

**Opening Message of
Archbishop Vincenzo Paglia
President of the Pontifical Academy for Life**

I would first like to express my gratitude to the World Medical Association, as well as to the German Medical Association, for welcoming the collaboration of the Pontifical Academy for Life in hosting this European Region Meeting on end-of-life questions. The theme of this Meeting, a theme that is meaningful for all of human society, makes clear why we have chosen the Vatican as the venue for our scientific consideration of certain difficult issues that the world is struggling with today. We needed a place where dialogue can flourish far from the passions that are unleashed in the discussion of issues that are sensitive and controversial, not only by reason of the pluralism that characterizes today's world, but also by reason of the way they are sensationalized in the media. What must be done is to go beyond initial reactions and emotional considerations and search for the deeper reasons for the choices we have to make as we pursue doing good. This is one of the principal tasks that Pope Francis has entrusted to the Pontifical Academy for Life as it explores the full range of human sensitivity with respect to fundamental life-related questions. The Academy's methodology is not based on ideological conflict and on the dictatorship of public opinion, but on the shared search for a common ground on which even differing opinions can find points of agreement about the truth of the human being. Clearly, the question of what choices are to be made at the end of life falls within the Pope's mandate to the Academy. We are truly grateful to him for having sent his greetings to this Meeting and for proposing guidelines for making the difficult decisions that face us all as death draws near.

As I begin the conversations among us—and then I'll leave the floor to Professor Franz Ulrich Montgomery for his introduction—I would like to highlight some aspects of the theme of our Meeting, starting from the principle that the final decision with respect to the proportionality of any medical choice belongs to the patient. This principle is easy to accept in theory but difficult to apply in practice, and those difficulties increase when the patient is no longer able to make the necessary decisions. It is in this area that Advance Directives can provide a treatment team with reliable guidance as to the preferences of the patient. Naturally, draft Directives they should be gathered with appropriate care. First to be considered would be the conversations—the dialogue—that should be part of process that produces the Directives. The Directives are not to be simply a

bureaucratic act, isolated from medical and healthcare concerns and lacking appropriate accompaniment in an atmosphere of mutual trust.

In these circumstances, the Pope's call for *loving closeness* offers us sure guidance. It is a closeness that is not to be understood as paternalistic, rigid or opposed to the patient's right of self-determination. Patient autonomy plays a central role, as is rightly stated in your Association's recently revised Declaration of Geneva. However, we know that autonomy is subject to differing interpretations and in my opinion it should not be considered as individualistic and abstract but rather as relational and concrete. On the one hand, life and liberty always include relationships with others. Neither life nor liberty can ever be privatized, as if they belonged to an isolated individual who has no ties with relatives and with a wider circle of persons. On the other hand, freedom is always conditioned by many internal constraints and external pressures, especially when it finds itself in—or is headed toward—a situation of suffering and illness, which makes it more fragile and vulnerable.

We know as well that the word "dignity" can have different meanings: it can be interpreted from a relational point of view, following that tradition of European thought of which Immanuel Kant is an outstanding exponent, or else in an optic that defends the individual from intrusive power structures, thus placing more emphasis on self-determination than on responsibility. I think it is important not to break off the dialogue between these two perspectives. And I am convinced that the most promising path to finding a commonality between them is to recognize that humans are made for relationships and that mutual recognition and respect is essential to our life together as humans.

There is one point, however, on which all must agree: we must accompany and support those who suffer, especially when the moment of death approaches, and we must never accept what might be called "therapeutic abandonment." Two improvements we could make are the following: expressions like "discontinue treatment" (even worse, "pull the plug") could be abandoned in favor of terms that are more able to convey the idea that "care continues"; and sustainable protocols could be adopted that are not uselessly invasive and that temper care according to the actual needs of the patient and the current stage of the patient's illness.

The Pope also noted in his greeting the distinction between discontinuing disproportionate care and euthanasia, that is, the distinction between accepting

death and causing it intentionally. Now, however, it may seem that such a distinction does not take into account the case of assisted suicide. In that case, it is not the physician who intervenes as the prime actor in the shortening of life. He merely provides the patient with the means, both the instructions and the substances, to autonomously bring about death. Still, such participation in a series of actions that the patient proposes to undertake implies a sharing in the intention of the patient to shorten his or her life (in the traditional terminology of moral theology, this is called “formal cooperation,” in this case, in an “illicit act”). It is therefore important to reflect carefully on the questions posed by the phenomenon of medically assisted suicide because they go far beyond the private sphere, understood individualistically, and they involve the public sphere—the alliance between society and the medical profession. How can a person who has been given the task of protecting health and of working in defense of the fundamental human right that health care represents shorten life itself? What effect does that have on the relationship of trust between doctor and patient? And even if such action were claimed to be justified by a narrow conception of autonomy, would that not still give rise to a contradiction between theory and practice? In fact, when we see more and more how vulnerable freedom is in situations of suffering, as is seen in the difficulty of the concrete practice of informed consent, we come to a somewhat contradictory situation: the legitimization of decisions that are heavily influenced by external (social) or internal (psychological) factors, and that are therefore not really autonomous. We are then faced with a dilemma that, in the name of autonomy, forces those who are weakest to make choices under conditions that make autonomy impossible or else reduces the choices available to persons who can actually choose freely—persons who, in the light of our experience, are in any case a minority. In these circumstances, would it not be reasonable to give priority to the protection of those who can’t effectively choose, even if we reduce the number of choices available to those who can, especially when we consider the fundamental importance of the value that is at risk, that is, life itself, and the irreversibility of choosing death? To this we can add that staying alive, certainly with the provision of proportionate care and with effective accompaniment, always makes it possible to change (through whatever circumstances) the beliefs that motivated the request of death.

These questions, and others that could be added, have long been the subject of debate. Today, however, they are particularly urgent and must be studied in their implications and causes, according to the best traditions of your Association, which treats ethical issues with care and prudence commensurate with their novelty

and their complexity. (see WMA, *Medical Ethics Manual*, 2015 p. 25). I note that it is precisely for this reason that you have insisted on the unacceptability of any medical intervention that intentionally causes death.

I am sure that our discussions during these two days will be serious and deep, as we pursue the best ways to promote health, to defend the human person and the human person's fundamental and inalienable rights. In the end, the human work of care for human material and spiritual vulnerability, in whatever form or profession that care manifests itself, always lives on the edge of the anti-utilitarian paradox. But it is the paradox that makes us human.

The men and women we have felt committed to care for from time immemorial are mortals. And we can't cure them of their mortality. Yet, nothing more identifies us, and moves us, than our daily struggle against the painful signs of weakness that reminds us that we are all mortal. We struggle hard not to let the gloom of death be what decides the value of life. We struggle not let disease be what decides the usefulness of our lives, the worth of our persons, the genuineness of our affections. We accept our mortal condition. We resist the fevered delusion that we can overcome the mystery of our inevitable passing, with all its painful contradictions. The care we provide shows our commitment to making acceptance of death more human while at the same time not becoming death's accomplice. We refuse to do the work of death, even if only symbolically. Providing care is an acceptance of, and will help us to accept, our own insurmountable limits, with the tenderness of love, with all respect for the person, and with all the power of dedication of which we are capable. No care, however, is to show any complicity, not even seeming complicity, with death.

Dear friends, this is the challenge—a very difficult but humane challenge—that must bring us together. Accompaniment in order to accept the need to live humanly, and to live the reality of death without losing the love that struggles against its darkness, is the goal of that "responsible closeness" to which all, as human beings, are called. The whole community must be involved. We will not stand by without doing anything while death goes about its task. But neither will we do the work of death, simply to relieve ourselves of a burden and think we are acting out of love. That love for life within which we have loved and been loved is no longer just ours, it belongs to all those with whom it has been shared. And that's how it must be, to the end. No one should feel guilty about the burden that his or her mortal condition lays on the community. We are human, and the human

idea of care is radically opposed to the notion that sickness requires exclusion from the community, that it is an unpardonable failing. And I must add to that human idea of care the Gospel message that frees us theologically from our fear of death.

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