Accompanying the Dying: A Catholic Response to Assisted Death

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Should we choose the means of our own death? We all know, with certainty, that we will die. The immediate question at hand for many is whether we should bring our own lives to an end because of a terminal or painful illness. With a grim prognosis, is it more human to choose to end our lives or to continue to live through the process of dying? These questions arise because of legal changes to assisted dying, both in the United States and internationally.

Yet these questions are not the most significant ones, although at first glance they appear to be. They have assumptions about individual autonomy, community, dignity and our responsibility to care for the dying. The questions that those assumptions raise must be addressed first to answer the question of whether we should choose the means of our own death.

Medically assisted dying, variously termed medical aid in dying (MAID), physician-assisted suicide, voluntary assisted dying or euthanasia, has become one of the most contested bioethical and legal debates of the late 20th and early 21st centuries. To try and describe the choice as neutrally as possible, the term assisted dying will be used throughout this article. Between 1999 and 2023, nearly 185,000 people chose to end their lives through assisted dying across 20 jurisdictions where it was legal, accounting for approximately 1.4% of all deaths in those areas.[1]

While it remains an ethical issue for Catholic healthcare and beyond, assisted dying does not currently constitute a public health crisis. In short, most people who die do not choose assisted dying. Assisted death is controversial because of competing worldviews, but it remains a rare choice despite publicity that suggests it is more common.

The laws permitting such deaths now exist in France, Belgium, the Netherlands, Luxembourg, Switzerland, Canada, New Zealand, several Australian states and a growing number of U.S. states. In 2025, the U.K. declined to legalize the practice, although the same legislation has been reintroduced this year. Yet the numbers are rising each year. Behind the policy debates and legal frameworks lie deeply personal stories: individuals confronting terminal illness, loss of independence, and the erosion of the lives they once knew.

The conflicts between those who advocate for and against assisted dying do not lie in disagreements about hospice and palliative care, but rather in differences about the place of autonomy in healthcare decision-making. Advocates for assisted dying believe in an absolute value of individual choice. Those who advocate for limits on

assisted dying believe in a choice that is grounded in a community that assists in the final moments of dying.

The primary reasons people seek assisted dying, as reflected in empirical data and patient testimony, stand in sharp contrast with Catholic ethical and theological teaching, which holds such acts are gravely contrary to human dignity and God's sovereignty over human life.

MOTIVATIONS FOR ASSISTED DYING

Before examining the reasons behind requests for assisted dying, it is instructive to understand who makes them. Data consistently show that the practice is not evenly distributed across the population. Terminal cancer accounts for the majority of qualifying diagnoses — approximately 68% in the U.S. — with neurodegenerative diseases such as ALS or Huntington's disease making up the second-largest group at around 11%.[2] Those who request assisted dying tend to be older, predominantly white and relatively well-educated.

The Oregon Death with Dignity Act, enacted in 1997, mandated annual reports documenting patient motivations; these represent some of the most reliable longitudinal data available. These Oregon reports indicate that most patients are 65 and over, and there are concerns about racial disparities in access, with people of color consistently underrepresented in the data.[3]

These are not people in the early stages of illness seeking a quick escape. The majority face prognoses of six months or less to live and most are already hospice patients. Individuals have often lived full lives and arrived at the decision after sustained reflection, often informed by witnessing the deaths of others and by having formed strong convictions about how they wished their own deaths to proceed.

Contrary to popular assumptions, the desire to avoid physical pain is not the primary driver of assisted death requests, so strong palliative care programs will not diminish these requests. While pain is a factor for some patients, the most consistently reported reasons relate to existential and psychological concerns about the quality and meaning of life in its final stages.

The single most consistently cited reason across decades of Oregon data is the loss of autonomy. In the "2023 Oregon Death with Dignity Annual Report," 92% of patients listed loss of autonomy as an end-of-life concern contributing to their decision.[4] In earlier consolidated studies covering both Oregon and Washington state, loss of autonomy was reported by approximately 87% of patients.[5]

For many individuals, particularly those who have exercised significant agency throughout their lives, the progressive loss of control over bodily functions — being unable to dress oneself, to move freely, or to make independent decisions about daily life — represents a profound and unbearable diminishment. Early research from Oregon noted that patients' decisions were "more associated with attitudes about autonomy and dying, and less with fears about intractable pain or financial loss," reflecting a philosophy about controlling the manner of one's death that many patients described as a long-standing personal value.[6]

Closely related to autonomy is dignity. In the 2023 Oregon report, nearly 64% of patients cited loss of dignity as a significant factor.[7] Patients frequently describe their concern not merely about physical indignity — incontinence or dependence on others for intimate care — but about the erosion of their sense of self. The fear is becoming, in their own perception, a diminished or unrecognizable version of themselves: present in body but absent as the person they have been throughout their lives. For many, assisted dying represents not an act of despair but the final assertion of a self-defined identity.

The 2023 Oregon report also found that 88% of patients cited a decreasing ability to participate in activities that made life enjoyable as a significant factor in their decision. Terminal illness often involves a progressive narrowing of the world: first the abandonment of hobbies and social activities, then of work, then of mobility and then of basic functions. For individuals whose sense of self is bound up with activity — gardening, sports, music, intellectual engagement, time with grandchildren — this progressive withdrawal can render life, in their own estimation, no longer worth living on terms they can accept. Physicians who have worked with assisted dying patients describe this frequently: A patient who defined themself through a love of activity cannot reconcile themself to a bedridden death.

Physical pain and suffering remain significant factors only for a minority. Studies from Oregon report inadequate pain control as a reason in roughly 25% of cases.[8] Fatigue was cited in 31%

and difficulty breathing in 27% of cases in a *New England Journal of Medicine* study of physicians' experiences with assisted dying requests.[9] For patients with conditions that are particularly difficult to palliate — advanced cancer, ALS or severe heart failure — the anticipation of future suffering can be as motivating as present pain. The prospect of a slow, painful, dying process drives many patients to seek a degree of control over both the timing and manner of death.

A further and troubling motivation is the fear of becoming a financial or emotional burden to family members and caregivers. While financial concerns are cited in only a small percentage of cases — approximately 11% in early Oregon data[10] — critics have noted a broader cultural anxiety about dependency. Critics of assisted dying laws point to the fact that, over time, the profile of Oregon patients has shifted, with nearly 80% now relying on government-funded healthcare, raising questions about whether systemic inequities in palliative care access may be subtly coercing vulnerable people toward assisted death rather than enabling a genuinely free choice.[11]

The differences between Catholic teaching and the proponents of medically assisted death reflect long-standing philosophical differences about autonomy, dignity and how to approach suffering.

Underpinning all these motivations is a common thread: the desire for control or autonomy. Studies from *The New England Journal of Medicine* found that a desire to control the circumstances of death was cited by 53% of patients.[12] Proponents often frame access to assisted dying as an extension of the broader right to self-determination in medical decision-making. If patients may refuse treatment, decline resuscitation or choose palliative sedation, advocates argue it is inconsistent to deny them the right to determine the moment and manner of their deaths. For many patients, obtaining the prescription itself — even if never used — provides psychological relief, a sense of having an "exit available" should suffering become intolerable.

AUTONOMY, DIGNITY AND SUFFERING: THE CATHOLIC RESPONSE

The Catholic Church's position on assisted dying is absolute and unequivocal: It is morally wrong, regardless of the circumstances or motivations involved. This teaching is grounded in several interlocking theological and philosophical convictions concerning the nature of human life, the meaning of suffering, the limits of personal autonomy and the sovereignty of God. The differences between Catholic teaching and the proponents of medically assisted death reflect long-standing philosophical differences about autonomy, dignity and how to approach suffering.

At the foundation of Catholic opposition to assisted dying is the conviction that human life is not a possession, but a gift entrusted to each person by God. As the *Catechism of the Catholic Church* states, "We are stewards, not owners, of the life God has entrusted to us. It is not ours to dispose of."[13] This means that neither the desire to avoid suffering nor the exercise of personal autonomy can justify deliberately ending a human life. It also explicitly states: "Whatever its motives and means, direct euthanasia consists in putting an end to the lives of handicapped, sick or dying persons. It is morally unacceptable."[14]

Pope John Paul II's encyclical *Evangelium Vitae* (The Gospel of Life) represents the most comprehensive magisterial statement on these questions. He declared euthanasia a "grave violation of the law of God, since it is the deliberate and morally unacceptable killing of a human person."[15] Crucially, the encyclical engages directly with the compassionate framing often used to justify assisted dying. Pope John Paul II coined the phrase "false mercy" to describe the idea that killing a suffering person represents an act of compassion. As he stated, "True 'compassion' leads to sharing another's pain; it does not kill the person whose suffering we cannot bear."[16]

In the encyclical's framework, assisted dying does not resolve the problem of suffering; it

eliminates the sufferer, a fundamentally different and morally impermissible act. The pope also situates this debate within a broader "culture of death," by which he means a cultural and ideological tendency to see human life as valuable only conditionally, when it meets certain standards of productivity, independence or quality.

Catholic anthropology differs sharply from views that regard suffering as merely a problem to be eliminated. Rooted in the passion and death of Jesus Christ, it holds that suffering can be redemptive. In *Spe Salvi*, Pope Benedict XVI developed this theme, emphasizing Christian hope for eternal life and the need to accompany the sick with love rather than to hasten their deaths.[17]

To be clear, this does not mean Catholics are required to seek or prolong suffering. The Church explicitly supports the use of palliative care, including pain management, and permits the withholding of treatments that offer little or no benefit, in proportion to the burden of the treatment. What it opposes is the direct and intentional ending of life as a means of diminishing suffering.

In September 2020, the Congregation for the Doctrine of the Faith, with the approbation of Pope Francis, issued "*Samaritanus Bonus*: On the Care of Persons in the Critical and Terminal Phases of Life." This document was explicitly prompted by the global expansion of assisted dying laws and represents the Church's most detailed recent engagement with end-of-life questions.[18]

The document makes several significant arguments. First, it addresses the autonomy argument directly, drawing an analogy: "Just as we cannot make another person our slave, even if they ask to be, so we cannot directly choose to take the life of another, even if they request it." The limits of personal autonomy are thus understood not as arbitrary impositions but as reflections of the inherent dignity that makes people more than instruments of their own or others' preferences.

Second, *Samaritanus Bonus* challenges the premise that requests for assisted dying represent settled, autonomous decisions, noting that "the request for death is in many cases itself a symptom of disease, aggravated by isolation and discomfort." The document argues that with adequate palliative care and human accompaniment, requests for assisted dying are "considerably" reduced. This is not merely a theological assertion: Research on patients in palliative care settings consistently finds that depression, social isolation and undertreated pain are significant drivers of assisted dying requests, and that many patients change their minds when these conditions are properly addressed.[19]

Third, the letter emphasizes that palliative care is not a consolation prize but "an authentic expression of the human and Christian activity of providing care, the tangible symbol of the compassionate 'remaining' at the side of the suffering person." The Catholic vision does not leave the dying person alone with their suffering; it accompanies them through it, addressing physical, emotional and spiritual dimensions of their experience.

One of the sharpest points of tension between Catholic teaching and the arguments in favor of assisted dying concerns the concept of dignity. Advocates of assisted dying frequently cite dignity as a justification, arguing that individuals should be able to die with dignity, on their own terms. Catholic teaching does not deny the importance of dignity but contests its meaning. In the Church's understanding, human dignity is not contingent on independence, cognitive capacity or freedom from suffering; it is inherent to being made in the image of God (*imago Dei*). A person in the final stages of terminal illness, wholly dependent on others for basic care, retains every part of their dignity as a human being. To suggest otherwise is, in the Church's view, to embrace a dangerously conditional view of human worth.

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The tension between the reasons people give for seeking assisted dying and the Catholic Church's response reveals not a simple conflict between compassion and dogma, but a deep disagreement about fundamental philosophical and theological questions: the nature of the self, the meaning of suffering, the source of human dignity and the limits of personal freedom. Those who seek assisted dying predominantly frame their choice in terms of self-determination and the integrity of a life lived on one's own terms. For them, the capacity to choose the moment and manner of death is the final expression of the autonomy they have exercised throughout life. To be compelled to endure a dying process experienced as degrading or contrary to one's values is, in this view, an injustice imposed by the state and by social norms.

The Catholic Church, by contrast, sees this view as a misunderstanding of the nature of personhood. The self is not sovereign over life itself, and the meaning of one's life is not simply what one makes of it, but is constituted by one's relationship with God, with others and with the created order. As we share our lives with others, so, too, we share our deaths.

The disagreement on suffering is equally fundamental. Secular proponents of assisted dying view suffering as a pathology to be managed or, where it cannot be managed, eliminated. The Church sees it as a dimension of human existence that can be transformative when accompanied rather than fled. While *Samaritanus Bonus* calls for greater investment in palliative care,[20] it insists that eliminating the sufferer is not the same as relieving suffering, and that the impulse to do so reflects a failure of moral imagination.

DIVERSE TRADITIONS, SHARED QUESTIONS

There are, nonetheless, areas of genuine convergence. Both Catholic teaching and the empirical research on assisted dying agree that inadequate palliative care is a significant driver of requests for assisted dying, and that improved access to holistic end-of-life care would reduce such requests. Both traditions insist that the dying deserve accompaniment rather than abandonment. And both grapple seriously with how societies should respond to people facing unrelievable suffering at the end of life.

The decision to seek medically assisted dying is rarely simple. It emerges from the collision of progressive illness with deeply held values about autonomy, dignity and the kind of life one wishes to live. Empirical data consistently show that the primary drivers are existential — loss of independence, loss of dignity and diminishing engagement with what makes life meaningful — rather than purely the desire to escape physical pain. These motivations deserve to be taken seriously and understood with empathy, regardless of one's ultimate ethical position.

The Catholic Church's response to these motivations is not a refusal to engage but a sustained theological and philosophical challenge to their premises. In documents from *Evangelium Vitae* to *Samaritanus Bonus*, the Church argues that human dignity is not dependent on independence or capacity, that suffering can be endured and accompanied rather than escaped by death, and that the sovereignty of God over human life imposes limits on individual autonomy that no civil law or personal desire can override. True compassion, in this view, walks with the dying person rather than hastening their departure.

These two frameworks — the autonomy-centered case for assisted dying and the Catholic vision of accompanied dying — represent profoundly different accounts of what it means to be human, to suffer and to die well. As assisted dying laws expand worldwide and usage rises, the conversation between these traditions will become increasingly urgent, not merely for legislators and clinicians, but for all who must eventually confront their own deaths. I choose the Catholic path of accompaniment until natural death.

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NOTES

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