

Dignified life at the end of the road: bioethical reflections for contemporary clinical practice

Vida digna al final del camino: reflexiones bioéticas para la práctica clínica contemporánea

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Abstract

This article reflects on the concept of “dying with dignity” through a narrative literature review. It aims to contrast the secular view grounded in autonomy with the Catholic view grounded in ontological dignity, and to consolidate an ethical stance among healthcare professionals that attends to the integrity of the person in the terminal phase of illness.

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Drawing on clinical experience and bioethics training, the article analyzes the tension between patient autonomy and the sacred value of life. It proposes that dignity should not be understood as a variable attribute linked to quality of life, but rather as an ontological and inalienable reality. This reflection concludes that the right to die with dignity should be redefined as the right to a dignified life at the end of life, guaranteed by palliative care and respect for human mortality.

Keywords: dignified death, human dignity, palliative care, autonomy.

1. Introduction

Contemporary medical practice constantly confronts us with the mystery of the end of life, a scenario in which scientific techniques and personal ethics intersect.

As physicians, the tension between the ability to prolong biological existence and the need to respect the human integrity of the suffering patient demands a clear and well-founded stance (1).

This article is intended for medical students and physicians in general. Its objective is not only to contrast the secular view based on autonomy with the Catholic view grounded in ontological dignity, but also to provoke deep reflection among those who care for terminally ill patients. Furthermore, it seeks to strengthen the Catholic perspective among professionals who profess it, offering solid arguments for clinical practice consistent with Christian humanism.

Although it may seem bold, it is proposed that the approach to this topic should not be oriented toward death, but rather toward a “dignified life at the end of the journey” (2,3). In light of this, it is worth asking: Is it possible to reconcile the autonomy championed by secular medicine with the Catholic faith’s view of the sacred value of existence?

2. Materials and methods

A narrative review was conducted using a structured search strategy in the PubMed and SciELO databases and the repository of the journal *Medicina y Ética*. Health sciences descriptors (DeCS/MeSH) were used in combination with Boolean operators: (“Palliative care” OR “Terminal Care”) AND (“Dignity” OR “Personhood”) AND (“Catholicism” OR “Personalism”).

Inclusion criteria

Original articles and review articles published between 2018 and 2026, with full texts and peer review. Key documents from the Magisterium of the Church (1980–2024) and treatises on personalist bioethics were also included due to their doctrinal and ethical relevance. Articles that did not address the ethical or anthropological dimension of the dying process were excluded. The search yielded a total of 19 selected sources that met the criteria of temporal scope, thematic relevance, and methodological quality for qualitative analysis and narrative synthesis.

The information gathered was organized in a comparative manner to contrast the secular view based on autonomy with the Catholic view grounded in the intrinsic dignity of the person.

3. Discussion

It is imperative to define the concept of a dignified death from the current perspective.

Secular perspective

From a contemporary secular and medical perspective, the definition of a dignified death centers on patient autonomy, quality of life,

and the humanization of healthcare grounded in human rights and biomedical ethics (4).

The pillars defining this concept from a medical and civil standpoint are:

4. Patient autonomy (The central pillar)

In the bioethical paradigm, particularly under the influence of Beauchamp and Childress's principlism (5), autonomy has evolved from a secondary value to become the central pillar of the physician-patient relationship. In this context, dignity is not understood as a static essence, but rather as the active exercise of individual freedom. A human being is "worthy" to the extent that they possess the capacity for self-governance and to dictate the terms of their own existence, even in the face of imminent death.

From this perspective, dignity is intimately linked to the capacity for choice. Respect for the person translates, almost exclusively, into respect for their will. This has led to a reconfiguration of clinical ethics, in which the physician no longer acts out of benevolent paternalism but rather as a technical facilitator of the patient's decisions. Freedom becomes the standard of justice: a death is "dignified" if it aligns with the wishes and values previously expressed by the individual, regardless of the moral content of those wishes.

The operationalization of this individual freedom is manifested in two fundamental legal instruments (6, 7):

- Informed consent: understood as the patient's right to know their prognosis and to decide which medical interventions they wish to receive and which they do not.
- Advance directives: legal documents (living wills) in which a person sets forth in writing how they wish to be treated if they lose the ability to communicate, ensuring that their wishes prevail over the opinions of third parties.

It is imperative to clarify that, within the secular framework, the concept of “dignified death” is not unambiguous. On the one hand, it is identified as a standard of good clinical practice that includes the rejection of futile medical treatment and the implementation of palliative care to ensure a transition free from unnecessary suffering. On the other hand, some contemporary legal contexts have expanded this definition to include euthanasia and assisted suicide as expressions of individual autonomy. This review highlights that, while good clinical practice supports the natural process of dying, the legal expansion seeks the deliberate termination of life, posing a fundamental ethical dilemma for healthcare professionals.

5. The rejection of over-treatment

From the perspective of medical ethics, a dignified death implies an appropriate therapeutic effort aimed at beneficence (8).

- Artificially prolonging life when there is no hope of recovery (disthanasia) is not considered an ethical medical act, but rather a violation of the person’s integrity.
- Modern medicine understands that “letting die” when a cure is impossible is an act of respect for the natural course of the disease.

6. Quality of life

This is a multidimensional and subjective concept that assesses an individual’s overall well-being in relation to their health (9). · Two people with the same disease may report completely different qualities of life.

- A “dignified death” is one that occurs without unnecessary suffering, while maintaining the greatest possible level of consciousness and comfort.

- The focus shifts from prolonging life to the patient's well-being in their final days. A crucial aspect in medicine is that quality of life can only be defined by the patient themselves; for example:
- For a surgeon, an operation may be a "technical success," but if the patient feels that their life has lost value following the procedure, their health-related quality of life decreases.

If dignity depended on "quality of life" or functional autonomy, the vulnerable patient would be a "less dignified" being. In consolidating the Catholic vision within the hospital setting, the physician must propose vulnerability as a category of justice: it is precisely because the patient is fragile that he or she deserves a greater investment of time, affection, and palliative resources. Ontological dignity is the shield against the utilitarian temptation to hasten death in order to "save" suffering or resources.

7. Palliative care and sedation

Medically speaking, a dignified death is one that is supported by technical measures to alleviate refractory symptoms, as defined by (10,11):

- Symptom control: includes rigorous management of pain, dyspnea, anxiety, and delirium.
- Palliative sedation: consists of administering medications to lower the patient's level of consciousness in the face of symptoms that cannot be controlled otherwise, allowing death to occur without conscious agony.

8. Euthanasia and assisted suicide

In some civil laws, the definition of a dignified death has been expanded to include the right to choose the time and manner of death.

From this perspective, dignity ceases to be a static essence and becomes a quality perceived and managed by the individual, extending to the ability to avoid physical or mental degradation that the individual considers unacceptable for themselves. It is not viewed as an attack on life, but rather as the ultimate exercise of individual freedom (12).

- Euthanasia: The healthcare professional is the direct agent who administers the lethal substance to cause death at the patient's request.
- Medically assisted suicide: The physician provides the means (the prescription or the drug), but it is the patient who performs the final act of ingestion.

In both cases, the secular ethical justification lies in the principle of absolute autonomy, where the physician acts as a “guardian of rights” rather than as a healer of life.

9. Catholic religious perspective

Theologically, dying with dignity means accepting human finitude or mortality with hope. It is the moment when a person prepares for the encounter with God. Therefore, dignity does not depend on the patient's abilities or health, but on the ontological dignity of being a child of God until the very last breath.

For the Catholic Church, the concept of a dignified death is radically distinct from euthanasia or assisted suicide. It is not understood as the “right to die,” but rather as the right to die with Christian dignity, respecting life as a sacred gift that human beings cannot destroy at will.

The official position is based on the encyclical *Evangelium Vitae* by St. John Paul II (13) and the letter *Samaritanus bonus* (14) from the Congregation for the Doctrine of the Faith.

It is proposed that the approach to this debate should not focus exclusively on the event of death, but rather on ensuring a “dignified life at the end of the journey.” In this way, the “right to die with dignity” is redefined as the right to reach the end of one’s life in conditions of peace, care, and absolute respect for the inalienable dignity of the person who is passing away.

Thus, for the Catholic Church, the answer is not the “right to die,” but the right to die with dignity. It may seem like a play on words, but the theological difference is fundamental. The Church approaches this stage not as the end of a right, but as the fulfillment of a dignified life.

The Church views the end of life as a sacred stage of existence. Dying with dignity means:

- Going through the process of dying without being killed (euthanasia).
- Going through the process of dying without being subjected to medical procedures that cause undue suffering (over-treatment or futile medical care).
- Going through the process of dying at peace with God and with humanity.

This fundamental distinction establishes that dignity is an ontological and inalienable dignity of the person, which is not diminished by illness, suffering, or the loss of autonomy. From this perspective, the right to die with dignity translates into comprehensive care that rejects both euthanasia—understood as the deliberate termination of life—and therapeutic obstinacy, which seeks to prolong agony through disproportionate treatments (15).

According to Catholic doctrine, a dignified death consists of ensuring palliative care, pain relief, spiritual support, and human warmth, allowing the individual to journey toward the mystery of eternity in peace, while respecting the natural cycle of their existence as a sacred gift (16).

10. The encounter between mortality and transcendence

One's stance toward the end of life cannot be sustained without a profound understanding of death and dignity, understood as the point where biological fragility and spiritual greatness converge.

From a medical perspective, we accept that death is the irreversible cessation of the organism's functional unity; however, from a faith perspective, we recognize it as the sacred passage of the soul toward eternity (4,17). This duality teaches us that, while medicine must fight against disease, it must also have the humility to recognize when the process of dying has begun, avoiding turning the end of life into a meaningless technical battle.

One of the greatest challenges in end-of-life clinical practice is the moral distinction between palliative sedation and euthanasia. This confusion, common among medical students, often stems from observing the effect of sedation on a patient who loses consciousness and the death that occurs shortly thereafter, without analyzing the intent and proportionality of this medical act.

11. The principle of double effect

To establish an ethically sound position, the physician must master this principle, which allows for an action that has a desired effect (relief of a refractory symptom) and an undesired but foreseeable effect (the possible shortening of life). According to personalist bioethics, for sedation to be permissible, four conditions must be met (2):

- The action must be compassionate in and of itself; that is, the medical act consists of administering analgesic or sedative drugs to alleviate suffering, not to cause death.
- The intention must be upright; the physician seeks to alleviate refractory pain or dyspnea. If the intention were to hasten death, this would constitute covert euthanasia.

- The desired effect must not be a consequence of the undesired; the patient's relief is due to the pharmacological action of the sedative, not to the intention that the patient dies.
- There must be a proportionally serious cause; that is, sedation is justified only in the case of symptoms refractory to other treatments that are proving ineffective.

12. Palliative sedation vs. euthanasia: ontological differences

It is imperative to instill in healthcare professionals the understanding that palliative sedation is an act of comprehensive care, whereas euthanasia is an act of rupture (2,4). Table 1 provides further insight into this distinction:

Table 1. Ontological Differences

Criterion	Palliative sedation	Euthanasia
Objective	To relieve refractory symptoms.	To cause the patient's death.
Dosage	Proportional to the symptom response.	Deadly by definition.
Result	Relief from suffering; death occurs as a result of the natural course of the disease.	Death caused by a lethal pharmacological effect.
Vision of Dignity	Ontological: the person is cared for.	Functional: life without "quality" is eliminated.

Source: prepared by the author.

13. The right to spiritual accompaniment

theologically, dying with dignity means accepting human finitude or mortality with hope (14). For this reason, palliative sedation should

never be an obstacle to a person's preparation for the encounter with God. As the letter *Samaritanus bonus* points out, deep sedation that deprives the patient of the possibility of consciously experiencing their sacred passage should be avoided whenever possible, unless the symptoms are unbearable and the patient has been able to perform their religious rites, if they so desire, and in the presence of family members.

14. Finitude or mortality as clinical acceptance

At the end of the journey, the physician must recognize that human mortality is not a biological error, but a reality of our contingent nature—that is, understanding life as a gift received and not as an absolute property that science must preserve at all costs.

By rigorously applying the principle of double effect, the physician does not “succumb” to death but rather practices medicine with the humility necessary to recognize that the ontological dignity of being a child of God is not diminished by the loss of pharmacologically induced consciousness.

However, the expansion of legislation that decriminalizes or regulates euthanasia and assisted suicide in various parts of the world has posed an unprecedented dilemma for healthcare professionals. In this context, conscientious objection should not be understood as a privilege or mere ideological resistance, but rather as a fundamental right derived from freedom of thought and moral integrity, essential to the practice of a humanized medicine (18).

15. Rationale based on *evangelium vitae*

St. John Paul II, in his encyclical *Evangelium Vitae* (13), clearly establishes that there is a grave moral duty not to participate in actions that directly threaten human life, even if such actions are permitted

by civil law. The document affirms that laws authorizing euthanasia “not only do not create any obligation of conscience, but, on the contrary, establish a grave and precise obligation to oppose them through conscientious objection.”

From the Catholic perspective, the physician is not merely an executor of the patient’s wishes nor a state official, but a servant of life. Therefore, conscientious objection is the necessary ethical response when legal regulations conflict with natural law and the intrinsic mission of medicine: to heal whenever possible, to care at all times, but never to kill (7,10).

16. Conscientious objection as a protection for the profession

The integrity of the medical profession depends on its fidelity to its ultimate purpose (19). Conscientious objection protects this integrity in three fundamental ways:

- **Preservation of medical identity:** Historically, since the Hippocratic Oath, medicine has been defined by the prohibition against administering lethal drugs. Conscientious objection allows the physician to maintain his or her identity as a healer and not as an agent of death.
- **Defense of professional autonomy:** in the face of a utilitarian model that seeks to turn the physician into a neutral technician who obeys legal mandates or subjective requests, conscientious objection reaffirms that the physician is a moral agent with the capacity for independent judgment.
- **Guaranteeing pluralism in healthcare:** a democratic society must ensure that healthcare professionals can practice without betraying their values. Forcing participation in euthanasia would lead to the self-exclusion of professionals with strong ethical principles, thereby diminishing the human quality of healthcare systems.

17. Limits and clinical responsibility

It is crucial that medical students understand that conscientious objection does not imply abandonment of the patient. As the letter Samaritanus bonus points out, the objecting physician has an obligation to continue providing all necessary basic and palliative care to alleviate suffering, ensuring that the patient feels accompanied in their biological decline while being recognized in their inalienable dignity.

Conscientious objection is, ultimately, an act of integrity that proclaims that human life —especially in its terminal phase— possesses a sacred value that transcends any legislative agreement. For the Catholic physician, it is the exercise of a freedom placed at the service of Truth and of respect for the human person as a child of God.

It follows that a dignified death is grounded in patient autonomy, understood as the right to exercise individual freedom until the very end. This vision is realized through informed consent and advanced directives, which allow the individual to decide on the medical interventions they wish to receive.

It can also be concluded, from the perspective of medical ethics, that therapeutic obstinacy (disthanasia) is rejected, since artificially prolonging life without hope of recovery violates the person's integrity. Therefore, quality of life is prioritized over mere quantity. Modern medicine understands that a “dignified death” is one that occurs without unnecessary suffering, ensuring well-being through palliative care and, if necessary, palliative sedation to prevent conscious agony.

However, in some circles, this definition has been expanded to include the “right to choose the time of death,” whether through euthanasia (an active act by the physician) or assisted suicide (the patient self-administers the medication), viewing it as the ultimate exercise of freedom to avoid a state of degradation that the individual considers unacceptable.

On the other hand, dignity should not be understood as a variable quality that depends on autonomy or the absence of pain, but

rather as an ontological value (linked to one's very being) and an inalienable right (which cannot be taken away), which we possess because we are made in the image of God. While the secular view often makes dignity contingent on "quality of life," the Catholic perspective maintains that the human person is dignified in their entirety, especially in their vulnerability.

Therefore, the right to die with dignity is not the right to choose the moment of death, but the right to be recognized as a person until the very last breath: receiving the necessary relief for the body through palliative care, and the necessary comfort for the soul through love and hope.

Conclusion

In this summary, the answer to this initial dilemma lies in integrating both perspectives: understanding that death is not a clinical failure, but rather the point where biological fragility and spiritual greatness converge. A holistic approach recognizes that, while medicine must combat pain through palliative care, it must also have the humility to accept human mortality by ensuring relief for the body and comfort for the soul, transforming the clinical event of death into the supreme act of surrender and trust in the Creator.

Ethical considerations

This manuscript is a narrative review article that does not include patient data or human experimentation; therefore, it does not require approval from an ethics committee.

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