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# THE CONCEPT OF PROPORTIONALITY IN END-OF-LIFE CARE. FROM *IURA ET BONA* TO *SAMARITANUS BONUS*

Ioan Robu[1],
Doctoral School of Religious Studies and Theology, University of Bucharest, Romania

Claudiu Eva[2],
Doctoral School of Religious Studies and Theology, University of Bucharest, Romania
E-mail:claudiueva14@gmail.com

**Abstract**
**Introduction.** The concept of proportionality, as reflected in the documents *Iura et Bona* and *Samaritanus Bonus*, is an important issue in Catholic bioethics, particularly in the care of terminally ill persons. Both documents emphasize the difference between ordinary (necessary) and extraordinary (optional) treatments and encourage the avoidance of invasive and painful measures that do not bring significant benefit. By reaffirming the value of integral human care, emphasizing that medical interventions must be weighed in terms of real benefits and respect for life, both documents regard proportionality as an ethical guide for medical decisions and a benchmark for the maintenance of human dignity, providing a solid moral foundation in Catholic medical ethics. **Purpose of the paper.** To analyze the application of the concept of proportionality through the lens of these two documents, and to reaffirm bioethical principles in the treatment and care of terminally ill persons. **Materials and methods.** Articles and documents of the Catholic Church from the last 40 years were investigated by using the analytical-descriptive method and by researching of information. **Conclusions**. 1. The constant concern of the Catholic Church in respecting the person and human dignity in palliative care centers and hospitals; 2. Sounding an alarm bell against utilitarian conceptions of the perception and definition of the human person; 3. To form and stimulate charitable sensitivity according to the model of the "Good Samaritan" in the Gospel.

**Key words:** Catholic bioethics, palliative care, accompaniment and care, the human person

## Premise

From the search for the meaning of life, the human person becomes a seeker of the meaning of the suffering in his own life, and sometimes in the lives of others, a search that leads to the question: why? "It is a question about cause, reason; a question about purpose (*for what*); in short, about meaning. The question not only accompanies human suffering, but seems to determine its very human content, which makes suffering truly human suffering", John Paul II reminds us in *Salvifici doloris* 9. The personal example of Pope John Paul II, who in the last years of his life struggled with the difficulties of Parkinson's, the disease that he suffered from, was a support for many sufferers in their moments of pain. He bore witness to the end that he who entrusts his life to Christ crucified with all that it entails - joys and sorrows, suffering, sickness - is never alone. This was witnessed by the hundreds of thousands of people who

[1] His Excelence Ioan Robu, Archbishop emeritus of Bucharest, professor of the Doctoral School of Theology and Religious Studies at the Faculty of Roman-Catholic Theology in Bucharest, is an honorary member of the Romanian Academy and a doctoral supervisor in moral theology.
[2] Fr. Claudiu Eva is a doctoral student in moral theology at the Doctoral School of Theology and Religious Studies at the Faculty of Roman-Catholic Theology of the University of Bucharest, an assistant professor at the Faculty of Roman-Catholic Theology and responsible for the Office for Liturgical Pastoral Care and Sacraments in the Archdiocese of Bucharest.

accompanied this great saint with their prayers, songs and presence in St. Peter's Square in Rome during the last days of his life.

John Paul II gives us a contemporary perspective of those who care for the terminally ill by proposing as a model the person of *the Good Samaritan* from the Gospel of St. Luke, whose name is unknown, a model for all those who care for the terminally ill, the dying in hospitals or old people's homes. Can any doctor, loved one or nurse be that *compassionate Samaritan of* dying patients?

In the words of John Paul II (*Salvifici doloris* 29) -

> "it could be said that suffering, which in so many different forms is present in the human world, is also present to radiate love for man, precisely that selfless gift of the 'I' for the benefit of other men and women, for men and women who suffer (...) the 'neighbor' cannot, in the name of fundamental human solidarity and even less in the name of love of one's neighbor, pass by disinterestedly in the face of the suffering of others. He must "get up", "move", like the Samaritan in the Gospel parable. The parable itself expresses *a truth that is profoundly Christian,* but at the same time so universally human" -

we discover God's caring and profound compassion for the dying through the hands and feet of specialized health workers.

We live in contexts and situations that are not so different and that challenge us, contexts in which, for example, the dignity of the person and in particular of the dying or terminally ill person is not respected by the civil laws of various countries, and this has given rise to vehement Christian and moral positions and reactions from the Catholic Church. One example is the case of the Netherlands, where for some time now the legislation in that country has not criminalized doctors who perform euthanasia at the patient's request, thus legalizing the practice. This situation was debated in 2000 at the annual conference of the Pontifical Academy for Life in the Vatican: "The Church has followed this development of thought with concern, recognizing in it one of the manifestations of a spiritual and moral weakness with regard to the dignity of the dying person and a "utilitarian" way of disregarding the real needs of the patient" (Pontificia Accademia per la Vita, 2000).

In the Magisterium of the Catholic Church this is an emerging theme, in the context of the proliferation and engagement of more and more European states (and not only) in the non-moral and non-deontological-therapeutic resolution of terminally ill patients. The Church has become (for how many times?) the voice of those who cry out from their suffering and whom no one wants to hear. One of the documents of the Dicastery for the Doctrine of the Faith, which thus becomes the mouthpiece of those who suffer, the *Declaration on Euthanasia: Iura et Bona*, recalls that:

> "It is very important today to protect, at the moment of death, the dignity of the human person and the Christian concept of life against a technique that risks becoming abusive. In fact, some speak of the "right to die", an expression which does not mean the right to procure or to be helped to procure one's own death at one's pleasure, but the right to die with serenity, with human and Christian dignity" (Congregation for The Doctrine Of The Faith, 1980).

Inspired by the Apostolic Letter *Salvifici doloris* of John Paul II and *Iura et bona*, in the midst of the Covid-19 pandemic, in 2020 the Congregation for the Doctrine of the Faith published the letter *Samaritanus bonus. On the care of persons in the critical and terminal phases of life*. The purpose of this letter is "to clarify certain doubts about the relationship of trust between patient and doctor" and to respond to "the challenges raised by assisted suicide and voluntary euthanasia legitimized by some national norms with particular reference to those working or hospitalized in hospital facilities, even Catholic ones". The letter also reaffirms the

principles of Catholic Christian morality regarding the modalities and use of therapies on patients in terminal stages.

We will analyze the concept of proportionality starting from these two documents issued by the Dicastery for the Doctrine of the Faith 40 years apart, emphasizing on the one hand *the Catholic Church's constant concern for respect for the human person and human dignity in palliative care centers and hospitals* (1), and on the other hand *sounding an alarm bell against utilitarian conceptions of the utilitarian perception and definition of the human person* (2). Finally, we will present some ideas on how to *form and foster charitable sensitivity according to the model of the "Good Samaritan" in the Gospel* (3).

## 1. The Catholic Church's constant concern for respect for the human person and human dignity in palliative care centers and *hospices* or centers for the care of dying people

It is important to clarify these two terms as they are defined in the documents of the Catholic Church, in particular in the Letter *Samaritanus bonus*.

***Palliative care*** is specialized medical care for people with serious illnesses, focused on relieving symptoms and stress while they are still in search of a cure. Patients are candidates for palliative care whenever they experience a serious illness. Care can pursue goals of healing and comfort that can be achieved over months, years and decades. These goals may change as the disease or condition progresses. Palliative care is comprehensive in that it is provided by a team of physicians, nurses, social workers, chaplains and other professionals who focus on the management of physical pain and symptoms as well as psychosocial and spiritual needs. The palliative care team works with the patient to coordinate all aspects of palliative care, communication and decision making, as well as clarifying and adjusting goals of care over time, and also provides support to the family.

***Hospice care (homes or nursing homes specializing in the care of the terminally ill or dying)*** is a type of palliative care, but with a special emphasis and recognition that the patient is nearing the end of life and that the goal of care is no longer to cure the illness, but to provide comfort and relieve symptoms. The hospice team of physicians, nurses, chaplains and social workers addresses patient and family concerns related to illness and approaching death. Hospice is for patients in the final stages of an illness (usually in the last six months of life) for whom treatment is no longer effective. Hospice helps patients better live out their remaining time on earth by stopping curative measures and continuing to focus on comfort and symptom management goals, as well as providing the psychological, spiritual and social support that patients and their families need.

The *Samaritanus bonus* letter emphasizes the role of hospices in providing a very useful service when receiving terminally ill patients, to ensure their care until the very last moment. In this way, they can provide a sanctuary where suffering takes on great meaning.

The same document from the Dicastery for the Doctrine of the Faith explains, echoing the Church's teaching in *Iura et bona*, that it is morally permissible to choose not to accept disproportionate treatment that would only prolong life in a precarious or painful way. Refusing extraordinary means of care expresses acceptance of the human condition, but does not seek to hasten death. Refusal of disproportionate therapies should not suppress basic care, including pain relief, hydration, nutrition, thermoregulation, and others. In addition, when pain relief is necessary at the end of life, the Church affirms that it is morally permissible to use analgesics that cause unconsciousness and may even hasten the moment of death, as long as this hastening of death is a side effect of the drugs and not their direct or intended purpose. In such cases, informed consent must be obtained from the patient, designated surrogate or family members. All medical actions should always aim to promote life and never to seek death. In addition, patients should receive appropriate spiritual care so that they can consciously approach their death as an encounter with God. Pastoral care on the part of all, family members, doctors,

nurses and chaplains, can help the sick person to persevere in sanctifying grace and to die in charity, in God's love.

Both types of care are aimed at relieving the suffering of the person, the sick person, seeking a solution for healing or, if that is not possible, preparing for a dignified death. *Iura et bona* drew attention to the changes in society in the 1980s, changes which were still strongly felt at the end of the 1990s, but especially as a result of the diversification of medical biotechnology. It drew attention to the danger to the values of human life at the confluence of cultural and technical changes: "medicine has increased its capacity to cure and prolong life under certain conditions, which sometimes give rise to moral problems" (Congregation for The Doctrine Of The Faith, 1980).

John Paul II also sounded the alarm when he stated in his Encyclical *Evangelium vitae*: "in affluent societies, the mentality of efficiency considers the growing number of elderly and sick people to be too burdensome and unbearable" (John Paul II, 1995).

God became man to save us and call us to communion with him. Sometimes it is difficult to recognize the profound value of human life when, despite all our efforts to help it, it continues to show us its weakness and fragility. Yet every person has been entrusted with the mission of faithfully guarding and respecting human life until its natural fulfillment.

Faced with challenges that can test our understanding of medicine, the significance of caring for the sick person and our social responsibility towards the most vulnerable, the Church reminds us that we all have a duty to accompany those in the critical and terminal phases of life and to bear witness alongside the sick person. Sadly, requesting death by euthanasia or assisted suicide is often a symptom of the illness magnified by isolation and despair. Care for life is therefore the first responsibility in our encounter with the sick. This responsibility exists not only when health could be restored, but even when healing is impossible. Only a context of human warmth and evangelical fraternity is capable of opening up a positive horizon and sustaining the sick in hope (United States Conference Of Catholic Bishops, 2024).

The magisterial documents *Iura et bona*, *Samaritanus bonus* and *Evangelium vitae* offer us some principles of Catholic morality regarding palliative and dying care starting from the principle of proportionality which states that medical treatments must be evaluated according to their benefits for the patient in relation to the burden they impose. Thus, a treatment is considered proportionate if it offers a reasonable expectation of benefit and does not impose an excessive or unnecessary burden on the patient, family or community.

A first principle is that "every person has a duty to care for and be cared for": those who care for the sick are imperatively required to do their duty conscientiously and to administer the remedies necessary or useful to care for and maintain life (Congregation for The Doctrine Of The Faith, 1980).

A second principle is that of "understanding the need for of the sick: needs for assistance, pain relief, emotional, affective and spiritual needs".

A third principle in the use of "proportionate" means consists in having recourse "with the patient's consent, to the means made available by the most advanced medicine, even if they are still at the experimental stage and are not without some risk. By accepting them, the sick person will even be able to set an example of generosity for the good of mankind"(Congregation for The Doctrine Of The Faith, 1980).

The fourth principle concerns the discontinuation of the use of these means if a prolongation of life is observed which in no way responds to the treatment imposed:

> "It is also licit to discontinue the use of such means when the results disappoint the hopes placed in them. But in making a decision of this kind, the just wishes of the patient and his family must be taken into account, as well as the opinion of truly competent physicians; they will doubtless be in a better position than any other to judge whether the use of instruments and personnel is disproportionate to

> the foreseeable results, and whether the techniques applied impose greater suffering and inconvenience on the patient than the benefits to be gained thereby" (Congregation for The Doctrine Of The Faith, 1980).
>
> The fifth principle refers to the normal means that medicine can offer:
>
> "no one may therefore be obliged to have recourse to a type of care which, even if already in use, is not yet safe or is too burdensome. To refuse it is not tantamount to suicide: rather, it signifies either simple acceptance of the human condition, or a desire to avoid implementing a medical device disproportionate to the results that might be hoped for, or even a desire not to impose too great a burden on the family or the community" (Congregation for The Doctrine Of The Faith, 1980).

The sixth principle refers to the renunciation of treatment in the face of imminent death:

> "in the imminence of an inevitable death despite the means employed, it is lawful in conscience to decide to renounce treatments which would only lead to a precarious and difficult prolongation of life, without however interrupting the normal care due to the patient in such cases. There is therefore no reason for the doctor to be concerned, as if he had not given assistance to a person in danger" (Congregation for The Doctrine Of The Faith, 1980).

In his address to the participants of the International Congress on "Life-Sustaining Treatments and the Vegetative State. Scientific Progress and Ethical Dilemmas" in 2004, John Paul II emphasized a point that we also find in the Magisterium of Pope Benedict XVI and Pope Francis:

> "In the face of a patient in such clinical conditions, there are those who go so far as to question even the permanence of the patient's 'human quality', almost as if the adjective 'vegetable' (the use of which has now been consolidated), symbolically descriptive of a clinical state, could or should refer instead to the patient as such, in fact degrading his or her personal value and dignity. In this regard, it should be noted that the term, even if used only in the clinical field, is certainly not the most appropriate term to refer to human subjects. In opposition to such tendencies of thought, I feel it is my duty to strongly reaffirm that the intrinsic value and personal dignity of every human being does not change, regardless of the concrete circumstances of his or her life. *A human being, however seriously ill or handicapped in the exercise of his highest functions, is and will always be a human being; he* will never become a "vegetable" or an "animal". Even our brothers and sisters in the clinical "vegetative state" retain their full human dignity. The loving gaze of God the Father continues to rest upon them, recognizing them as his children in need of special care" (John Paul II, 2004).

The document of the Dicastery for the Doctrine of the Faith, in the fifth chapter (*Teaching of the Magisterium*) of *Samaritanus bonus* reaffirms the principle of proportionality with regard to the care of patients in the vegetative state and minimally conscious state: "patients who are in the 'vegetative state' are still living human beings with inherent dignity, deserving the same basic care as other patients; nutrition and hydration, even when provided with artificial assistance, are generally part of that normal care due to patients in this state, along with other basic needs such as warmth and cleanliness. Care extends from patient to family, the health worker taking care that the patient has timely pastoral care and accompaniment.

## 2. Utilitarian concepts on the perception and definition of the human person

A society that promotes *ethical relativism* is representative of many aspects of contemporary culture. John Paul II in *Evangelium vitae* no. 70 draws attention to this danger as a "condition of democracy, while moral norms, considered objective and binding, would lead to authoritarianism and intolerance". It is in fact a question of respect for life and the human person. The urgency of rediscovering human and moral values derives "from the very truth of the human being and expresses and protects the dignity of the person". These values no one (individual, majority or States) "can ever create, modify or destroy, but only must recognize, respect and promote them" (EV 71).

Reaffirming the role of civil law, which is so limited and different from moral law that "in no sphere of life can civil law substitute itself for conscience or dictate norms that go beyond its competence" (Congregation for The Doctrine Of The Faith, 1980), John Paul II defines the function of civil law: "to guarantee orderly social coexistence in true justice". Its role is to ensure that all members of society respect certain fundamental rights. The first and most important of these is the inviolable right to life of every innocent human being. Legal tolerance of abortion or euthanasia can in no way invoke respect for the conscience of others (EV 72).

Gonzalo Herranz in his presentation "Euthanasia and the Dignity of Dying" at the International Bioethics Days on the theme "Bioethics and Dignity in a Pluralistic Society" quotes one of the critics of medicine Richard Taylor, who formulated particularly harsh criticism of the therapeutic abuse of intensive care units in the 1970s in these terms:

> "Rows of physiologic preparations, also known as human beings, are surrounded by a bewildering number of mechanical devices.... Through countless tubes, liquids of thousands of colors are injected or drained. Ventilators pump gases, dialysis machines pump, monitors set off their alarms, oxygen bubbles into humidifiers. The unfortunate prisoners of technology, blissfully unaware of what is going on around them, whether because of the drugs or their illness, lie helpless as the ritual desecration of their dignity is carried out" (Taylor, 1979 apud Herranz 2020).

An image that no one likes, that disgusts or arouses pity. For Taylor, the human person is condemned by medical technology to an abuse that removes all dignity. It is neither novel, nor unusual, today's society to look at people from the point of view of their usefulness, of their performance. Once again, the human person, and especially the terminally ill human person, is called into question.

I invite you now to look at some of the concepts presented by *Juan Manuel Burgos* in his book *Reconstruir la persona. Ensayos personalistas*, which presents personalism in dialogue with certain issues of interest in today's society: bioethics, *gender* theories, and accentuated secularization. In the third chapter he raises an issue that has implications for ethical and moral judgments of human acts: the *person* versus the *human being*, which he moves from the philosophical field into the realm of bioethical debate. According to the following theories to be briefly outlined below, embryos, fetuses, children, comatose persons, terminally ill elderly people, etc. would not be persons, because none of them are fully self-aware (they have no self-awareness).

*Peter Singer* one of the utilitarian bioethicists of the 20th century reformulates the concept of person in bioethics: "What I propose is to use person in the sense of a rational, self-aware being, to encompass those elements of the popular sense of *human being* that do not fit into the concept of 'member of the species *homo sapiens*'. For Singer, to have all these qualities is worthy of respect. In fact, what he states, and what happens according to his thinking, is that not all human beings are persons, not all human beings are persons. There are various human persons who are neither rational nor self-conscious: embryos, fetuses, children in the early stages of growth, comatose persons. They cannot be called persons because they lack the qualities listed above. It is found that other beings, mammals, which are superior beings, are

self-aware and rational, fulfilling the established criteria, and can thus be considered human persons. Briefly, Singer distinguishes three categories of beings:

(a) animal-persons, such as the higher mammals and perhaps whales, dolphins, elephants, dogs, pigs and other animals;

(b) human persons, i.e., self-conscious and rational human beings;

c) non-person members of the human species: fetuses, embryos, comatose persons, etc.

*Hugo Tristram Engelhardt* approaches bioethics differently, but the meaning of the concepts of person and human being are the same as Singer's. For Engelhardt the *person* is the *being that possesses certain characteristics in action*, which distinguishes between human being and person. If Singer holds that animals are persons, Engelhardt is of the contrary opinion, because he holds that animals do not possess reason. He does, however, put forward the idea that there are "potential persons", halfway between human beings and persons in the strict sense. The person is characterized by self-reflection, rationality and moral sense (the Kantian moral agent). Engelhardt distinguishes three fundamental categories of beings, with slight modifications from Singer's position:

a) possible non-human persons: perhaps extraterrestrial beings, provided they are peaceful and possess a basic moral structure (aliens would be a possible example), but not animals;

b) human persons, i.e. human beings capable of giving permission;

c) non-person members of the human species: fetuses, embryos, comatose persons, etc.

*Juan Carlos Álvarez* presents other theoretical premises, but develops a similar conception to that of Engelhardt and Singer (Alvarez, 2005 apud Masiá, 2005). He distinguishes between human being, individual of the human species and person. Alvarez argues for abandoning the term "person" because "to continue to use a term as ambiguous, confusing and polysemantic as "person" does not seem to help us much; on the contrary, it creates more problems" (Masiá, 2005). Here are the three categories that Alvarez presents:

a) God, angels, humanoids, Engelhardt's extraterrestrial agent, etc.;

b) human beings who possess what is properly and specifically human;

c) beings that are genetically human but do not possess what is specifically human: brain-dead subjects in permanent vegetative states, embryos in the initial or frozen stages, anencephalic fetuses.

*John Harris* has a fluid and continuous vision of life that begins from the moment of conception and continues with the individual that both gametes form without making a clear separation between before and after fertilization (Harris, 1989). In all this flux presented by Harris the person appears or disappears, this being determined by the capacity of the being to *value*its *own existence*.

Harris criticizes Engelhardt's position (Harris, 1998), which he defines as confusing in comparison with his clear and self-evident position, but classifies human beings into three categories:

a) pre-persons: individuals, human beings, persons in formation;

b) persons: human beings capable of valuing their own existence;

c) ex-persons: human beings who have lost the capacity to value their own existence (which is not necessarily the case).

All these demarcations between the concept of *person* and that of *human being* can create much confusion among bioethicists and, above all, can lead to a redefinition of the concept of human person according to criteria that run counter to Christian ethics and morality. These theories are alarming and may also pave the way for a personalistic and even scientistic justification of abortion and euthanasia. In contrast to the teaching of the Catholic Church presented in the first part of the article, these utilitarian theories and the fruit of a liquid society may be the subject of another bioethical debate.

**Conclusion: the "Good Samaritan" - shaper and stimulus of charitable sensitivity**

Even if he does not have a name, the "Good Samaritan" gives a name to his acts of charity. It can represent so many 'anonymous' people in hospitals or hospices who devote their lives and their acquired medical knowledge to give life and value to those who face that limit of life we call illness and suffering.

Both John Paul II in *Evangelium vitae* and the Letter *Samaritanus bonus* bring to the fore the figure of a Samaritan, who is not even one of the chosen people, but proves himself to be more sensitive and faithful than other "just" people.

The 'Good Samaritan' is the one who has a compassionate 'seeing heart' and acts accordingly. Life is sacred, a sacred gift (EV 49) therefore it is inviolable. The Good Samaritan who goes out of his way to help a wounded man symbolizes Jesus, who goes out to meet humanity in need of salvation and cares for our wounds and suffering. Sometimes it is difficult to recognize the profound value of human life when, despite all our efforts to help, it continues to show us its weakness and fragility. Yet every person has been entrusted with the mission of faithfully guarding human life until its natural fulfillment.

One of the current promoters of formation in charitable sensitivity and service is Pope Francis (Francesco, 2021). He has frequently and profoundly addressed the care of the incurably ill, emphasizing the importance of a pastoral response that is both human and spiritual. His statements highlight how human suffering and frailty must be met with compassion and accompanied by care that respects the dignity of the person. Through encyclicals, speeches and letters, the Pope has reaffirmed the Church's mission to be present with those who suffer. During the World Days of the Sick, Pope Francis has repeatedly reminded that caring for the sick must be a concrete witness of Christian love. He urged Christian communities never to abandon those who suffer, but to offer them moral and spiritual support. In a speech to members of Catholic health care associations, the Pope said: "The true measure of the greatness of a society is how it treats the most needy, those who have no means to defend themselves" (Francesco, 2020). This statement underlines the Church's call to care for the most vulnerable, including the terminally ill.

Pope Francis also addressed the issue of pain management and the importance of adequate palliative care. He reiterated that the relief of suffering is an act of compassion that the Church supports, as long as it is done with respect for human life and without the intention of causing death. From this perspective, the Pontiff praised the work of hospices and organizations that work to accompany the incurably ill, offering them not only medical care but also emotional and spiritual support.

Accompaniment is a recurring theme in Pope Francis' statements, which he sees as an act of Christian solidarity. He explained that "accompaniment" means going alongside the sick person, offering not only physical care but also constant attention and presence. The Pope emphasized that the task of accompaniment is not reserved only to health professionals, but must involve families, parish communities and all the faithful, creating a network of support that contributes to the well-being of the patient.

Central to Pope Francis' teaching is a critique of the "culture of rejection", a mentality that believes that some lives are less worth living, especially when illness or suffering makes them less productive or effective. Francis warned that a society that abandons the terminally ill is a society that has lost its humanity and fundamental values. "We must fight against the mentality that considers suffering useless and seeks to eliminate it through euthanasia." (Francesco, 2016).

Pope Francis spoke favorably of palliative care, calling it an ethical option that respects human dignity and recognizes the value of life until its natural end. He emphasized that pain relief and quality of life are central aspects of caring for the sick, always in a context that rejects

any form of unnecessary therapy. His statements indicate that palliative care must be part of an integrated approach, including spiritual support and community presence.

Another aspect that emerges from Pope Francis' speeches is the evangelizing dimension of care for the terminally ill. According to the Pope, caring for the suffering is a form of Christian witnessing that brings the Gospel message to the world. "When we visit a sick person, we bring the consolation of Jesus," the Pontiff said, emphasizing how the simple act of closeness can be transformed into a powerful message of faith and hope (Francesco, 2013).

Throughout his reflections, Pope Francis calls on the Church and the faithful to take greater responsibility in caring for the terminally ill. He calls for the promotion of a culture that respects life and embraces the meaning of suffering as part of the human condition, but also strives to alleviate pain and offer hope. His vision integrates traditional Catholic ethics with a pastoral care of presence, emphasizing that caring for the sick is ultimately an expression of divine love for humanity.

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