To My Esteemed Brother
Archbishop Vincenzo Paglia
President of the Pontifical Academy for Life

I send my cordial greetings to you and to all the participants in the European Regional Meeting of the *World Medical Association* that is addressing end-of life issues and that has being held in the Vatican together with the German Medical Association, under the sponsorship of the Pontifical Academy for Life.

Your meeting will address the questions that deal with the end of earthly life. They are questions that have always challenged humanity, but that today take on new formulations by reason of the evolution of human knowledge and of the technical tools made available by human ingenuity. Medicine has in fact developed an ever greater therapeutic capability that has made it possible to overcome many diseases, to improve health and to prolong life. It has had a very positive effect. At the same time, today it is also possible to extend life with means that in the past could not even be imagined. Surgical and other medical interventions have become more and more effective, but they are not always dispositive: they can sustain, or even substitute, failing vital functions, but that is not the same as promoting health. We thus need greater wisdom today because the temptation to insist on treatments that have powerful effects on the body but that at times do not promote the full good of the person has become more insidious.

Pope Pius XII, in a memorable address to anesthesiologists and intensive care specialists sixty years ago, affirmed that there is no obligation to have recourse in all circumstances to all possible remedies and that, in certain specific cases, it is allowed to refrain from their use (see Acta Apostolicae Sedis XLIX [1957], 1027-1033). He said that it is morally licit to decline to adopt measures, and licit to interrupt them, when their use does not meet that ethical and humanistic standard that later was to be called "due proportion in the use of

remedies" (see Congregation for the Doctrine of the Faith, *Declaration on Euthanasia*, May 5, 1980, IV: Acta Apostolicae Sedis LXXII [1980], 542-552). The particular feature of this standard is that it takes into account "the result that can be expected, taking into account the state of the sick person and his or her physical and moral resources" (ibid.). It thus makes possible a decision that is morally qualified as withdrawal of "therapeutic obstinacy".

This standard reflects a choice that responsibly accepts the limit of human mortality, once it becomes clear that opposition to it is futile. "Here one does not will to cause death; one's inability to impede it is merely accepted" (*Catechism of the Catholic Church* n. 2278). This difference of perspective commits humanity to an accompaniment of dying without supporting a justification of the suppression of life. It is clear, in fact, that not adopting, or else suspending, disproportionate measures has an ethical value completely different from that of euthanasia, which is always wrongful, in that the intent of euthanasia is to end life and cause death.

Of course, when we encounter the concreteness of critical situations in clinical practice, the factors that come into play are often difficult to evaluate. In order to determine whether a clinically appropriate medical intervention is actually proportionate, it is not enough to mechanically apply a general rule. Careful discernment of the moral object, the attending circumstances, and the intentions of the participants is required. In the care for and accompaniment of a given patient, the personal and relational elements in his or her life and death—which is after all the last moment in life—must be given a consideration that respects the human being's dignity. In this process, the patient has the primary role. The *Catechism of the Catholic Church* clearly states: "The decisions should be made by the patient if he is competent and able" (ibid.). The patient, first and foremost, has the right, in dialogue with medical professionals of course, to evaluate a proposed treatment and to judge its actual proportionality in each concrete case, making refusal obligatory if such proportionality is judged

absent. That judgment is not easy to reach in today's medical environment where the doctor-patient relationship has become increasingly fragmented and medical care has many technological and organizational aspects.

It should also be noted that these processes of evaluation are conditioned by the growing gap in healthcare opportunities, which result from the combined influence of technoscientific power and economic interests. Progressively more sophisticated and costly treatments are available to ever more limited and privileged population segments, which raises questions about the sustainability of care delivery organization, and about what might be called a systemic tendency toward increasing healthcare inequality. This tendency is clearly visible at a global level, particularly when several continents are compared. But it is also present within the more wealthy countries where access to healthcare risks being more dependent on peoples' economic resources than on their actual need for treatment.

In the complexity resulting from the influence of these various factors on clinical practice, but also from medical culture in general, the great requirement of *responsible closeness*, must be kept clearly in mind, remembering the Gospel story of the Samaritan (cf. Luke 10:25 -37). One might say that the categorical imperative is to never abandon one who is ill. The suffering from conditions that take us to the outer limit of our human mortality, and the difficult choices we have to make, tempt us to abandon our relationship with a person who is ill. But this is precisely where, more than anywhere else, we are called on to love and to be close, recognizing the limits that we all share and that make us one. Each one of us must give love in his or her own way—as a father, a mother, a son, a daughter, a brother or sister, a doctor or a nurse. Just give love! And even if we know that we cannot always guarantee the healing of person who is still living, we can and must always take care of that person, without shortening his or her life, but also without futilely resisting that person's death. This approach in reflected in palliative care, which is acquiring great importance in our culture

as it opposes what makes death most terrifying and unwelcome—pain and loneliness

In democratic societies these arguments must be addressed calmly in a serious and reflective way, and in a way that is open to finding solutions— even at the juridical level—that are shared as much as possible. On the one hand, in fact, we must take into account the diversity of world views, of ethical convictions and of religious affiliations, in a climate of mutual listening and acceptance. On the other hand, the state must protect all persons, defending the fundamental equality by which everyone is recognized under law as a human being who is living with others in society. Particular attention is to be paid to the weakest, who cannot protect his/her own interests. If the core of values that are essential to coexistence is lost, then lost as well is the possibility of agreement on that recognition of the other that is a presupposition to every dialogue and of life in society. Healthcare law also needs this broad vision and a comprehensive view of what most promotes the common good in each concrete situation.

In the hope that these reflections of mine can be of assistance, I am sure that your meeting will take place in a serene and constructive atmosphere; and that you can find the most appropriate ways of addressing these delicate issues with a view to the good of all you meet and with whom you work in your demanding profession.

May the Lord bless you and Our Lady protect you.

From the Vatican, November 7th 2017

Pope Francis