christian Accompaniment is a continuation of the ministry of Jesus Christ, who reached out to the sick, the outcast and the sinner. He never condoned evil. He did not condemn the wayward, but he always called them to conversion."

"The life and death of each of us has its influence on others."[1] This is particularly true as death approaches, as others are called to encircle and accompany the one who is dying. Some of these will be family members, some will be healthcare professionals and others will be members of the clergy, pastoral care workers and volunteers in pastoral ministry.

This document is offered as a service to those who are called to attend to the spiritual and pastoral needs of patients who access or seek to access services that are designed to terminate a person's life.

Catholic teaching on euthanasia is clear and well-documented locally and universally.[2] The purpose of this paper is to assist those who exercise sacramental and pastoral ministry to respond to the families and patients who seek to access or who have accessed services that the Church teaches to be morally unacceptable. We owe particular gratitude to the New Zealand Catholic Bishops Conference, which gave permission to use its documents *Bearers of Consolation and Hope* and *Ministers of Consolation and Hope* in the formation of this document.

While responses to a patient considering euthanasia will vary somewhat according to a person's relationship with the patient, or role in their life, there are four irreducible elements of Christian accompaniment in the context of terminal illness:

- A commitment to be the patient's companion during this last phase of their life.
- An understanding of the medical care that will assist the patient at this time.
- An understanding and acceptance of the Church's teaching about the sacred and intrinsic value of every human life and why euthanasia and suicide are wrong.
- A readiness to provide appropriate forms of pastoral care as life nears its end.

In this document, we will often refer to a person considering euthanasia as a "patient" since we expect that pastoral ministry with a person requesting euthanasia will be for a patient with

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[1] Romans 14:7.

[2] Cf. Sacred Congregation for the Doctrine of the Faith, Declaration on Euthanasia*, Iura et Bona,* May 5, 1980*,* Pope John Paul II, Encyclical Letter, *Evangelium Vitae,* 25 March 1995, Catechism of the Catholic Church, 2nd Australian Edition, 2000.

a terminal illness who is likely to die within a foreseeable time (as determined by the governing legislation).[3]

Introduction

1. With the words, "Zacchaeus, come down. Hurry, because I am to stay at your house today"[4], Jesus demonstrates the power of Christian accompaniment. In this passage from Luke's Gospel, Zacchaeus, a tax collector, climbs a tree to glimpse Jesus because he is too short to see above the crowds. Jesus sees him in the tree and declares that he intends to stay with Zacchaeus that night. Jesus' offer of companionship and availability inspires Zacchaeus' promise to give away half his property and repay anyone he may have cheated. Jesus looks beyond Zacchaeus' past to see the person in need of love and companionship, in keeping with his mission to "seek out and save what was lost".[5]

2. Christian accompaniment is a continuation of the ministry of Jesus Christ, who reached out to the sick, the outcast and the sinner. He never condoned evil. He did not condemn the wayward, but he always called them to conversion. In the Scriptures, Jesus provides a template for us to affirm life without compromising truth.

Part A. Responding to a person considering euthanasia – common principles

3. In recent years, a practice described as "voluntary assisted dying" (VAD) has been legalised in all Australian states. While the label "VAD" is convenient, the seemingly comforting words it uses are gravely misleading, as VAD actually involves the intentional ending of a human life. This practice, which brings about death, is assisted suicide when a doctor assists by prescribing a lethal substance. It is euthanasia when a healthcare professional administers the lethal dose. While noting this distinction, in this document, we will refer to all intentional ending of life through a medical prescription as euthanasia.

4. The legalisation of euthanasia raises acute questions and ethical dilemmas for family members, healthcare professionals, pastoral care workers and clergy when someone for whom they care is considering, or has decided upon, euthanasia. When people hear that someone is considering euthanasia, they can feel shocked and distressed and struggle with conflicting feelings. They may feel pressured to condone euthanasia while also feeling

[3] Cf. *Voluntary Assisted Dying Act* (Qld) 2021, S 10 (1) (a) and *Voluntary Assisted Dying Act* (Vic) 2017 S9 (1) (d).
[4] Luke 19:5.
[5] Luke 19:10.

confused or ashamed. They may find it hard to know what to say, or even how to stay close to the patient, which can be physically, emotionally and/or financially exhausting.

5. As Christians, we look to the example of Jesus. When Christians accompany a patient who is considering euthanasia, they recognise that euthanasia would be an erroneous choice, but they also see the patient's emotional and spiritual needs. They then witness to the saving presence of God, who journeys with humanity on its pilgrim way, inviting each person to allow divine grace to renew them, especially when they are facing difficult decisions as life comes to an end. A patient considering euthanasia, even if they make an erroneous choice, remains a son or daughter of the Heavenly Father, a brother or sister in Christ, and a loved member of the Church.

Why euthanasia is wrong

6. Catholic teaching on euthanasia flows from our understanding of the human person. Euthanasia contradicts the goodness and dignity of each human person, created in the image of God – a unique, irreplaceable individual. This dignity can never be lost, no matter how "undignified" a patient may feel when affected by the frailty of illness and old age. Just as we begin our lives as fragile babies totally dependent on others, we commonly end our lives more or less dependent on others. What matters is the person we become in the intervening years: the relationships we have formed, the virtues we have developed and the faith in God that we have nurtured. When the last phase of earthly life arrives, with trust in God, the giver of all life, we can pass the weeks or days that remain to us in the best possible ways while preparing for the gift of eternal life. Therefore, "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".[6]

7. Euthanasia is contrary to the Fifth Commandment, "You shall not kill", and "the deepest element of God's commandment to protect human life is the requirement to show reverence and love for every person and the life of every person".[7] This requirement extends to one's own life. To appreciate why euthanasia is wrong, it is helpful to recall why – in every other circumstance – we regard every intentional ending of life as a tragedy. The reasons are multiple: the despair and isolation of the person who dies, the impact on their family and friends, the future opportunities and blessings for the person that have been cut off, and more. Why should anyone suppose that these reasons cease to matter in the case of a

[6] *Samaritanus Bonus*, I. Care for One's Neighbor. Samaritanus Bonus is a letter from the Congregation for the Doctrine of the Faith "On the care of persons in the critical and terminal phases of life", 14 July 2020. https://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20200714_samaritanus-bonus_en.html.

[7] *Evangelium Vitae, 41.*

person with a terminal illness, or someone who is "tired of life", or who feels they are a burden to others, or who is afraid of becoming "undignified" through frailty?

A Christian response to suffering

8. When suffering is caused by disease and illness, it arrives uninvited and is particularly unwelcome when the condition is painful and takes away the enjoyment of life. In the case of patients with terminal conditions, the diminishment of physical ability and mental facility can give rise to a certain sense of helplessness and self-reflection that can bring into question the meaning of life itself. Similarly, the family and friends who attend upon a patient in a diminished state of health can experience vicarious suffering and feelings of helplessness.

9. For people of faith, suffering can have a redemptive quality. We do not choose suffering, but Jesus Christ did (cf. John 10:18). He freely chose to enter into the world's suffering on the Cross – and he did so from a font of love that not only enters but embraces, not only transcends but transfigures suffering and makes it redemptive. It is the love that turns death to life: it is the Gospel (good news) of God.

10. The mystery of redemption was accomplished in suffering where the nails fixed hands and feet to a cross and all human autonomy was finally restricted. In that moment of excruciation, suffering became redemptive. Jesus did not baulk at the suffering inflicted on him. He did not seek to avoid it nor bring it to a premature end. In the face of his impending diminishment, he handed his suffering over to his Heavenly Father with the words, "Not my will, but yours be done".[8] Because Jesus offered his own suffering for the good of the world, we believe that we can do the same when we experience suffering. We believe that we can unite our own sufferings with Jesus' and thus participate in his redemptive plan for the good of all humanity.[9]

11. Suffering never diminishes the fact that our lives are always worth living and that we can see the best in human beings in times of suffering. Even in times of suffering near the end of life, there is still so much for which to live. This is because the meaning of our lives is found in cultivating love and relationships with the people around us and not just in the collection of experiences that we undergo. When everything else falls away, and all we have are our relationships with the people around us, it is clear that autonomy and our ability to control our own lives are never absolute. Instead, we see that love is most powerfully realised

[8] Luke 22:42.
[9] Cf. Romans 8:17, Colossians 1:24.

through vulnerability, disempowerment, bearing the burdens of others and the truth that we are connected and that we need each other. Living for this kind of love is what motivates spouses, siblings, children, friends, healthcare professionals and chaplains to attend upon patients with heroic love, even when little recognition or gratitude may be received. In these moments, everyone – including a patient who is sick and suffering – can participate in the moments of love and presence that make life worth living.[10]

12. An aspect of the love and community that can shine through suffering is doing what we can to alleviate the physical, emotional and spiritual causes of suffering that a patient considering euthanasia might be feeling. For example, much of the physical suffering can be ameliorated through palliative care, which can control most symptoms of pain and discomfort. Clinical experience also highlights the value gained by providing patients with the pastoral support they need to reflect on the life they have lived and the meaningful legacies they will leave behind, such as their family, children, a fulfilling career and contribution to society. This then leads to helping them to meaningfully prepare for death through family prayers, meals and holidays, making memories and recording their legacy or life story. In many instances, these activities ameliorate the psycho-emotional symptoms of suffering by helping to remind a patient of their intrinsic value and dignity.

What Christian accompaniment means

13. Pope Francis has encouraged a pastoral ministry of accompaniment since "everyone needs to be touched by the comfort and attraction of God's saving love, which is mysteriously at work in each person, above and beyond their faults and failings".[11] This is a ministry that "calls for much time and patience", requiring a listening heart formed in prudence, understanding and receptivity to the Holy Spirit.[12] Above all, "one who accompanies others has to realise that each person's situation before God and their life in grace are mysteries which no one can fully know from without".[13]

14. Pastoral companions should bear in mind that, in many cases, people expressing an intention to end their life through euthanasia may be motivated not by an intentional rejection of God or of Catholic teaching but by a range of personal concerns related to their quality of life and/or concerns about the impact of their serious health issues on family, friends and others. They may not appreciate the various other options for end-of-life care that are available to them. A request for euthanasia is often a cry for help. Many patients who at one point say, "I want to die", change their minds once their symptoms are managed through palliative care and their existential distress is addressed by healthcare professionals and others.

[10] *Samaritanus Bonus*, V. The Teaching of the Magisterium, 4.
[11] Pope Francis, Apostolic Exhortation, *Evangelii Gaudium*, 24 November 2013, 44.
[12] *Evangelii Gaudium*, 171.
[13] *Evangelii Gaudium*, 172.

15. Accompanying someone who is expressing a desire for euthanasia is an act of charity that should be offered in a way that does not require the pastoral companion to suspend their firm commitment to the Church's clear teaching that euthanasia is never morally permissible. The Church, which holds the health of souls to be its highest law,[14] advocates appropriate and effective forms of personal accompaniment and hope-filled witness while not abandoning the patients. Pastoral care in these situations can help the patient to reconsider their position.[15]

16. Christian accompaniment involves a commitment to walk with a patient and their family on a journey without necessarily knowing how that journey will unfold. It requires of the priest, chaplain or pastoral worker an open heart characterised by "humility, discretion and love for the Church and her teaching," [16] which is not compromised in the name of a pastoral response. It requires a type of listening that provides the patient with a companion to whom they can express their deepest hopes, fears and questions.

17. As the Church has taught, "the end of life is a time of relationships, a time when loneliness and abandonment must be defeated".[17] The relationship of care toward a dying patient is built on "a contemplative gaze 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 … finds in illness the readiness to abandon oneself to the Lord of life who is manifest therein."[18]

Effective medical care

18. Christian accompaniment of a patient who is considering euthanasia includes helping them to appreciate the medical care that is available to relieve their symptoms and distress. There is no doubt that there have been amazing advances in medicine over the past century. Unfortunately, however, when highly specialised and expensive curative treatments are no longer effective, healthcare professionals can be heard to say, "there's no more we can do for you" – thereby, unintentionally leaving the patient with a feeling of abandonment. In

[14] Cf. *Code of Canon Law*, c.1752.

[15] Pastoral practitioners will be careful not to coerce the patient whilst recognising the provisions of laws which allow the euthanasia process to cease. Cf.
The Voluntary Assisted Dying Act 2021 (Qld), §48, which says, "A person in respect of whom the request and assessment process has been completed may decide at any time not to take any further step in relation to access to voluntary assisted dying."

The *Voluntary Assisted Dying Act 2021* (Qld), §141 (1), says "A person must not, dishonestly or by coercion, induce another person to make, or revoke, a request for access to voluntary assisted dying. Maximum penalty—7 years imprisonment." In the legislation glossary, "coercion includes intimidation or a threat or promise, including by an improper use of a position of trust or influence".

[16] Pope Francis, Post-Synodal Apostolic Exhortation, *Amoris Laetitia*, 19 March 2016, 300.

[17] *Samaritanus Bonus*, II. The Living Experiences of the Suffering Christ and the Proclamation of Hope.

[18] *Samaritanus Bonus*, I. Care for One's Neighbor.

truth, there is much more that modern palliative and supportive medical care can do to assist patients when a cure is no longer possible.

19. Of course, we should recognise the limits of curative medical treatments, both when they cease to be effective and when they impose unreasonable side effects. The time will come when death should be allowed to arrive naturally. We are not obliged to prolong the dying process. Fortunately, modern medicine provides many forms of treatment that genuinely ease the dying process, relieve distressing symptoms and help a patient remain comfortable and able to relate to their family and friends. Palliative care professionals commonly tell of patients who, even though they had previously asked for euthanasia, find that they want to go on living once their symptoms have been managed. They are given the chance to spend more time with family and loved ones, and can receive care at home, which is where most people wish to die.

20. It is true that palliative care resources are spread unevenly across the country, even though they can provide much less expensive improvements in quality of life than some aggressive and invasive procedures. The lack of palliative care in many places explains why some people fear pain, loneliness and being a burden to others and so may be tempted to choose euthanasia. The better solution is for adequate palliative and supportive care to be available for all who need it. The Church continues to advocate strongly for this.

Pastoral companions and the Catholic community

21. Pastoral companions do not enter into accompaniment on their own but always with and for God, the Church and those who have entrusted their care to them. Christian accompaniment best occurs within a pastoral framework that provides adequate formation along with access to spiritual, emotional and psychological support, including appropriate supervision. This means that the Church has a responsibility to ensure that all Catholic ministers providing pastoral care in healthcare environments receive adequate formation in pastoral care and the teaching of the Church.

22. Parishes and other Catholic communities also have a responsibility to support and nurture their ordained ministers, chaplains and pastoral workers. Similarly, individual Catholics working in different ways to care for those who are dying, including in places where euthanasia is provided, should be able to draw strength from their faith communities as they journey alongside those whose time on earth is drawing to a close.

Part B. Specific responsibilities of family members, healthcare professionals and pastoral workers

The responsibility of the acting subject

23. A key insight of the Church's moral tradition is expressed in the teaching of St John Paul II that ethical understanding and evaluation should be conducted from the perspective of the "acting subject".[19] In the context of euthanasia, this means that we must examine the goal or purpose of the person undertaking the action. This insight helps us appreciate the difference between ceasing a medical treatment that has become highly burdensome for the patient (e.g. the use of dialysis, the continuation of chemotherapy that proves toxic, the use of nasogastric tubes or other drainage tubes and catheters) and ceasing the same treatment with the purpose of bringing about death.[20]

24. From an onlooker's perspective, in both cases, a treatment stops and the patient dies shortly after. Ethically, however, these are completely different human actions, if understood from the perspective of what the agent (or subject) is intending to do: in the first case, to assist the patient by removing the cause of unacceptable burdens (effects of the treatment); in the second case, to bring about death by removing a treatment that is keeping the patient alive. This is why, in order truly to know what someone (a "subject") is doing, we need to know what is their goal and what choices they have made in pursuit of that goal.

25. Recognising the importance of understanding our actions in the light of a truthful statement of our goals and intentions is crucial for considering the extent to which other people – e.g. family members, chaplains, priests – may or may not provide companionship to a patient who is intending to take their own life. The Church teaches that we should in no way approve, support or become complicit in the act of euthanasia. Clearly, a doctor who provides a lethal prescription is directly cooperating with the patient's act of intentionally ending their own life. Sadly, for the patient also, the action they are partaking in is not "assisting my dying" but is "deliberately bringing about my death" (i.e. killing myself).

26. What should we say, however, about the various other ways in which those who accompany a patient might also be thought to be assisting the person? As explained already, we should and do wish to support and accompany the people we love and care for, even when we cannot support the actions they are taking. This is our Christian duty – but how are we to do

[19] Pope John Paul II, Encyclical Letter, *Veritatis Splendour*, 6 August 1993, 78.
[20] *Samaritanus Bonus*, V. The Teaching of the Magisterium, 1.

this without being complicit in the act of euthanasia? Perhaps the most acute instance of the tension between assisting a person and assisting their action concerns the question of whether one may be present at the actual time when the lethal substance is administered.

27. Taking up the perspective of the acting subject, we will see that the answers to this and related questions will vary somewhat depending on who we are in relation to the patient, our professional responsibilities or our institutional roles etc. We will consider the distinct situations of family and friends, healthcare professionals, pastoral workers and priests.

Family and friends

28. The role of the family is central to the care of the terminally ill patient.[21] However, family members know that situations can arise in which another member's actions cannot be endorsed or even tolerated. Particularly regarding euthanasia, considered or accessed, the tension between supporting a person in contrast to supporting their actions is very familiar to family members, especially spouses, parents and siblings. However, family members should strive to remain faithful to each other despite the disagreements and tensions that arise.

29. In the case of a person requesting euthanasia, Catholic family members should make clear that, while they will continue to love and support the patient, they cannot endorse this course of action, and they will not facilitate it.

Healthcare professionals

30. Healthcare professionals may have both personal and institutional responsibilities in relation to the euthanasia provisions that are in place across the country. Insofar as the topic of euthanasia arises within an individual medical or nursing practice, healthcare professionals should explain to patients and families why euthanasia is not part of ethical medical practice. Euthanasia is not "effective end-of-life" care and the administration of a lethal substance does not address a patient's medical needs. Euthanasia is not a medical treatment because it takes the life of a patient and eliminates the possibility of further medical care.

31. From the perspective of a doctor as the "acting subject", what is misleadingly termed "voluntary assisted dying" is not in fact "assisting another's dying" – it is providing a lethal prescription that will enable a patient to deliberately take their own life. The doctor is assisting in an act of killing, not the natural process of dying. A request for euthanasia is a request for a doctor to do something that is contrary to one of the foundational principles of medicine: "First, do no harm. "

[21] *Samaritanus Bonus*, V. The Teaching of the Magisterium, 5.

32. Healthcare professionals have an obligation to inform their patients about the effective end-of-life and palliative care that is available to them. Patients may carry a much deeper fear of palliative care than they do of euthanasia. This may stem from their own experiences of delayed or ineffective palliative care treatments, mostly caused by the under-resourcing of palliative care. Many families also carry memories of agitation, pain, grief, frailty and vulnerability through the deaths of relatives they have observed. Genuine, high-quality medical care is, by and large, able to ameliorate the physical, and even the psychological, suffering associated with dying, but patients also need to be encouraged to seek assistance from their general practitioner, clinical psychologist and pastoral practitioners.

33. In some cases, healthcare professionals may tend to find more success in ameliorating physical symptoms than psychological worry or internal turmoil, such as loneliness and the fear of being a burden to family and carers, that are experienced by many who express a desire to hasten their death. There is still a need for better training for clinicians and pastoral practitioners so that they can better recognise, understand and develop skills in responding to psychological and existential distress.[22]

34. An important clinical task can be to listen carefully to these fears, understand and acknowledge what has been said and gently guide patients and their families to alternative possibilities which palliative care can provide. Healthcare professionals also need to ensure that there is room for hope to be kept alive. Better care can be ensured through facilitating conversations and therapies that can help a patient, and their families and carers, with the psychological symptoms that they may be experiencing. Healthcare professionals can facilitate reflection on whether the patients and families consider life precious and what about their life holds continuing value for the patient.

Pastoral care workers and chaplains

35. Pastoral care workers, whether they be lay pastoral care workers, chaplains or ordained ministers, epitomise the dual responsibility of witnessing to the truth about reverence for the gift of human life, while accompanying those whose lives are ending and/or who are considering intentionally ending their own life. Chaplains and carers will commonly be able to take a slightly more independent or "objective" view of the situation compared with the immediate family. This will enable them to explain to, and model for, family members the

[22] Existential distress at the end of life may be experienced as hopelessness, burden to others, loss of a sense of dignity, loss of a will to live, and other threats to self-identity.

responsibility to accompany the patient without endorsing or facilitating the patient's request for euthanasia.[23]

36. Chaplains and carers who are not priests will not have to face directly the questions about the reception of the sacraments, and will take every opportunity to pray with and listen to the patient. Typically, they will have more time for an unconditional listening which allows the patient to know that he or she is truly heard and valued. Families also need direction and guidance as to how to be present at the bedside of the dying, how to normalise death and how to partake in the care of the dying patient.

Part C. Specific responsibilities of Ministers of the Sacraments of Penance and Anointing of the Sick

Priests as ministers of the sacraments of healing[24]

37. The Church's sacraments of Penance, Anointing of the Sick and the Eucharist received as Viaticum, as "food for the final journey"[25] from this life, offer special graces to people as death approaches. In the case of patients who are considering, or have decided upon, euthanasia, questions obviously arise about whether – and, if so, under what conditions – these sacraments may be offered and worthily received. When reflecting on these situations, it is important to understand whether the patient is still considering their decision, and hence open to changing their mind, or whether their decision is final. Pastoral accompaniment and discernment in these cases might unfold in the way outlined below.

A pastoral conversation

38. If a patient requests the sacraments, the priest will attend promptly and with a presumption that the person is acting "in good faith" for "hope deferred makes the heart sick".[26]

39. If the priest knows that the patient is considering but has not yet decided upon euthanasia – because either the patient or others tell him – the question is whether the priest might help the patient make a good confession and receive absolution. The priest will firstly welcome the patient's desire for the sacrament of God's mercy and allow the patient to

[23] Cf. *Samaritanus Bonus*, V. The Teaching of the Magisterium, 10: "Being men and women skilled in humanity means that our way of caring for our suffering neighbour should favour 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."

[24] Cf. Catechism of the Catholic Church, 1421.

[25] International Commission on English in the Liturgy [ICEL] (1983). *Pastoral Care of the Sick: Rites of Anointing and Viaticum*, 181.

[26] Proverbs 13:12.

explain their situation and identify the areas of sinfulness in their life for which they seek God's forgiveness. When the topic of euthanasia arises or is raised by the priest on the basis of what he already knows, the priest will explain why euthanasia is not consistent with respect for God's gift of life and with "love of oneself" as a person made in the image of God.

40. The priest will explain to the patient that God's law, "You shall not kill", and the imperative to "respect, defend, love and serve life, every human 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".[27] It may also help for the priest to ask a healthcare professional to explain why assisting people in the intentional ending of their life is never a part of good medical practice.

41. The priest will explain that "following one's conscience" presupposes that a Catholic has sincerely tried to form their conscience by listening to the Word of God and the teachings of the Church. He will spend time praying with the patient and together listening to the Word of God, and he will explain that the reception of the sacraments, especially the Eucharist, is never a private matter. By receiving the Eucharistic Body of Christ, we are joined in closer communion with the ecclesial Body of Christ, the Church. Fruitful reception of a sacrament always requires a suitable disposition on the part of the recipient.

Absolution when the patient is open to conversion

42. When death is not imminent, and there is no immediate intention to receive a lethal substance, the priest, as doctor of the soul, will seek to discern evidence of conversion, leading to an orientation of the heart that "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".[28] The suitable penances (or "next steps") for someone still considering euthanasia, and/or for someone who is willing to "put on hold" an earlier decision to access euthanasia, might include a promise to reconsider the issue, to speak further with a qualified healthcare professional about the kind of palliative care that would assist the patient through their final illness and to ask their family about the impact that euthanasia would have on them.

43. On the basis of conversations like this, the priest will discern whether the patient should receive absolution and so be admitted to the other sacraments: Anointing of the Sick and

[27] *Samaritanus Bonus*, Conclusion.
[28] *Samaritanus Bonus*, I. Care For One's Neighbor.

Eucharist.[29] The pastoral conversations just outlined, and the sacrament of the Anointing of the Sick, which offers healing of body and spirit, best occurs when a patient begins to approach the last part of their life, when a patient receives a terminal diagnosis or when euthanasia is first being considered.

When a patient has definitively chosen euthanasia

44. In a situation where, despite their best efforts to appreciate the Church's teaching, a patient choosing euthanasia is, or appears to remain, "in good faith", due to reduced personal culpability, and/or an inability to truly understand the Church's teaching, is such a person bound to follow their (erroneous) conscience?

45. We continue the pastoral conversations considered earlier. It is possible that, despite a patient's best efforts to make the Church's teaching their own, and the best efforts of the priest and other carers to explain that teaching and to provide personal support and understanding, a patient remains convinced that deliberately ending their life is a good thing for them to do. If such a person really is "in good faith", then he or she will experience a conflict between their own personal judgement and the teachings of the Church to which they give their allegiance. How is this conflict to be resolved?

46. The obligation to follow one's informed conscience has different implications depending on whether one feels obliged to do something or whether one believes one is permitted to do something. If a Catholic believes (albeit mistakenly) that they are permitted to access euthanasia, they are not bound to do so. The best way to resolve this conflict is for the patient – out of respect and love for the teachings of their Church – to refrain from doing that which the Church teaches is wrong, even if the patient themselves may believe they are free to do it.

47. In some cases, however, this resolution may not be possible because – for various reasons – the patient really is convinced that euthanasia is their only course of action. They might be focused on such thoughts as "I cannot go on living this way" or "I cannot ask my family to keep supporting me". The priest will be alert to the difference between, on the one hand, mistaken reasoning that is based on deep, unresolved psychological factors (fears, obsessions, compulsions etc.) which limit the patient's freedom and insight into the good, and, on the other, mistaken reasoning which is based on a resolution made against the possibilities of God's grace and the goodness of life.

[29] *Samaritanus Bonus*, V, 10. The Teaching of the Magisterium: "Penance and the Anointing of the Sick … culminate in the Eucharist which is the 'viaticum' for eternal life."

48. If a patient is resolved upon a course of action, such as euthanasia, which is so clearly and gravely in conflict with the teaching and life of the Church, then – even if the patient believes they are choosing rightly – the patient should nonetheless recognise, or be helped to recognise, that it would not be right for him or her to receive the sacraments. Such patients cannot ask or expect the Church to publicly endorse a practice it holds to be gravely wrong. As the document *Samaritanus Bonus* notes, because of the need for the presence of true contrition for the validity of absolution, when "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", there is "… a manifest absence of the proper disposition for the reception of the Sacraments of Penance, with absolution, and Anointing, with Viaticum."[30]

49. In this circumstance, it is still necessary, as a doctor of the soul, to remain close to a patient who may not be able to receive the sacraments because, in the words of Samaritanus Bonus, "this nearness is an invitation to conversion, especially when euthanasia, requested or accepted, will not take place immediately or imminently".[31] It is also necessary to remember that, although the priest needs to make a judgement about whether it is appropriate for the patient to receive the sacraments, they are not making a judgement about the imputability of the patient's guilt since personal responsibility may be diminished. One should be mindful of the Holy Father's indications concerning the subjective condition of the individual penitent, namely "… it should be clear that all the conditions that are usually attached to confession are generally not applicable when the person is in a situation of agony or has very limited mental and psychological capacities." [32]

50. If the priest has given absolution because the patient has not firmly decided the issue or their earlier decision is rescinded, and then proceeds to anoint the patient and give Holy Communion, it will be evident to others that the patient is still in communion with the Church.[33] In this situation, the patient should be encouraged to explain to their family and friends that they are not settled upon the choice of euthanasia.

51. However, if it becomes clear that the patient is determined upon euthanasia, then reception of the Eucharist is not permissible, for the reasons explained above. A patient who has determined that they will take the path of euthanasia is not in communion with the faith

[30] *Samaritanus Bonus*, V. The Teaching of the Magisterium, 11.

[31] *Samaritanus Bonus*, V. The Teaching of the Magisterium, 11.

[32] Pope Francis. (2023). "Respuestas" of the Holy Father "a los Dubia propuestos por dos Cardenales". Retrieved from https://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_risposta-dubia-2023_en.pdf.

[33] Cf. *Samaritanus Bonus*, V. The Teaching of the Magisterium, 11: "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".

and teachings of the Church. Thus, the sacraments, including Anointing of the Sick, will not be celebrated. The priest will not be present at the time of death.[34] However, the priest will assure the patient that he will pray for them and that, if requested, he will return to pray the Prayers for the Dead.

Preparing the funeral rites

52. The patient whose life has ended through euthanasia continues to be a son or daughter of the Heavenly Father, a brother or sister in Christ and a loved member of the Church who ought to be kept in our prayers seeking, through God's infinite mercy, the repose of their soul. Therefore, if requested, a Catholic funeral service should be celebrated for the repose of the soul of the deceased (providing there is no serious risk of damage to the faith of others).[35] If there is doubt over whether a funeral should be celebrated, the local Ordinary should be consulted.[36]

53. In the Catholic funeral liturgy, the Church gathers "to give thanks and praise to God for Christ's victory over sin and death, to commend the deceased to God's tender mercy and compassion, and to seek strength in the proclamation of the paschal mystery".37 For the deceased, the Church pleads for the forgiveness of their sins.[38] For the bereaved, the Church exercises a ministry of consolation: "The faith of the Christian Community in the resurrection of the dead brings support and strength to those who suffer the loss of someone whom they love."[39]

54. Priests and pastoral workers should ensure that the funeral occurs with deep respect for, and the involvement of, all concerned. When preparing or presiding at a funeral, a priest or minister will attend carefully to any pastoral and liturgical recommendations relating to the funeral rites of those who die through euthanasia, being careful to affirm, first and foremost, the boundless mystery of God's mercy and love. Catholic rites do not include eulogies,[40] but allow for brief words of remembrance.[41] Care must be taken to ensure that the words chosen maintain the integrity of the rite and do not endorse euthanasia. Extended reflection on the life of the deceased may be appropriate at another time.

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[34] *Samaritanus Bonus*, V. The Teaching of the Magisterium, 11: "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".

[35] *Code of Canon Law* c.1184, §1.3.

[36] *Code of Canon Law* c.1184, §2.

[37] The Roman Ritual (2019). *Order of Christian Funerals*, 129.

[38] The Roman Ritual (2019). *Order of Christian Funerals*, 6.

[39] The Roman Ritual (2019). *Order of Christian Funerals*, 9.

[40] The Roman Ritual (2019). *Order of Christian Funerals*, 27, 141.

[41] The Roman Ritual (2019). *Order of Christian Funerals*, 170, "A member or friend of the family may speak in remembrance of the deceased." Care must be taken that these words maintain the integrity of the funeral rite and do not support euthanasia.

Conclusion

55. Christian pastoral ministers respond to and live out their belief in the intrinsic value of all human persons. When priests celebrate the sacraments of Penan and Anointing of the Sick, they are "fulfilling the ministry of the Good Shepherd who seeks the lost sheep, of the Good Samaritan who binds up wounds, of the Father who awaits the prodigal son and welcomes him on his return, and of the just and impartial judge whose judgement is both just and merciful … signs and the instruments of God's merciful love".[42]

56. Even in circumstances when the sacraments cannot be celebrated and although a pastoral minister must not be present at the moment of administering of a lethal substance, the compassionate Christian always seeks to accompany people who are sick and suffering. By accompanying a person and listening to their griefs, fears and sufferings, as well as offering the Prayers for the Dead after death, we can share with them (and their family) the love of Christ without condoning any choice to intentionally end their life.

57. Sixty years ago, the Second Vatican Council taught:

> The joys and the hopes, the griefs and the anxieties of the … [people] of this age, especially those who are poor or in any way afflicted, these are the joys and hopes, the griefs and anxieties of the followers of Christ. Indeed, nothing genuinely human fails to raise an echo in their hearts. [43]

58. Priests and pastoral ministers "have welcomed the news of salvation which is meant for every person."[44] They are ministers of hope who acknowledge that everyone is in need of the grace and mercy of God. Pope Francis provided a timely encouragement for this important and challenging ministry when he wrote:

> We need witnesses to hope and true joy if we are to dispel the illusions that promise quick and easy happiness through artificial paradises. The profound sense of emptiness felt by so many people can be overcome by the hope we bear in our hearts… [45]

59. In Australia medical care has advanced so that our citizens have very high life expectancies. Developments mean that we can live longer, our ailments can be treated and our pain can be largely ameliorated or managed. However, the

[42] Catechism of the Catholic Church, 1465
[43] Second Vatican Council, Pastoral Constitution on the Church in the Modern World, *Gaudium et Spes,* 1.
[44] *Gaudium et Spes,* 1.
[45] Pope Francis, Apostolic Letter, *Misericordia et Misera,* 20 November 2016, 3.

introduction of euthanasia demonstrates that the progress of technology does not always serve humanity, moral rectitude or hope.

> The world is still far from the desired peace because of threats arising from the very progress of science, marvellous though it be, but not always responsive to the higher law of morality. Our prayer is that in the midst of this world there may radiate the light of our great hope in Jesus Christ, our only Saviour. [46]

60. May Mary, present beneath the Cross of Jesus in his suffering, support our enduring commitment to compassionate care, which points to God's unconditional love for every person and to our great hope in eternal life.

Glossary

Anointing of the Sick – A sacrament administered by a priest which involves prayers for healing and anointing with oil administered both to the dying and to those who are gravely ill for the recovery of their health and for spiritual strength. It is a ritual of healing appropriate not only for physical but also for mental and spiritual sickness. See paragraphs 37, 43, 48-51 and 55.

Assisted suicide – See Euthanasia

Christian accompaniment – This is a continuation of the ministry of Jesus Christ, who reached out to the sick, the outcast and the sinner. It is spiritual support offered to others, especially those who are struggling. It requires a type of listening that provides the person who needs it with a companion to whom they can express their deepest hopes, fears and questions. Accompaniment is being present to them, listening to them with the goal of assisting them in hearing God's call in their lives and to enable them to connect with the love of Christ. For the purposes of this document, Christian accompaniment occurs in relation to the support of a dying person and their family who may be considering euthanasia. See paragraphs 2, 13-18 and 21.

Eucharist as Viaticum – *Viaticum* is a Latin word meaning "provision for a journey". Viaticum is where the Eucharist is given to a person in danger of death as the food for the passage through death to eternal life. For Communion as Viaticum, the Eucharist is given in the usual form, with the added words "May the Lord Jesus Christ protect you and lead you to eternal life". See paragraphs 37, 41, 43 and 48-51.

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[46] Message to Humanity at the Beginning of the Second Vatican Council, (Final paragraph) in *The Documents of Vatican II: Vatican Translation*, St Paul, Australian Edition, 2009, p. 15.

Euthanasia – This involves the intentional ending of a human life. This practice, which brings about death, is assisted suicide when a doctor assists by prescribing a lethal substance. It is euthanasia when a health professional administers the lethal dose. While noting this distinction, in this document, we will refer to all intentional ending of life through a medical prescription as euthanasia. While the label "VAD" (Voluntary assisted dying) is convenient, the seemingly comforting words it uses are gravely misleading as it involves the intentional ending of a human life. See paragraphs 3-7.

Healthcare Professionals – This is a broad term used in the document to refer to doctors and nurses, but also to other professionals like clinical psychologists, depending on the context. See paragraphs 18-20, 30-34.

Palliative care – Palliative care aims to sustain quality of life until natural death intervenes. Palliative care values life and strives to optimise the patients' experience of it. See paragraphs 12, 14, 18-20 and 32-34.

Pastoral worker/care worker/companion – This person can be an ordained minister, as in priest or deacon, or religious, or a lay person with formal training in pastoral care who provides spiritual and emotional support to a dying person and their family and carers. See paragraphs 14-16, 21-22 and 35-36.

Patient – In the context of this document, a person considering euthanasia. See preface.

Penance – Also referred to as **Confession** or **Reconciliation**, is the sacrament of absolution of sins committed after Baptism. The sacrament consists of four parts: contrition, confession, penance and absolution. See paragraphs 37, 48-49 and 55.

Physician assisted suicide – See Euthanasia

Sacrament – A rite of the Catholic Church such as Penance, Anointing of the Sick and Eucharist, ordained by Christ and a means of divine grace or to be a sign or symbol of a spiritual reality. "The purpose of the sacraments is to sanctify the person, to build up the body of Christ, and, finally, to give worship to God; because they are signs they also instruct. They not only presuppose faith, but by words and objects they also nourish, strengthen, and express it; that is why they are called "sacraments of faith." They do indeed impart grace, but, in addition, the very act of celebrating them most effectively disposes the faithful to receive this grace in a fruitful manner, to worship God duly, and to practice charity." *Sacrosanctum Concilium*, 59. See paragraphs 37-39, 41, 48-49 and 55-56.

Voluntary assisted dying (VAD) – See Euthanasia

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