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Death With Dignity: A Roman Catholic Perspective

by

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The question of a dignified death is raised anew against the advancements in medical technology that provide the means to maintain human life. There is fear that in face of technology the possibility for a dignified death may be diminished. Protecting human dignity means being able to remove medicine's unnatural obstacles to death. The focus of the discussion, however, is not to assume that a "natural" death is more worthy of the human person. That is clearly a naive position; not providing available medical means to a suffering person may certainly compromise human dignity as much as the excessive use of those means. The discussion, rather, has turned on freedom's ability to choose the manner and time of one's death. Can the freedom that persons enjoy over nature be extended even to the time and manner of death? Can the self-disposing of human life ever be a reasonable, responsible, and dignified act or does it necessarily entail an encroachment of God's dominion over life?

The purpose of this article is to delineate the meaning of a dignified death within the Roman Catholic moral tradition including some of the Magisterium's most recent statements. Providing a more accurate hermeneutic of what constitutes a dignified death will expand the discussion beyond the demand of human autonomy and freedom from excessive or futile technology. From a Catholic perspective, a dignified death will include the knowledge that death is approaching and one's treatment choices will be respected, the confidence that one will not suffer useless pain or be abandoned by friends and family, and the opportunity to be reconciled with one's life project.

Before deconstructing the meaning of a dignified death, some observations can be made concerning the character of Christian morality. These considerations will provide the background from which to approach the issue of death with dignity as it confronts contemporary society.

First, Christian morality is not understood as a system of prescriptions and proscriptions requiring the submissive obedience of the believer. Moral norms

are not ends in themselves but reveal a conception of human flourishing and dignity which they tacitly embody; norms are messengers of the meaning of human flourishing. In this way, moral norms have a prophylactic role. Like the walls of a medieval city which guaranteed the protection of the citizens, moral norms protect an underlying vision of human dignity which does not exclude suffering, self-sacrifices, or solidarity with those in need. This vision or horizon is the hermeneutical key to unlock the meaning of the behavior a norm proscribes or prescribes. This horizon which contains assumptions about human life, suffering, and death is specified, extended, and deciphered through moral reasoning and the pastoral practice of the Church. In a way, this horizon provides the background grammar which structures meaningful discourse about a human and dignified death. To forget that the inner-worldly behavior sanctioned or prohibited by a moral norm embodies a more original vision of human flourishing is to work with a truncated notion of the reasoning process.

Secondly, moral norms cannot be limited to prescriptive language - what we should and should not do - but must open up to the narrative language of the community. When speaking about the topic of euthanasia (literally a "good" or "easy" death) this characteristic of the moral norm has a particular importance. In face of human suffering and the experience of death, normative language gives way to the invitation to enter into solidarity with a brother or sister in need. The compassion and care of the believing community for the sick and dying will be an eloquent testimony to the meaning of Christian living. The compassion and solidarity with those facing their fragility and mortality will be evidence to the communitarian character of Christian ethics.

1. Christian Anthropology and Moral Reasoning

The starting point for Christian moral reasoning is reason illuminated by faith (DS. 3006). The introduction of a religious voice to the discussion on euthanasia does not mean a simplistic or naive use of Scripture. The tradition of natural law argumentation guards against any moral proscription being grounded on biblical authority (Gen. 9:6; Dt. 5:17). The autonomous nature of moral reasoning protects the moral law from being imposed heteronomously by even a divine authority.¹ Faith does not replace the need for study and reflection; faith does not suppress our rational capabilities. Nevertheless, any conception of moral reasoning that is sensitive to the exigencies of contemporary philosophy will understand the autonomy of moral reasoning as a relational autonomy. This means that as informed by faith, moral reasoning is always embedded in a more original narrative or context. The creed is effective at this deeper level. What we profess and believe (*fides quae*) acts as a presupposition to our reason in a way that it conditions and stimulates reason. Our faith sensitizes reason to perceive moral values. This approach is seen most clearly in the new *Ethical and Religious Directives for Catholic Health Care Services* where the Bishops introduce the individual chapters with a narrative that "provides the context in which concrete issues can be discussed from the perspective of the Catholic faith." Only then are the directives given "which promote and protect the truths

of the Catholic faith as those truths are brought to bear on concrete issues in health care."²

There are a number of presuppositions that stem from the Christian creed and which come into play in the discussion surrounding our obligations to the sick and dying. While not providing any concrete norm, these presuppositions help identify relevant problems and point the direction in which moral reflection will go to find adequate solutions. They constitute the cognitive matrix in which moral reasoning works.

First, there is the recognition of the indestructible dignity of the person. The religious warrant for human dignity is the creation account in Genesis 1:26 where humankind is created in the image of God. Human dignity is not merited; it cannot be forfeited by sin; it is not diminished by sickness; it cannot be revoked by society or the will of the individual. Human dignity entails a respect for another that frees her from the fear of any kind of arbitrary manipulation by others.

Secondly, there is the recognition of the equality of all persons. The warrant for this claim is the Incarnation where, by becoming us, Christ renders us equal (Gal. 3:28). The Incarnation also gives a new quality to human solidarity. God's nearness to us is shown in our willingness to draw near to each other.

A third presupposition that will guide the moral practice of the Christian community is the conviction that death is not a catastrophe to be avoided at all costs. For the Christian death is not an insoluble puzzle. Christ's death has put death to death (1 Cor. 15:56). His resurrection has removed the veil of absurdity from human history. Through death the Christian enters eternal life (Rom. 6:23). Belief in the resurrection anchors the Christian's sense of hope in the face of suffering and death. Because death is anticipated and integrated into one's daily life, the Christian can embrace death serenely as the culmination of life.

2. Teaching and Practice of the Church

Within the Catholic tradition, life is a fundamental good. Life is the basis for the enjoyment for all other human goods. At the same time, because life is not an absolute good, it need not be maintained at all costs or by all technological means available.

What is proscribed absolutely by the Church is "an action or an omission which of itself or by intention causes death, in order that all suffering may in this way be eliminated."³ In condemning the direct killing of oneself or another because that life is seen as absurd, the Catholic tradition also recognizes that death must not be staved off at all costs. Even within a theological anthropology that integrates suffering into the mystery of Christ's death and resurrection, the Catholic tradition recognizes that suffering can become futile, excessive, and offensive to human dignity; the tradition does not degenerate into a cult of suffering. Catholic normative reasoning moves between these two extremes: human life is never regarded as meaningless even in its final and most vulnerable stages, but the technology used to maintain human life can be regarded at times as meaningless or useless.

The Christian affirmation of life and the recognition of the appropriateness of

death stand behind the Church's traditional nomenclature of extraordinary and ordinary means of treatment to maintain life.⁴ The obligation to utilize ordinary means of treatment implies that an individual may forgo or omit treatment procedures when the burdens outweigh the benefits. The *Declaration on Euthanasia* nuanced the traditional terminology when it spoke of proportionate and disproportionate means of medical treatment. This is also the language used in the new Catechism and the new Directives.⁵ Whatever the language, however, the criterion for determining proportionate and disproportionate means is the integral well-being of the patient. Means of life support are proportionate or disproportionate relative to the condition of the patient. In the traditional manuals of moral theology, a variety of factors were offered to guide the prudential judgment of the patient: the reasonable hope of recovery, the ability to interact in familiar surroundings, the bearable level of pain and discomfort, and the tolerable hardship or inconvenience entailed in the provision of life support.⁶

What is clear in the tradition is that the guiding criterion is *not* the state of medical science or technology alone. If that were the case, what is ordinary today was extraordinary yesterday, and what is extraordinary today will be ordinary tomorrow. Of course, technological advancements may imply new obligations. Advancements in the treatment of an illness obviously diminish the risks and burden involved and offer the hope of greater therapeutic benefits. In other words, the determination of proportionate or disproportionate means of treatment will be flexible.

A subtle but real threat to the Catholic tradition is that society has come to understand the most advanced medical technology as ordinary and commonplace. Technology is taken for granted in a way that was unimaginable a generation ago. This attitude has the tendency to restrict rather than refine the retrieval of the Catholic moral tradition and its application in a contemporary context. In a technological society, the duty to maintain life can be equated with the use of all available technology to maintain life; death occurs when technology has reached its limit; death becomes a medical failure. But to use technology in an uncritical way - that is regardless of the patient's condition - is to make an idol of it and risks turning the patient into an object. Such a naive use of technology, ironically, will have the tendency to reinforce initiatives for physician-assisted suicide. As a reaction to an uncritical use of technology, initiatives for physician-assisted suicide unfortunately will be interpreted as a way of safeguarding the patient from manipulation. Within the Roman Catholic tradition, the object of offering or withdrawing medical technology is to allow the dying to live their final stages of life with human and Christian dignity.

To this end, what is offered to the patient cannot be limited to the technological or medical means to support life or relieve physical pain. "Assistance" offered to the sick and dying will include human solidarity and compassion (Lk. 10:25-38). The goal of treatment is not merely to relieve pain, but to humanize suffering. The willingness of the community to draw close to those who are dying broadens the moral discussion about a dignified death to include the interpersonal aspects of human suffering and care. This means that the measure of Christian praxis will not be the technology that can be offered to the suffering and dying, but the

compassion and love provided for those who experience in their suffering and dying the limitations of the human condition.⁷ The trust, love and support so necessary for human living is a necessity for human dying as well. As solitary as death will be, it does not mean that we should die alone. When disproportionate means of treatment are withdrawn or withheld, the dying patient is not abandoned; the logic guiding the obligation to humanize suffering shifts from therapy to care.

In this context, the preparations that a dying person may make to take his own life or his request to have a physician or nurse remedy pain by terminating life—far from being an act of freedom or self-determination—can be interpreted as an “anguished plea for help and love.”⁸ The challenge to the Christian community is to create the conditions wherein the person does not have to gain meaning by choosing death. There is a mutually conditioning relationship between law and culture. What we need are not merely laws prohibiting physician-assisted suicide, but we need to create what John Paul II has named in his recent Encyclical *The Gospel of Life*, a “culture of life.” We must see that the request to have one’s life terminated by another can signal the moral failure of the community to support the dying in their last stages of life, and to provide meaning to the fragility of human existence. Such persons feel abandoned. In an environment where the dying experience themselves as isolated and far from human solidarity, and where they are not offered any purpose to their suffering, they are even more susceptible to suggestions of “physician assisted” suicide. When such a tragedy occurs, then, the moral condemnation should not be directed to the physician or the patient alone, but the community that has lost its sense of human solidarity with the weakest and most vulnerable members of society.

The witness of religious communities of men and women provides a rich insight into the meaning of a dignified death. Health care communities of religious take time to gather with a dying sister and help her prepare for an impending death. Community members stay with her around the clock; they pray with her, and comfort her with Scripture, poetry and songs. The room of the dying becomes like a chapel. The others allow the dying sister the opportunity to take stock of life, to be forgiven her transgressions, and to make final farewells. The example of the religious teaches us that one should not fear the inevitable confrontation with death; one should fear, rather, being unprepared for death, dying unreconciled with one’s life choices, and dying alone and isolated from human love.

The witness of such religious communities introduce a necessary corrective into the discussion about the right to die which is often contextualized within the assumption that the freedom to choose is tantamount to human dignity. In its turn, this conception of freedom is based on a decidedly modern epistemology which emphasizes personal autonomy.⁹ Within this scheme, moral problems are defined in terms of the restrictions on freedom or the impairment of autonomy. The witness of the Christian community does not question the right to die; it questions the validity of the modern project which sees dependency on others and human dignity as antithetical.

The Church realizes that burdens of caring for a dying family member also must be taken into consideration when evaluating the means of treatment. Each family will face definite limits — not merely financial but psychological and moral — to the care that they can provide to a dying loved one. Here again is an opportunity for the community's support to humanize suffering in face of the growing technological possibilities to prolong life. Concretely, the hospice movement and parish nurse program are examples of care not only for the terminally ill, allowing the individual to remain in familial surroundings, but also examples of communal support for the families who otherwise would not be able to provide this kind of care on their own. By supporting these kinds of programs and initiatives, the ecclesial community can provide a high standard of care to be imitated. A Christian ethic will be characterized by its sensitivity to those who suffer; the sick and dying should find a privileged place within the Christian community. The Christian vision of human dignity not only includes the ability to accept suffering and to transform it by the light of faith, but also the ability to bear the sufferings of one another generously and compassionately.

Excessive expense to the family or community can also be a factor in judging certain means to be extraordinary or disproportionate. An individual has a responsibility not to invest the financial resources of the family in treatment or technology disproportionate to the anticipated results.¹⁰ It often happens that when a family is not able to pay for a potentially beneficial treatment, public support is mobilized to assist the family. Such cases even may provoke the development of new criterion of resource allocation or new forms of health care delivery in order to prevent similar cases from becoming commonplace. Publicly established limits to medical treatment, however, must be done in a way that does not entail the further marginalization of those most in need.

3. The Professional-Patient Relationship

The teaching of the Church underlines the fundamental right to life of every human person.¹¹ A person should be certain that the right to life is respected and that no one presumes the authority to abrogate it. The ethos of the medical profession is built around the obligation to maintain and protect human life. Upon this professional duty is built the patient's trust to receive medical care in a human and dignified way. Advancements in medical technology do not cast this professional duty into doubt; increasing technological control over human life in its most fragile and vulnerable moments, however, raises questions of the scope and limits of this duty.

The duty to maintain life should not compromise other responsibilities that the physician has toward the patient. This means that the right to life does not exhaust the professional-patient relationship. The physician's duty to maintain life is balanced with the duty to relieve pain, even when doing so will shorten the patient's life.¹² Naturally, persons will have different levels of tolerance for physical pain, but no one is bound to a heroic measure of endurance. It is fully in accord with the Catholic tradition for a physician to administer analgesics to alleviate pain even though their administration may quicken the patient's death.

Though the phenomenal structure entails the taking of human life, the loss of life does not exhaust the moral meaning of the act. The physician does not intend the death of the patient; the moral object of the act is pain control. This is an acceptable application of the traditional principle of the double effect.

Effective pain management also enters into the discussion on physician-assisted suicide. At this level of the discussion, the "right to die" no longer means the patient's freedom to relinquish disproportionate means, but the physician's ability to help end the lives of ill patients suffering intolerably. In arguing by analogy, there is oftentimes a similarity drawn with the case of a fatally wounded soldier requesting to be shot in order to avoid a more agonizing death.¹³ It is quite true that no one should suffer a physically painful death, but the tragedy of the mortally wounded soldier should not be over interpreted. In this case, the taking of life is done precisely because there are no other alternatives. The question is how comparable this case is to the contemporary medical situation? What are the relevant similarities to the professional-patient relationship? The purpose of effective pain management is to guarantee adequate relief to the dying.

In addition to the duties to maintain life and to relieve pain, the physician has the responsibility to insure - as much as possible - that the dying patient remains conscious and aware of his or her surroundings.¹⁴ The patient has the right to embrace death while still alert and cognizant. A dying patient should not be deprived of consciousness or the ability to communicate with care providers, family, or friends merely for the sake of prolonging life. This duty serves the humanization of an individual's suffering and protects the patient from an uncritical and abusive use of technology.

The professional-patient relationship is a human relationship based on confidence and trust. The patient has the right to truthful information about his or her condition. The duty to provide this information will depend upon the ability of the patient to receive it. The responsibility to provide this information, however, does not fall upon the physician alone. The patient oftentimes will need emotional, psychological and spiritual support. Hence, there must be collaboration between health care providers, the family of the patient, and pastoral care providers. A patient unprepared for death may meet an unfavorable diagnosis and prognosis with anger, resistance and denial. Conversely, the more prepared a person is to face death, the easier will be the sharing of information about that person's condition. Learning the truth about one's condition will be experienced as a relief and an invitation to prepare for death. While the truth should be told to a patient in a compassionate and, at times, in a gradual way, to withhold the truth from a patient is a subtle hegemony over the patient; it is a form of paternalism.

Knowing the truth of one's condition serves the individual's freedom. As the Bishops write, the information to which a patient is entitled includes "all reasonable information about the essential nature of the proposed treatment and its benefits; its risks, side-effects, consequences, and cost; and any reasonable and morally legitimate alternatives, including no treatment at all."¹⁵ This information will be the basis for the informed consent of the patient. The free and informed consent of the patient is to be respected.

Although the informed decision of the patient binds the physician, this does not mean that the physician is obligated to cooperate with the patient with treatment contrary to the physician's moral or professional standards. The physician preserves the right to her own conscience.

4. Promoting Human Dignity in Cases of Doubt

Cases of doubt are solved through what are known as moral systems. The moral systems provide the agent with the practical certainty needed to act in a responsible way. Among the various moral systems are probabilism and tutiorism. The moral system of probabilism holds that a solidly probable opinion is sufficient to solve the doubt in favor of liberty. The guiding principle is *qui probabiliter agit prudenter agit*. On the other hand, the moral system of tutiorism holds that in cases of doubt, even when there is an opinion for liberty, one acts responsibly when the safer course is followed. Where the fundamental good of life is concerned, as in the care for the dying, one proceeds in a tutioristic manner.

Tutiorism, however, should not be understood naively or simplistically. Tutiorism does not mean that life must be protected and maintained at all costs. Tutiorism does not mean rigorism; it does not make the maintenance of human life absolute at the expense of other goods to be considered. Tutiorism refers to the certainty of diagnosis and prognosis so that health care decisions can serve the patient's right to die with human and Christian dignity.

There is no doubt that in an emergency situation a physician will act in a prudent way by initiating treatment with the hope of its success. Yet the *praesumptio cedit veritati* and treatment may reach the limit of its purpose. When, for instance, continued treatment would only mean a miserable state of life, or put the patient in a state where she would not recognize family members or familiar surroundings, or life would be maintained in a permanently comatose state, a prudent and responsible course of action could be the withdrawal or withholding of treatment. This freedom need not be questioned in those cases when a patient is still competent to decide or when an individual has left explicit and written wishes to this effect in an advance medical directive. The more difficult case is when the wishes of the patient are unknown or when he is not competent; then the decision falls upon the family in consultation with health care providers. As the Bishops state, "decisions . . . should be faithful to Catholic moral principles and to the person's intentions and values, or if the person's intentions are unknown, to the person's best interests."¹⁶

5. Casuistry Surrounding a Recent Dilemma

One question that has emerged recently is whether there are means of life support that are always to be provided regardless of the condition of the patient? Some Catholic bishops have addressed the issue of artificially administered nutrition and hydration.¹⁷ All are guided by the Church's teaching prohibiting euthanasia. There is also universal agreement that hydration and nutrition are not morally obligatory when they bring no comfort to a patient who is imminently

dying or when the patient's body cannot assimilate them. There is no consensus, however, concerning whether it is morally permissible to withdraw artificially administered nutrition and hydration when the person is in a persistent vegetative state. In the recent *Ethical and Religious Directives*, the body of Bishops steer a cautious and middle course when they write,

there should be a presumption in favor of providing nutrition and hydration to all patients, including patients who require medically assisted nutrition and hydration, as long as this is of sufficient benefit to outweigh the burdens involved to the patient.¹⁸

Rather than dispute the casuistry that surrounds this issue, it may be more helpful to recall recent studies on the relationship between language and thought.¹⁹ Those studies have drawn attention to the fact that problem-setting precedes problem-solving in a way that draws attention to what is labeled "the cognitive function" of language. By looking at the language which sculpts a problem, or in this case, the metaphors we use to describe the person in a persistent vegetative state, the attention will shift from problem-solving to the cognitive taxonomy created by language which guides moral reasoning in weighing the burdens and benefits of treatment.

Oftentimes, it is said that to remove nutrition and hydration from a person in a persistent vegetative state is to starve the person to death. There is a similarity drawn between the person in a persistent vegetative state and someone who is starving. This similarity erects a cognitive taxonomy. Clearly, if someone is starving the obligation is to provide food and water. How nutrition and hydration are provided is irrelevant. When the problem is confined to this metaphor, one may even have recourse to the social teaching of the Church to underline the obligation to provide food and water: "feed the man dying of hunger, because if you have not fed him you have killed him." Surely, this is the most emotional argument to provide nutrition and hydration to a patient in a persistent vegetative state. Within this metaphor, providing nutrition and hydration can be nothing other than a proportionate means to maintain life; withdrawing or withholding them can be nothing other than forcing the patient to die. Consequently, the meaning attributed to the act of withdrawing or withholding nutrition and hydration is strictly circumscribed: it can be nothing other than the direct killing of a patient through starvation and dehydration.²⁰

A second metaphor sees the persistent vegetative state as a mental impairment.²¹ This is often used in tandem with the first conceptual schema. The person in a persistent vegetative state is severely disabled and unable to feed himself or herself. Within the conceptual horizon sketched by this metaphor, there is no morally relevant difference between a coma, dementia, a persistent vegetative state or any other disability. This language builds a conceptual schema in which to remove nutrition and hydration from a PVS patient is not only a form of neglect and abuse, but a form of discrimination against the disabled. Another element within this conceptual network is the strict difference between treatment and care: nutrition and hydration are normal care to be provided to every patient. Proponents of this schema point out that nutrition and hydration do not treat an illness but simply maintain life. To remove this ordinary care from a PVS patient is

to say that the life of the mentally impaired patient is expendable. There is no difference in the act of removing nutrition and hydration from an individual in a persistent vegetative state and the intention of killing the individual. Admittedly death is brought about by omitting nutrition and hydration, but such an omission is really euthanasia in its intent.²² Thus to argue for the removal or withholding of nutrition and hydration from PVS patients is another step down the slippery slope leading to the active causing of death.

No doubt, the conceptual schema set up by the metaphor which sees a persistent vegetative state as a disability is guided by the duty to maintain life. When tutorism is invoked by this schema, the moral system means that one has the duty to maintain physical life. The use of technology is unchecked as long as it serves the continuation of physical life. Within this conceptual schema, because the good to be achieved is the maintenance of life, the inability of the patient to communicate or relate to one's surroundings is of little importance. Consequently, the burden of the gastrointestinal tube is minimized since it does not increase the physical suffering of the patient, can be monitored easily by a nurse or trained person, and is not expensive.

The third possible metaphor sees patients in a persistent vegetative state as dying. This metaphor sets up a broader conceptual schema in which to weigh the benefits and burdens of treatment when compared with the other two metaphors.²³ Within this context no one stage of the patient's condition is isolated, but the patient's diagnosis and prognosis are set on a continuum which moves from treatment aimed at recovery to the eventual futility of treatment aimed at protecting human dignity. On this continuum, the inability to relate and communicate with one's surroundings is a morally relevant factor in determining the burdens and benefits of treatment. When tutorism is invoked within this topography, it refers to the certainty needed to diagnose a persistent vegetative state, not to the duty to maintain life irrespective of the patient's condition. Not as in the other schemata, this schema draws a clear line between a persistent vegetative state and both a coma and dementia, but the line is less clearly defined distinguishing care and treatment. This conceptual topography focuses less on what is provided than who receives it and why.

When the patient in a persistent vegetative state is seen as dying, artificially assisted nutrition and hydration are not maintained simply because their removal would lead inevitably to death. The inevitability of death is not the determining criterion of the disproportionality of treatment. Rather, the criterion judging the proportionality of any treatment is the total well-being of the patient which cannot be divorced from one's convictions about a meaningful life and a dignified death. Against this background, technology is made to serve human ends which transcend the mere maintenance of physical life. Within this schema, providing a PVS patient with nutrition and hydration can be interpreted as burdensome by virtue of its permanence; life without treatment is judged better than life with treatment.

Furthermore, within the conceptual schema that sees the patient as dying, the removing or withholding of nutrition and hydration takes on a new moral object. The purpose of the action must be clear; removing or withholding nutrition and

hydration is never done to leave the patient to die or to shorten the patient's life or to discriminate against the disabled; the moral object of the action is to remove from the patient a burdensome means of maintaining life. Removing treatment does not signal a callous abandonment of the patient but an acceptance of the human condition and the limits of meaningful treatment.

Conclusion

Though the "right to die" and "dying with dignity" have become political slogans, they also can be used to guide the pastoral practice of the Church. In the face of an unrelenting use of medical technology to maintain life, sometimes in the name of the sanctity of life, the Church must protect the right to die with human and Christian dignity. In an ecclesial context, however, the meaning of a dignified death is given a deeper meaning than simply the ability to be made dead by one's own choosing. Within the Catholic tradition, protecting a dignified death means that the dying need to be assured that their lives will not be arbitrarily shortened, that they will not have to suffer uselessly, that they will not be subject to unreasonable and burdensome therapies, that medical technology will be used for their integral well-being, that their free and informed decisions will be respected, and that they will not be marginalized or abandoned by the community in their dying.

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9. See for instance, Timothy Quill, "Death and Dignity: A Case of Individualized Decision Making," in *The New England Journal of Medicine* 324 (1991) 691-94.
10. *Declaration on Euthanasia*.
11. *Catechism of the Catholic Church*, n. 2258, 2270; *The Gospel of Life*, 57, 62, and 65.
12. This is consistent throughout Church teaching; see for instance *Catechism of the Catholic Church*, n. 2279; *Ethical and Religious Directives*, 61.
13. This case is presented by Fuchs, "Christian Faith and the Disposing of Human Life," p. 678.
14. Pope Pius XII, "Address to the Ninth Congress of the Italian Anaesthesiological Society," in *Acta Apostolica Sedis* 49 (1957) 129-47; also his "Address to the International College of

Neuro-Psycho Pharmacology," in *Acta Apostolica Sedis* 50 (1958) 687-96; *Ethical and Religious Directives*, 61.

15. *Ethical and Religious Directives*, 27.

16. *Ethical and Religious Directives*, 25.

17. The most complete survey is given by James F. Keenan and Myles Sheehan, "Life Supports: Sorting Bishops' Views," *Church* 8 (Winter, 1992) 10-17.

18. *Ethical and Religious Directives*, 58.

19. See for instance the works in Andrew Ortony, *Metaphor and Thought* (Cambridge: Cambridge University Press, 1979).

20. This metaphor is more emotional than factual. It ignores important medical information concerning the persistent vegetative state. When the blood supply is cut off from the brain (ischemia), the brain is deprived of oxygen (hypoxia). When the blood flow is cut off for four to six minutes the cerebral cortex is severely and irreversibly damaged; after being deprived of oxygen for fifteen minutes, the functional capacity of the brain is completely destroyed. Even though the cerebral cortex may die, the brainstem will continue to function normally; when this is the case, the patient is in a persistent vegetative state. A persistent vegetative state is medically different than complete brain death, a coma, or dementia. In the most acute cases of a persistent vegetative state, the neocortical tissues liquefy. An EEG will not detect any brain activity. Nevertheless, because the brainstem continues to function, patients are able to breathe without the aid of a respirator, their eyes remain open, and they go through what appear to be sleep/wake cycles. Yet, these patients have no awareness of their surroundings; they make no attempt to communicate or interact with others; they do not experience pain or suffering; they do not experience hunger or thirst. Unable to eat, they must be fed through a nasogastric or a gastrostomy tube. If nutrition and hydration are withheld and the patient continues to receive proper nursing care, the individual will not manifest the signs of starvation (dried out mouth, parched and cracked lips, dry heaves, convulsions, etc.).

21. Bishop James McHugh, "Principles in Regard to Withholding and Withdrawing Artificially Assisted Nutrition and Hydration," in *Origins* 19 (1989) 314-16; William E. May et alii, "Feeding and Hydrating the Permanently Unconscious and other Vulnerable Persons," in *Issues in Law and Medicine* 3 (1987) 203-11.

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