

Article

Pastoral Care vs. Freedom of Conscience: Responsibility for the Administration of the Anointing of the Sick Without Consent in Poland—Canonical–Legal, Religious, and Medical Aspects

Krzysztof Mikolajczuk ¹, Katarzyna Zielińska Król ^{2,*} , Magdalena Maksymiuk ³ and Justyna Wasiewicz ⁴ 

¹ Department of Church Procedural Law, Marriage Law and Penal Law and the Eastern Catholic Churches, Faculty of Law, Canon Law and Administration, The John Paul II Catholic University of Lublin, 20-950 Lublin, Poland; kmikolajczuk@kul.pl

² Department of Family Studies, The John Paul II Catholic University of Lublin, 20-950 Lublin, Poland

³ The Law and Administration Faculty, The Cardinal Stefan Wyszyński University in Warsaw, 01-938 Warszawa, Poland; m.maksymiuk@uksw.edu.pl

⁴ Institute of Medical Sciences, The John Paul II Catholic University of Lublin, 20-950 Lublin, Poland; jwasiewicz@student.kul.pl

* Correspondence: kzielinska@kul.pl

Abstract

This article addresses the issue of administering the Sacrament of the Anointing of the Sick without the recipient's consent, analysing it from canonical, religious, and medical perspectives in Poland. It indicates that, in accordance with the canon law of the Roman Catholic Church, it is permissible to act on the basis of a presumed request, particularly in emergency situations. At the same time, the fundamental importance of freedom of conscience and the autonomy of the human will is emphasised, as these constitute a significant limitation on pastoral intervention and are protected under Polish civil law. In conclusion, the paper argues for the necessity of maintaining the principle of proportionality between concern for spiritual welfare and respect for individual rights. The study employs an analysis and synthesis of normative and jurisprudential material. The analysis is comprehensive and multifaceted, whilst the synthesis enables the organisation and consolidation of the findings.

Keywords: canon law; Polish civil law; freedom of conscience; infringement of personal rights; priest; sacrament; medical care; medicine; hospital

1. Introduction

Pastoral care constitutes the Church's salvific mission, carried out through the proclamation of the Word of God, the administration of the sacraments, and the witness of Christian life. It involves providing comprehensive care for the faithful and supporting them in various life situations, with a particular focus on the elderly and those struggling with illness (*Catechismus Catholicae Ecclesiae* 1997, no. 1509–1510). At the same time, in accordance with the Declaration on Religious Freedom of the Second Vatican Council, every person has the right to religious freedom, understood as freedom from coercion in matters of conscience and the possibility of acting in accordance with it within the limits of the moral order, which stems from the dignity of the human person (*Second Vatican Council* 1965, no. 3). Practice shows that inevitable and often controversial situations arise at the intersection of these two spheres.



Academic Editor: Paul Weller

Received: 30 April 2026

Revised: 4 July 2026

Accepted: 6 July 2026

Published: 9 July 2026

Copyright: © 2026 by the authors.

Licensee MDPI, Basel, Switzerland.

This article is an open access article distributed under the terms and conditions of the [Creative Commons Attribution \(CC BY\)](https://creativecommons.org/licenses/by/4.0/) license.

The aim of this article is to analyse the relationship between pastoral care and freedom of conscience in the context of administering the Sacrament of the Anointing of the Sick in extraordinary situations. The central research problem concerns the normative tension between the canonical requirement of an explicit or implicit request for the sacrament and the civil-law requirement of consent, particularly in cases where the patient is unable to communicate his or her will. Accordingly, the article examines the extent to which these distinct normative frameworks may converge or diverge in determining the permissibility of pastoral intervention in emergency situations and at the end of life.

The study is based on the canon law of the Roman Catholic Church and its application within the Polish legal and institutional framework, with particular reference to the Guidelines of the Polish Bishops' Conference on the Ministry to the Sick and Dying. At the same time, the exercise of pastoral care must respect patients' rights protected under Polish law, particularly freedom of conscience and religion, the right to privacy, and the principle of informed consent. From a medical perspective, the administration of the Sacrament of the Anointing of the Sick is most often considered in cases involving patients in a serious, chronic, or terminal condition.

Modern medicine is increasingly moving away from a purely biomedical model towards a holistic approach—taking into account not only the patient's physical condition but also their spiritual, social, and psychological needs. In the care of patients who are at the end of life, the importance of so-called 'total pain'—encompassing physical, existential, emotional, and spiritual suffering—is emphasised (Rego and Nunes 2019, p. 281).

Research shows that patients' spiritual needs intensify as the disease progresses and in life-threatening situations (Quinn and Connolly 2023, p. 1). For many people, religiosity and spiritual practices constitute an alternative source of support—helping them to cope with anxiety, a sense of loss of control, and uncertainty. However, from a medical perspective, respect for the patient's autonomy—including their worldview and religious beliefs—is of paramount importance, as these constitute a significant factor in the clinical decision-making process (Steinhauser et al. 2017, pp. 429–30, 433). In this context, spiritual interventions—like other actions taken in relation to the patient—should take into account their wishes, level of consciousness, and previously expressed preferences.

The study adopted a mixed-methods approach, combining analysis and synthesis. The analysis is comprehensive and multidimensional, whilst the synthesis enables the findings to be organised and presented in a coherent manner.

2. Legal Guarantees of Pastoral and Spiritual Care in Poland

The legal framework governing access to pastoral and spiritual care for religious persons in Poland is primarily grounded in the Constitution of the Republic of Poland of 2 April 1997. It guarantees freedom of conscience and religion, including the right to profess or accept a religion and to manifest it individually or collectively, publicly or privately. This freedom further encompasses the right to participate in religious practices and to receive spiritual assistance (*Konstytucja Rzeczypospolitej Polskiej z dnia 2 kwietnia 1997*, art. 53). The constitutional framework also establishes the principle of impartiality of public authorities in matters of personal belief, ensuring state neutrality while simultaneously safeguarding the effective exercise of religious freedom (*Konstytucja Rzeczypospolitej Polskiej z dnia 2 kwietnia 1997*, art. 25). At the international level, an important legal basis is the Concordat between the Holy See and the Republic of Poland of 1993, ratified in 1998, which obliges the Polish state to ensure the exercise of religious rights, including access to pastoral care for Catholics staying in healthcare and social care institutions (*Konkordat między Stolicą Apostolską a Rzeczpospolitą Polską z 1998*, art. 17).

These constitutional and international guarantees are further specified in statutory law, in particular the Act of 6 November 2008 on Patients' Rights and the Patient Ombudsman. The Act grants persons of faith staying in stationary and 24 h healthcare institutions the right to pastoral care and obliges healthcare providers to ensure immediate contact with a clergyperson ([Ustawa z dnia 6 listopada 2009](#), art. 36). This provision transforms general constitutional freedoms into an enforceable subjective right within the healthcare system, and it is further reinforced by the protection of personal rights under Article 23 of the Civil Code ([Ustawa z dnia 23 kwietnia 1964](#), art. 23). Additional regulation is contained in the Act of 17 May 1989 on the Relationship between the State and the Catholic Church in the Republic of Poland, which confirms the right to religious practice and pastoral care for persons of faith staying in healthcare institutions and provides for organisational measures facilitating its exercise, including the establishment of chapels and the possibility of employing chaplains ([Ustawa z dnia 17 maja 1989](#), art. 31).

This framework effectively integrates international agreements and secular state legislation, as well as developing and binding internal regulations issued by the Polish Bishops' Conference (and, at times, diocesan bishops also issue specific norms governing the work of hospital chaplains). Within this structure, abstract constitutional freedoms are effectively translated into day-to-day institutional duties within the healthcare system, ensuring that both access to spiritual care and the right to live without it are protected in a practical, legal, and ethical manner as integral elements of human dignity.

3. The Sacrament of the Anointing of the Sick as a Sacrament of Healing

According to the teaching of the Catholic Church, the seven sacraments were instituted by Jesus Christ and form an integral part of the deposit of faith. As effective signs of grace entrusted to the Church, these sacraments serve to convey God's mysteries and lead people to salvation. For this reason, the Church is obliged to celebrate and administer them as visible signs of Christ's action. Each sacrament involves an inner, spiritual transformation of the recipient, brought about by the power of the Holy Spirit ([Catechismus Catholicae Ecclesiae 1997](#), no. 1129).

Through the Sacrament of the Anointing of the Sick, the Church entrusts those afflicted by serious illness to the suffering and glorified Christ, asking that He may strengthen them and grant them salvation ([John Paul II 1983](#), Codex Iuris Canonici, Can. 998). By receiving this sacrament, a person receives the gift of a special grace of the Holy Spirit, which strengthens and brings peace and courage in bearing the suffering associated with illness or old age. In accordance with God's will, this grace may contribute to the healing of the soul and, at times, also to physical recovery. The sacrament unites the sick person more closely with Christ's Passion and prepares him or her for the final passage to eternal life. Under certain circumstances, when the sick person is unable to receive the sacrament of Penance and has the requisite disposition, the Anointing of the Sick may also confer the forgiveness of sins ([Catechismus Catholicae Ecclesiae 1997](#), no. 1520–1523).

In everyday language, this sacrament is often referred to as 'the last rites', which suggests that it is administered at the end of life. Nevertheless, the Second Vatican Council, in the Apostolic Constitution **Sacrosanctum Concilium**, clearly explained that this sacrament is not intended solely for the dying ([Pawluk 2002](#), p. 377). It may be administered to a faithful person who, having reached the age of reason, is in danger of death due to illness or advanced age (Can. 1004 §1). It should be noted here that the ecclesiastical legislator confines himself to stating that the condition for receiving the sacrament is the serious nature of the illness, without specifying its type. It is therefore assumed that it may have both a somatic and a psychological dimension. Particular interpretative difficulties arise in relation to mental illnesses, where assessing the degree of risk is often more

complex. In such situations, it is advisable for the minister to seek the opinion of persons with the relevant expertise, which allows for a more prudent and appropriate discernment (Zubert 2011, p. 199). In medical terms, illness can be defined as a state of disturbance in the body's homeostasis, leading to impaired function of organs or entire systems. Chronic and terminal illnesses are characterised by a prolonged course, irreversible changes, and often a progressive deterioration in health. In the case of a terminal illness, curative treatment is replaced by palliative care, which aims to improve the patient's quality of life.

For a person, the experience of illness goes beyond the biological dimension. It encompasses physical pain, fear of death, a sense of loss of autonomy, dependence on others, and a crisis of meaning in life. Many studies emphasise that it is precisely at these moments that the spiritual dimension takes on particular significance. It can play an adaptive role, supporting the process of coping with illness, reducing levels of anxiety and low mood, and improving the patient's general well-being (Rego and Nunes 2019, p. 281; Quinn and Connolly 2023, p. 1).

Contemporary palliative care adopts an interdisciplinary approach, in which psychologists and chaplains play a significant role alongside medical staff. Their presence aims to provide support tailored to the patient's needs—both emotionally and spiritually. It should be emphasised, however, that these needs are individual in nature and cannot be presumed solely on the basis of cultural or statistical affiliation, a point also reflected in specific guidelines regarding the administration of the sacraments to patients (Quinn and Connolly 2023, p. 2).

In particular, the Sacrament of the Anointing of the Sick should be administered to a sick person before major surgery, if the surgery is necessitated by a serious illness, and also to children suffering from a serious illness and in danger of death, even when there is doubt as to whether they have already attained full use of reason. In the case of the elderly, it is possible to administer the sacrament regardless of the presence of a serious illness. The very fact of advanced age and the significant frailty that accompanies it constitutes a circumstance justifying the reception of anointing (Marzoa 2023, p. 604). As Z. Janczewski aptly pointed out, old age, understood as a natural stage in the development of the human body, progressing with the passing of the years, is associated with a general weakening of vital functions and a gradual loss of strength. This period is also frequently associated with the emergence of various health and existential threats. For this reason, it is justified to administer the sacrament to the elderly. The assessment of the stage of old age should, as far as possible, be carried out in consultation with persons possessing the relevant knowledge or expertise in this field (Janczewski 2012, pp. 45–46). In a medical context, old age is a physiological stage of life associated with a progressive decline in the body's functional reserves. The ageing process involves changes in virtually all systems, including the cardiovascular, nervous, and immune systems, resulting in increased susceptibility to disease and a reduced ability to adapt to physiological stress.

Multimorbidity is frequently observed in older adults, as is the co-occurrence of cognitive disorders such as dementia or delirium. These conditions can significantly affect the ability to make informed decisions, including consent to medical or spiritual interventions. For this reason, in clinical practice, it is essential to take into account the patient's prior declarations and the views of their relatives, whilst exercising particular caution in interpreting their current cognitive abilities. In situations of impaired decision-making capacity, the patient's previously expressed preferences, including those relating to spiritual needs, take on particular significance (Steinhauser et al. 2017, pp. 430, 434). Old age is associated with an intensification of existential reflections and spiritual needs, which means that for many patients, religious support becomes an essential element of care.

In cases of doubt as to whether the sick person has regained the use of reason, is seriously ill, or has died, the sacrament should be administered (Can. 1005). Any doubts regarding the validity of administering the sacrament should be resolved in favour of administering it (Marzoa 2023, p. 604). The above may imply that in situations of uncertainty regarding the fulfilment of the conditions for its reception, one should be guided by the principle of pastoral prudence and concern for the spiritual welfare of the sick person. Such an approach emphasises the primacy of mercy and spiritual support over a strict assessment of formal prerequisites.

The minister, that is, the person authorised to administer the Sacrament of the Anointing of the Sick, is a priest—that is, a man who has validly received at least the ordination to the presbyterate. Furthermore, in accordance with the intention of the ecclesiastical legislator, extraordinary ministry by a deacon or a layperson is excluded (Can. 1003 §1). In this case, the minister's role stems from the pastoral mission entrusted to him by the Church towards a specific group of the faithful. As W. Wenz noted, the ministry of administering the Sacrament of Anointing of the Sick is ordinarily carried out by bishops, parish priests, parish curates, and chaplains in hospitals and other institutions, such as hospices. Particularly, this task belongs to the parish priest, since it is he and the priests responsible for the sick who have a duty to visit them with care and support them with love. Such pastoral activity aims to strengthen the faith of the sick and to awaken in them the hope of receiving strength from the suffering and risen Christ, who gives new life (Wenz 2008, p. 330). Where there is a just cause, any priest is authorised to administer the sacrament, provided he has the consent, at least presumed, of the pastor responsible for the care of the faithful in question (Can. 1003 §2). Furthermore, every priest may carry consecrated oil with him, which enables him to administer the Sacrament of the Anointing of the Sick in emergencies or situations requiring immediate pastoral intervention (Can. 1003 §3). The place where this sacrament is administered is the current location of the person receiving it and thus, in particular, a hospital, hospice, or family home, as well as the place where a sudden illness, fainting spell or accident has occurred (Wenz 2008, p. 332).

It is also significant for the present discussion that the Rite of Anointing of the Sick involves an intrusion into the sphere of a person's bodily integrity. This sacrament is administered through anointing with oil and the recitation of the words prescribed in the liturgical books (Can. 998). The anointings should be performed with due care, in accordance with the verbal formula, order, and manner prescribed in the liturgical books. In cases of necessity, however, it is permissible to limit the rite to a single anointing on the forehead or another part of the body, whilst reciting the full sacramental formula (Can. 1000 §1). In urgent cases, it is therefore possible to simplify the celebration, especially when the patient's health prevents the full form of the rite from being used. As a rule, the minister of the sacrament should perform the anointing with his own hand, unless serious circumstances justify the use of a suitable instrument (Can. 1000 §2). This may be, for example, a small brush, particularly in situations involving a risk of infection (Adamowicz 1999, p. 171). The provisions of canon law also allow for the sacrament to be administered again if, after recovery, the sick person falls back into a state of serious illness or if, during the course of the same illness, there is a significant deterioration in health that increases the risk to life (Can. 1004 §2).

Not all the faithful are eligible to receive the Sacrament of the Anointing of the Sick. Church law clearly specifies situations in which it cannot be administered. Firstly, this applies when it is beyond doubt that the sick person has already died (Can. 1005). In such a situation, the priest, even if summoned belatedly, does not administer the sacrament but prays for the deceased, asking God to forgive their sins (Wenz 2008, p. 328). Secondly, the sacrament cannot be administered to a person who persists in manifest grave sin (Can. 1007)

and shows no willingness to convert and thus to break with its source. If the sick person does not express repentance for the sins committed, shows no desire for reconciliation, or outright refuses to receive the sacrament, the priest should not administer the Anointing of the Sick to them (Wenz 2008, p. 328). From a systemic perspective, a third situation can also be identified in which access to the sacrament is restricted, namely in the case of a canonical penalty for a committed offence. In such cases, the possibility of receiving the sacrament depends on the nature of the sanction and its possible lifting (Can. 1331).

4. Administering the Sacrament of the Anointing of the Sick in Ordinary Circumstances

In ordinary circumstances, the administration of the Sacrament of the Anointing of the Sick requires the request of the person who is to receive it. This stems from the need to respect religious freedom, as mentioned above, and the human right to self-determination. Canon law provides that this sacrament is to be conferred upon the sick who, while in possession of their faculties, at least implicitly requested it (Can. 1006). In the canonical legal context, an implicit request should not be equated with the absence of objection, but rather with a reasonably ascertainable expression of will derived from concrete circumstances. This norm must be read in conjunction with can. 843 §1, which establishes both the right of the faithful to receive the sacraments and the corresponding obligation of ministers not to refuse them when the faithful request them, are rightly disposed (*rite dispositi*) and are not prohibited by law from receiving them. In this context, *rite dispositi* is a legal category defined by the sacramental discipline of the Church. Its content, in the case of the Anointing of the Sick, must be interpreted in light of canons 1004–1007, which regulate the conditions for the valid and licit administration of the sacrament. Accordingly, the notion of proper disposition does not shift the focus from the juridical requirement of request and sacramental status of the recipient but specifies the conditions under which the right to receive the sacrament is exercised. Within this framework, the minister's role is not one of autonomous discernment beyond the law but of verifying whether the objective canonical conditions for administration of the sacrament are fulfilled.

As Warren Becket Soule observes in his commentary on the Code of Canons of the Eastern Churches (CCEO), in certain cases this discernment may, and sometimes should, be made by the minister; however, the relevant provision establishes a presumption in favour of the faithful, assuming their good faith and proper disposition to receive the sacraments worthily (Becket Soule 2019, p. 785). Although Becket Soule's analysis is situated within the Eastern Catholic canonical tradition, the underlying theological and legal principles bind the entire Catholic Church across all its rites and *sui iuris* Churches. Consequently, this norm reflects a universal sacramental rule and is therefore relevant, *mutatis mutandis*, to the present discussion in the Latin Church context.

In view of the particularly difficult situation faced by the sick and the elderly, Church law requires pastors and relatives to ensure that these faithful receive the sacrament in good time (Can. 1001). As A. Marzoa argues, this concern has a twofold dimension. On the one hand, it involves appropriate catechesis, helping to better understand the meaning and significance of the Sacrament of the Anointing of the Sick. On the other hand, it involves avoiding situations in which its reception is unnecessarily delayed, often until the moment of immediate danger to life. It is important that a sick or elderly person should be able to ask for this sacrament themselves, consciously and with faith, and receive it in a spirit of devotion (Marzoa 2023, p. 602). W. Wenz expressed a similar view, pointing out that the celebration of the sacrament in a home setting requires not only appropriate preparation but also the cooperation of those closest to the sick person. However, this must not take the form of an action imposed on either the sick person or their family—the priest's ministry should

be undertaken in response to an explicitly expressed request. Those requesting a pastoral visit should be asked in detail about the patient's current state of health, particularly regarding their consciousness, their ability to receive Holy Communion, and whether the patient themselves has expressed a wish and intention to receive the sacraments. A priest's ministry to the sick includes administering the Sacrament of Reconciliation, combined with a profession of faith and an act of contrition, as well as a plenary indulgence and the Sacrament of the Anointing of the Sick. It must be strongly emphasised that postponing a pastoral visit is not permissible. A call from a sick person should be met with an immediate and responsible response so as to prevent a situation in which negligence or delay might deprive the sick person of the opportunity for full sacramental reconciliation (Wenz 2008, p. 329). From the above positions, one can legitimately conclude that the initiative of third parties alone is not sufficient for the administration of the sacrament. If a family member requests its administration, but the sick person themselves does not consent, the priest should not administer it, for it is the intention of the recipient that is of key importance and not merely the concern of those around them.

In a hospital setting, pastoral care forms part of comprehensive patient care; however, its provision is subject to specific organisational and legal standards. In most medical facilities in Poland, upon admission to the hospital, a patient has the opportunity to indicate their religious affiliation or to express a wish to speak to a clergyman. This information may be recorded and form the basis for arranging a visit from a chaplain. It is accepted that contact with a chaplain should take place at the patient's express request or—if the patient is unable to communicate this—based on reliable information from relatives (Steinhauser et al. 2017, pp. 429, 432). In some facilities, consent forms or declarations regarding pastoral care are also used, although this is not uniformly regulated at the systemic level. Another important issue is the documentation of spiritual care provided. Information regarding a chaplain's visit or the administration of a sacrament may be recorded in the medical records; however, it should be treated as sensitive information relating to the patient's religious beliefs. For this reason, its processing requires respect for confidentiality principles.

In conclusion, in ordinary circumstances, the administration of the Sacrament of the Anointing of the Sick presupposes that the person concerned is able to express their own request. This reflects the ordinary canonical order, in which the initiative for receiving the sacrament belongs to the faithful themselves.

5. Administration of the Sacrament in Extraordinary Circumstances

In pastoral practice, there are situations in which a person is unable to personally and consciously express their intention to receive the Sacrament of Anointing of the Sick. This applies especially to the faithful who are seriously ill or who have suffered accidents resulting in loss of consciousness, perceptual disturbances, or impaired cognitive function, including those found unconscious at home. In such circumstances, reconstructing the actual intention to receive the sacrament becomes significantly difficult and, at times, even impossible.

From a medical point of view, a patient's inability to give informed consent stems from impaired consciousness or cognitive function. The most common causes of such conditions include stroke, head injuries, severe infections (e.g., sepsis), and cardiac arrest, followed by cerebral hypoxia, as well as conditions associated with pharmacological sedation in intensive care settings. Patients in intensive care units are often in a state of pharmacological coma or deep sedation and analgesia, which precludes any meaningful communication. Similarly, in the course of neurodegenerative or dementia-related conditions, the ability to make informed decisions may be significantly impaired or completely

lost. In such cases, treatment decisions are made based on the principle of the patient's best interests, taking into account their preferences, values, and spiritual beliefs, where known (Steinhauser et al. 2017, pp. 430, 434). A similar problem arises in relation to spiritual care—the inability to obtain direct consent requires particular caution and reliance on reliable evidence regarding the patient's worldview.

Notwithstanding the above, it should be noted that, in accordance with the guidelines set out in **Ordo unctionis infirmorum eorumque pastoralis curae**: “The sacrament should be administered to the sick who have lost consciousness or the use of reason, if it is likely that, as believers, they would have asked for it had they been conscious” (Sacraments of the Sick, no. 14). K. Niedziałkowski pointed out that this implies the need for prudent discernment on the part of the minister. If the priest knows the sick person and has moral certainty regarding their faith and their bond with the Church, he may proceed to administer the sacrament. In a different situation, he should base his decision on the testimony of close relatives or other reliable sources, which confirms the fact of baptism, the practice of the faith, and the presumed willingness to receive the sacraments in the face of a threat to life. However, in the absence of such grounds, the administration of the sacrament is not justified, as it is intended for the baptised who remain in a relationship of faith with the Church and at least indirectly request to receive it (Niedziałkowski 2017, p. 167).

But what should a priest do if he witnesses a road traffic accident? The victims are unconscious and, objectively speaking, are in a life-threatening condition. For obvious reasons, they are unable to request the sacrament of the anointing of the sick. To the priest, they are complete strangers; he does not know them and has no knowledge of their religious practices. It is difficult for him to determine the likelihood of their intention to receive the sacrament. In the literature, there is a common view that one should presume that a baptised Catholic has made a request unless there is evidence to the contrary (Marzoa 2023, p. 605). It is generally accepted as probable that the intention to receive the Sacrament of Anointing of the Sick exists in all those Christians for whom there are no indications of a contrary will (Jakubiak 2013, p. 172). The Polish Bishops' Conference recommends “encouraging the faithful to wear religious symbols, such as a medal, a cross, or a religious emblem in the form of a sticker on the car windscreen, which, in the event of an accident, would serve as a sign of their faith and membership of the Church, and thus facilitate the minister's administration of the sacraments in the face of imminent death. It is good practice for drivers to carry a card requesting that a priest be called in the event of a serious accident and a threat to life” (KEP, no. 14).

When a patient is unconscious in the hospital and their family—having contacted the attending doctor by telephone—requests the Sacrament of the Anointing of the Sick, the priest may administer it, based on the presumption that the patient wishes to receive the sacrament. Nevertheless, in the process of pastoral discernment, additional information indicating the patient's previous religious life may be helpful. Of significance may be, among other things, the presence at the bedside of objects of religious worship, such as a rosary or a holy card with a prayer, as well as previous participation in sacramental practices—for example, attending Mass celebrated in the hospital chapel or receiving other sacraments in a hospital setting prior to the deterioration of their health. Such elements can be of significant assistance in prudently discerning the patient's actual attitude of faith and presumed intention.

In the authors' view, the factors indicating a different intention may include both the attitudes and behaviour of the person concerned and the specific circumstances of their current situation. Examples include a written statement found in their possession rejecting the reception of the sacraments of the Catholic Church, the possession of items of a clearly iconoclastic nature, or the fact that the person sustained injuries during acts directed against

the Church or its teachings. Other circumstances may also lead to similar conclusions, such as long-standing, public declarations of unbelief or hostility towards religion; formal withdrawal from the Church; explicit rejection of the priestly ministry in the past (e.g., refusal to receive the sacraments despite a threat to life); or unequivocal testimony from close relatives confirming the patient's negative attitude towards religious practices. In such cases, administering the sacrament would be unjustified, as it would be contrary to the presumed request of the person concerned.

Notwithstanding the above, C. Krakowiak quite rightly observed that one cannot assume *a priori* that all those suffering from a serious illness or facing a life-threatening condition meet the criteria for receiving the Sacrament of the Sick. Contemporary realities show that it is increasingly common to encounter both unbaptised and baptised individuals who—even in the face of death—consciously refuse to receive the sacraments (Krakowiak 2006, p. 108). This phenomenon should also be considered in the context of increasing secularisation and formal departures from the Church.

In a hospital setting, the decision to administer a sacrament to an unconscious person is often made in emergency situations, when the patient's condition deteriorates rapidly. Medical staff then focus primarily on life-saving measures; however, at the same time, the patient's family may express a need for spiritual support. The literature emphasises that the spiritual needs of patients and their loved ones may intensify, particularly in situations of sudden deterioration in health and life-threatening conditions (Quinn and Connolly 2023, p. 1). From a clinical practice perspective, it is essential that such activities do not disrupt the treatment process or expose the patient to additional risks (e.g., infection or destabilisation of the patient's condition). Therefore, the presence of a chaplain with the patient should be coordinated with healthcare staff. At the same time, it should be emphasised that medical staff are not authorised to make religious decisions on behalf of the patient. Their role is limited to facilitating contact with a clergy member, provided that the organisational conditions allow for this and it does not conflict with the patient's best interests. On the basis of hospital practice and in accordance with Polish law, a patient should give consent, or such consent may be presumed, for the administration of the Sacrament of the Anointing of the Sick.

In the context of the above considerations, reference should also be made to the possibility of administering the sacrament of anointing of the sick conditionally. W. Wenz presented a position approving of such a practice, pointing out that the sacrament may be administered *sub conditione* to persons who are unconscious or in a state of agony, provided that the minister—guided by a reasonable probability—becomes convinced that, as believers, they would express a request to receive it were they conscious. Conversely, in a situation where the priest has serious doubts regarding the sick person's disposition to receive the sacrament, it is permissible to administer it under the express condition, expressed in the formula: 'if you are disposed' (Wenz 2008, pp. 331–32). This solution allows, on the one hand, for the theological nature of the sacrament to be respected whilst, on the other hand, taking into account the uncertainty regarding the patient's actual spiritual condition. It should be noted, however, that the view cited does not correspond to the current position of the Catholic Church, which unequivocally advocates the unconditional nature of this sacrament. This matter was finally settled in the Decree of the Congregation for the Sacraments and Divine Worship, *Promulgato Codice*, dated 12 September 1983, by which norm no. 133 contained in the *Ordo Unctionis infirmorum* of 1972 was repealed, thereby eliminating the conditional formula 'si vivis'. At the same time, this document refers to the only permissible practice, namely the administration of the sacrament unconditionally (no. 15), whereas the previous formulation still allowed for the possibility of using a conditional form (Marzoa 2023, p. 605).

Final decisions in such situations must be guided by the fundamental theological principle of canon law, according to which *salus animarum suprema lex*—the salvation of souls is the supreme law (Can. 1752). However, this principle cannot be invoked as a sweeping justification to bypass or substitute the formal canonical prerequisites for valid and licit sacramental administration. The danger of death, coupled with the contemporary impossibility of obtaining an explicit request and the absence of a known objection, is not automatically sufficient to render the administration of the sacrament permissible. Instead, the sacramental minister is strictly obliged to verify, as far as possible, whether the foundational criteria established by canon law—specifically the existence of at least an implicit prior desire or request under Canon 1006—are genuinely met. Therefore, the minister must exercise prudent and diligent discernment based on concrete indicators of the patient's faith and life, ensuring that the pastoral action remains an authentic response to the recipient's presumed will while simultaneously safeguarding their fundamental freedom of conscience. It should also be borne in mind that, although the sacraments are special and privileged means of grace, God's action is not limited solely to their administration. Consequently, a person may obtain the forgiveness of sins even outside the sacramental order, for example, through an act of perfect contrition (*Catechismus Catholicae Ecclesiae* 1997, no. 1452).

From a medical perspective, providing any form of care without the patient's consent constitutes an exceptional circumstance and is, as a rule, limited to life-saving measures. With regard to religious practices, the situation is more complex, as these do not constitute medical interventions and their significance depends on the patient's individual beliefs. Available analyses suggest that for believers, spiritual support in life-threatening situations can have significant therapeutic value, improving quality of life (Quinn and Connolly 2023, p. 2; Rego and Nunes 2019, pp. 279–81). However, imposing religious practices on a non-believer may lead to a violation of autonomy and a deterioration in the patient's mental well-being. Consequently, the medical community emphasises the need to respect the patient's prior declarations to the greatest extent possible and to avoid actions based on assumptions or which may harm the patient's health—in accordance with the principles of medical ethics, in particular, the principle of *primum non nocere*. There is also an increasing call for the introduction of clear procedures regarding spiritual care, which would help to reduce the risk of conflicts and ensure greater protection of patients' rights.

6. Between Pastoral Care and Freedom of Conscience: A Civil-Law Perspective

In the practice of administering the Sacrament of the Anointing of the Sick, particularly in extreme situations involving serious illness and an immediate threat to life, difficulties may arise where the recipient is unable to express consent or objection. Within canon law, the administration of sacraments may be grounded in either an explicit or a presumed (implicit) request of the faithful, particularly in situations where the person is unable to communicate. Such situations may give rise to a tension between pastoral care provided within the religious sphere and the protection of an individual's freedom of conscience as recognised in secular legal and ethical frameworks. On the one hand, sacramental ministry is understood within the Church as part of its pastoral mission to provide spiritual support and access to the means of grace; on the other hand, from the perspective of individual autonomy in matters of belief, questions may arise as to the limits of permissible religious intervention in the absence of clear consent. This section analyses civil-law responses to situations involving pastoral practice, and any references to canon law are intended solely to explain the internal logic of sacramental ministry, without transposing canonical criteria into civil-law evaluation.

Several years ago, a case arose in the courts concerning the administration of a sacrament to a patient in a medically induced coma. Whilst hospitalised in a cardiac surgery clinic, he underwent elective surgery. Immediately after the procedure, he remained conscious but was unable to communicate coherently. Due to his deteriorating health, he was administered sedatives and anticonvulsants, after which he was placed in a medically induced coma, in which he remained until the end of his hospitalisation. During this period, the hospital chaplain administered the Sacrament of the Anointing of the Sick to the patient whilst he was unconscious. Information regarding the administration of the sacrament was subsequently included in the medical records. Upon admission to the hospital, the patient was not asked whether he wished to receive sacramental ministry from a Catholic clergyman, nor did he himself make a statement objecting to such religious practices. After his discharge from the hospital and having reviewed his medical records, the patient discovered that he had received the Sacrament of the Anointing of the Sick. This information prompted his objection, as—although he had been baptised—he identifies as a non-believer and a non-practising Christian.

The patient brought a claim for damages against the medical facility, seeking compensation for an infringement of his personal rights, specifically an interference with his freedom of conscience, arising from the administration of the Sacrament of the Anointing of the Sick whilst he was undergoing treatment at the defendant's facility. The incident occurred when, as he claimed, the sacrament was administered without his knowledge and against his will, whilst he was in a state of medically induced coma. The claimant stated that, upon learning of the anointing, he suffered severe psychological shock, a nervous breakdown, and a deterioration in his mental and physical health, which he also linked to the risk of a further cardiac incident. The defendant medical institution moved to dismiss the claim, arguing that the claimant had failed to establish an adequate causal link between the administration of the sacrament and any potential adverse health consequences. In its view, given the claimant's declared lack of faith, the act had no real spiritual significance for him and cannot be treated as an event giving rise to effects in the sphere of personal rights. The defendant also pointed out that, in accordance with canon law, due to the claimant's state of health (pharmacological coma and risk of death), the sacrament was administered conditionally. It was further emphasised that the chaplain, acting without knowledge of the claimant's beliefs, assumed that he belonged to the dominant religion in Polish society.

In its judgment of 24 January 2012, the Regional Court in S. dismissed the claim, finding that there had been no infringement of the claimant's personal rights nor any unlawful conduct on the part of the defendant. It was noted that the chaplain administered the sacrament whilst the patient was unconscious and it was impossible to ascertain his wishes, acting on the presumption, accepted in pastoral practice, that he belonged to the Catholic Church. The court held that this action fell within the scope of canon law, the applicable legal order, and the principles of social coexistence and therefore was not unlawful, nor did it constitute an abuse of law. It was also emphasised that the assessment of a violation of personal rights must be made objectively and not solely on the basis of the claimant's subjective feelings. In the court's view, the mere administration of the sacrament to a non-believer did not cause any significant negative effects, either psychological or physical, and the emotions felt by the claimant (discomfort, regret) did not reach a level justifying legal protection. Nor was a causal link demonstrated between the deterioration in the claimant's health and the administration of the sacrament. The claimant lodged an appeal against the above judgment. By judgment of 6 June 2012, the Court of Appeal dismissed the claimant's appeal against the judgment of the Regional Court. The Court of Appeal dismissed the appeal and upheld the judgment of the court of first instance, finding that there had been no violation of the claimant's freedom of conscience. It pointed out

that the prohibition of religious coercion is of a general nature but had not been breached in this case. The assessment was made objectively—from the perspective of a ‘reasonable person’—on the basis that administering a sacrament to an unconscious person is symbolic in nature and does not constitute actual coercion or interference with one’s beliefs. It was held that the chaplain’s action constituted a form of support for the patient, not a sign of disrespect, and, as a matter of minor importance, did not warrant protection under Articles 23 and 24 of the Civil Code.

The Supreme Court ruled otherwise in its judgment of 20 September 2013: “The personal right protected as ‘freedom of conscience’ is therefore the freedom to adopt a particular worldview, including the freedom to adopt a particular religion. The freedom of conscience of a person professing a specific religion comprises the freedom to express their religious beliefs and to practise their religion. A person who declares themselves to be a non-believer cannot, admittedly, expect to have no contact with believers, their practices, and religious symbols, as in social life, this would be tantamount to restricting the freedom of conscience of believers, but they may expect not to be subjected to religious practices against their will or forced to participate in them or to use religious symbols. [...] For a believer, receiving a sacrament is an act of profound spiritual significance. The act through which this is performed does not become trivial or insignificant when carried out in the presence of a non-believer who declares their opposition to it. Subjecting a person to religious practices they do not accept is, therefore, not a minor, trivial matter unworthy of protection under Article 23 of the Civil Code. [...] The event which the claimant identified as infringing his freedom of conscience was the administration of the Sacrament of Anointing of the Sick whilst he was in a medically induced coma and unable to object to it. [...] “Receiving the sacrament is undoubtedly a religious practice; therefore, administering it to a person who—for whatever reason—objects to taking part in this act must be regarded as a form of subjecting them to a religious practice against their will.” This case is discussed exclusively as an illustration of the scope of civil-law protection of freedom of conscience under Articles 23 and 24 of the Polish Civil Code, and not as a basis for assessing canonical norms governing sacramental practice.

According to B. Rakoczy, the absence of explicit objection on the part of the patient allows the medical facility and the chaplain to assume that there are grounds for administering the sacrament of the anointing of the sick. In a situation where Polish legislation does not regulate this matter in detail, it must be recognised that the full formulation of rules in this regard remains within the remit of the ecclesiastical legislator (Rakoczy 2015, p. 220). K. Pluta, on the other hand, presents the view that subjecting a person to religious practices characteristic of a denomination they do not share constitutes an interference with their freedom of conscience and may lead to a violation of personal rights, regardless of the perpetrator’s intentions. Whether there is a threat to or a violation of this right is determined primarily by the effects caused by the action, rather than the chaplain’s subjective motives. Neither the chaplain nor the medical staff may rely on the assumption that the fact that the majority of society belongs to a particular religion automatically means that every patient shares the same faith. Even an action taken in good faith, arising from a desire to provide spiritual care to which the patient is entitled, does not eliminate unlawfulness if religious practices are imposed against the patient’s will (Pluta 2021, p. 234). When the same case was referred back to the Supreme Court, the Court, in its judgment of 2 September 2018, confirmed that in the present case “there had been a violation of the claimant’s personal rights in connection with his being subjected, against his will, to the sacrament of anointing of the sick, and that this incident was not of a minor, trivial nature, not deserving of protection under Article 23 of the Civil Code.” It should be noted that these arguments are grounded in different legal and normative perspectives, which should

not be directly transposed onto one another. The case illustrates that administering the sacrament without the patient's consent by a chaplain employed by a medical institution may constitute harmful conduct within the meaning of civil-law provisions and may lead to the institution's legal liability. Under canon law, the key issue is whether there was evidence of an explicit or at least implicit request for the sacrament in this case.

7. Conclusions

The above considerations reveal that the issue of administering the Sacrament of Anointing of the Sick in situations where the patient has not given explicit consent raises questions that must be distinguished according to the applicable normative framework. From the perspective of civil law, such cases concern the protection of freedom of conscience and personal rights, whereas within canon law, the relevant issue is the conditions under which a request for the sacrament may be regarded as explicit or implicit in accordance with the internal logic of sacramental practice.

In the light of the Supreme Court's case law, there is no doubt that subjecting a person to a religious practice against their will constitutes a violation of personal rights, regardless of the perpetrator's intentions or the pastoral context, for it is not the subjective conviction of the rightness of the action that is of key importance, but its objective effect in the form of interference with the sphere of religious freedom. Consequently, the chaplain's good faith or the conformity of the action with pastoral practice cannot in themselves preclude unlawfulness if a religious act is imposed on a person who does not accept it. The limit of permissibility is therefore determined by the patient's actual consent or, where this cannot be obtained, a sufficiently established indication of the patient's will.

At the same time, in emergency medical situations, the notion of a presumed request for the sacrament may be invoked within canon law, but only in a properly qualified sense, referring to circumstances that can reasonably be interpreted as indicating the will of the faithful, rather than as a legal fiction of consent or as a mere absence of objection. Such an interpretation must be grounded primarily in concrete and individually assessed factual indications, such as the person's known religious practice or prior expressions of faith. Reliable information obtained from family members or other persons close to the patient may also be taken into account, but only in a subsidiary and corroborative capacity and not as the sole or decisive basis for establishing a presumed request. It cannot be inferred from general social statistics, demographic assumptions, or the mere fact of baptism alone, which in itself is insufficient to establish a request for the sacrament.

There is also a need for clear regulations in medical facilities regarding the giving of consent to pastoral care, which could significantly reduce the risk of similar disputes (Jakubiak 2013, p. 176). At the same time, on the pastoral side, greater consideration must be given to the provisions of canon law, especially those emphasising the necessity of administering the sacrament at the appropriate time—in particular, before planned surgical procedures. This not only ensures the proper performance of spiritual ministry but also maintains due respect for the patient's will and beliefs (Jakubiak 2013, p. 177).

Author Contributions: Conceptualisation, K.M. and J.W.; Methodology, K.M.; Formal analysis, K.Z.K.; Investigation, K.Z.K. and J.W.; Writing—original draft, K.M.; Visualisation, J.W.; Supervision, M.M.; Project administration, M.M. All authors have read and agreed to the published version of the manuscript.

Funding: This research received no external funding.

Institutional Review Board Statement: Not applicable.

Informed Consent Statement: Not applicable.

Data Availability Statement: The original contributions presented in this study are included in the article. Further inquiries can be directed to the corresponding author.

Conflicts of Interest: The authors declare no conflicts of interest.

References

- Adamowicz, Leszek. 1999. *Wprowadzenie do prawa o sakramentach świętych według Kodeksu prawa kanonicznego oraz Kodeksu kanonów Kościołów wschodnich*. Lublin: Polihymnia.
- Becket Soule, Warren. 2019. Commentary on can. 381 CCEO. In *A Practical Commentary to the Code of Canons of the Eastern Churches*. Edited by John D. Faris and Jobe Abbass. 2 vols, Montréal: Librairie Wilson & Lafleur, Inc., pp. 785–86.
- Catechismus Catholicae Ecclesiae*. 1997. Città del Vaticano: Libreria Editrice Vaticana.
- Jakubiak, Tomasz. 2013. Intencja przyjęcia sakramentu namaszczenia chorych według obecnie obowiązującego prawa Kościoła łacińskiego. *Warszawskie Studia Teologiczne* 26: 145–59.
- Janczewski, Zbigniew. 2012. Przyjmujący sakrament namaszczenia chorych. *Prawo Kanoniczne* 55: 39–56. [CrossRef]
- John Paul II. 1983. Codex Iuris Canonici Auctoritate Ioannis Pauli PP. II Promulgatus (25 January 1983), AAS 75 (1983), Pars II: 1–317 as Amended (Valid as of 18 May 2022). Available online: https://www.vatican.va/archive/cod-iuris-canonici/cic_index_la.html#DE%20POPULO%20DEI (accessed on 19 May 2026).
- Konkordat między Stolicą Apostolską a Rzeczpospolitą Polską z dnia 28 lipca 1993 r. 1998. Dz.U. nr 51 poz. 318.
- Konstytucja Rzeczypospolitej Polskiej z dnia 2 kwietnia 1997 r. 1997. Dz.U. nr 78 poz. 483.
- Krakowiak, Czesław. 2006. Duszpasterstwo liturgiczne. Z praktyki pastoralnej sakramentu namaszczenia chorych. *Anamnesis* 12: 102–11.
- Marzoa, Ángel. 2023. Namasczenie chorych. In *Kodeks Prawa Kanonicznego. Komentarz. Powszechne i partykularne ustawodawstwo Kościoła katolickiego. Podstawowe akty polskiego prawa wyznaniowego*, 2nd ed. Edited by Piotr Majer. Warszawa: Wolters Kluwer, pp. 601–5.
- Niedziałkowski, Kamil. 2017. Udzielanie sakramentu namaszczenia chorych bez zgody przyjmującego—Aspekty cywilno-kanoniczne. *Kościół i Prawo* 6: 163–75. [CrossRef]
- Pawluk, Tadeusz. 2002. *Prawo kanoniczne według Kodeksu Jana Pawła II. T. 4: Lud Boży, jego nauczanie i uświęcanie*. Olsztyn: Warmińskie Wydawnictwo Diecezjalne.
- Pluta, Katarzyna. 2021. Udzielenie ateiście sakramentu namaszczenia chorych a naruszenie jego dóbr osobistych oraz zakazu przetwarzania szczególnych kategorii danych. *Przegląd Prawa Wyznaniowego* 13: 217–39.
- Quinn, Barry, and Michael Connolly. 2023. Spirituality in Palliative Care. *BMC Palliative Care* 22: 1. [CrossRef] [PubMed]
- Rakoczy, Bartosz. 2015. Udzielanie sakramentu namaszczenia chorych a naruszenie dobra osobistego pacjenta. Rozważania na tle wyroku Sądu Najwyższego z dnia 20 września 2013 roku (II CSK 1/13). In *Katolickie zasady relacji państwo–Kościół a prawo polskie*. Edited by Józef Krukowski, Mirosław Sitarz and Henryk Stawniak. Lublin: Towarzystwo Naukowe KUL, pp. 312–35.
- Rego, Francisca, and Rui Nunes. 2019. The interface between psychology and spirituality in palliative care. *Journal of Health Psychology* 24: 279–87. [PubMed]
- Second Vatican Council. 1965. Declaration on Religious Freedom “Dignitatis Humanae”. Available online: https://www.vatican.va/archive/hist_councils/ii_vatican_council/documents/vat-ii_decl_19651207_dignitatis-humanae_en.html (accessed on 19 April 2026).
- Steinhauser, Karen E., George Fitchett, George F. Handzo, Kimberly S. Johnson, Harold G. Koenig, Kenneth I. Pargament, Christina M. Puchalski, Shane Sinclair, Elizabeth J. Taylor, and Tracy A. Balboni. 2017. State of the Science of Spirituality and Palliative Care Research Part I: Definitions, Measurement, and Outcomes. *Journal of Pain and Symptom Management* 54: 428–40. [CrossRef] [PubMed]
- Ustawa z dnia 6 listopada 2008 r. o prawach pacjenta i Rzeczniku Praw Pacjenta. 2009. Dz.U. nr 52 poz. 417, z późn. zm.
- Ustawa z dnia 17 maja 1989 r. o stosunku Państwa do Kościoła Katolickiego w Rzeczypospolitej Polskiej. 1989. Dz.U. nr 29 poz. 154, z późn. zm.
- Ustawa z dnia 23 kwietnia 1964 r.—Kodeks cywilny. 1964. Dz.U. nr 16 poz. 93, z późn. zm.
- Wenz, Wiesław. 2008. *Kancelaria parafialna jako przestrzeń kościelnego posługiwania. Studium kanoniczno-pastoralne*. Wrocław: Papieski Wydział Teologiczny we Wrocławiu.
- Zubert, Bronisław. 2011. Sakrament namaszczenia chorych. In *Komentarz do Kodeksu Prawa Kanonicznego. T. III/2: Księga IV. Uświęcające zadanie Kościoła. Część I: Sakramenty. Część II: Pozostałe akty kultu Bożego. Część III: Miejsca i czasy święte..* Edited by Józef Krukowski. Poznań: Pallottinum, pp. 182–205.

Disclaimer/Publisher’s Note: The statements, opinions and data contained in all publications are solely those of the individual author(s) and contributor(s) and not of MDPI and/or the editor(s). MDPI and/or the editor(s) disclaim responsibility for any injury to people or property resulting from any ideas, methods, instructions or products referred to in the content.