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Care of PVS Patients: Catholic Opinion in the United States

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Members of the Catholic community in the United States often disagree concerning the proper care of a person in a state of permanent unconsciousness. For example, a few years ago, Hugh Finn, suffering from brain damage incurred in an automobile accident, was the person about whom the dispute centered. Even though they foresaw that his death would occur following removal of life support, his wife Michelle and one of Hugh's sisters wanted to have artificial hydration and nutrition (AHN) removed because "it was not helping him." Though Hugh had stated before his accident that he would not desire life support if he were permanently unconscious, other members of his family desired to have AHN continued. Said Hugh's father, "It's murder as far as I am concerned."¹ Even though they were diametrically opposed, members of the Catholic community, claiming "to speak for the Church," supported both sides of the family.

Why is there still such disagreement in regard to this issue within the Catholic community? Usually, the official position of the Church is clear, and though some people may disagree with the official position, there is no doubt that they are dissenting from the official teaching and have no right

“to speak for the Church.” While general principles for removing life support have been stated in magisterial teaching,² there is no authoritative magisterial teaching in regard to specific treatment of people in a state of permanent unconsciousness,³ so different theological opinions have been formulated. This article will present the various opinions held by members of the Catholic Church in the United States in regard to removing AHN from people in a permanent state of unconsciousness (persistent vegetative state, PVS). The first opinion views AHN as ordinary care and morally obligatory. The second viewpoint contends that AHN is a medical treatment that should be offered unless it is physiologically futile or excessively burdensome. The third opinion states that AHN may be discontinued in the case of the patient in PVS primarily because it offers no benefit to the patient and secondarily because it may at times impose a grave burden. This article will seek to evaluate these opinions, and opt for one of them as being more in accord with the anthropology identified with Catholic tradition.

Before examining the varying positions in the Catholic community, a few words to explain the condition of Hugh Finn and other persons in a permanent unconscious condition, in medical terminology often called persistent vegetative state (PVS, although more precisely for our discussion: permanent vegetative state), will be helpful.⁴ A person in PVS is still a human being, but functions only at the biological level. The brain stem is often intact so the functions of respiration, digestion and bodily homeostasis continue. In some patients however, the brain stem is partially damaged. For these patients, if physiological function is to be sustained, a ventilator may be necessary in order to assist pulmonary and cardiac functions. People in a permanent vegetative state have “sleep-wake” cycles meaning that their eyes are often open but they do not track on anything and have no meaningful response to stimulus. Grunts and groans may also be emitted, but they have no meaningful significance. Because of injury or dysfunction in the cerebral cortex (sometimes called the “higher brain”), the power to think, choose, love, and relate to others is lost. The function of eating is also lost due to a lack of coordination between chewing and swallowing even though gag, swallowing, and cough reflexes may be preserved and the functions of digesting and waste elimination are maintained. Bodily nutrition may be maintained through AHN. As far as medical research is able to discern, withdrawal of AHN from patients in PVS does not cause any change in pain level for the patient.⁵

PVS differs from other conditions such as coma, locked-in state, and akinetic mutism. People often recover from coma, but the unconscious condition associated with PVS is deemed to be permanent if the vegetative state persists for longer than a year in cases of acute traumatic injury or

three months in cases of non-traumatic acute injury. Recovery after such a period of time is exceedingly rare. It seems that only a few cases of recovery from PVS have been carefully documented; in two of these cases the patients were unable to speak and were bedridden for the rest of their lives.⁶ Recovery may not be physically impossible, but the paucity of cases of recovery, especially without severe impairment, allow the statement that recovery after a firm diagnosis of PVS is morally impossible. A permanent vegetative state then is a recognized medical prognosis based on observation over the course of a given time period. "Decisions to terminate treatment can only be reached after the PVS patient has been assessed by repeated neurological examinations performed on successive days by a physician experienced in the assessment of unconscious patients."⁷ For the purposes of this article, it is presumed that an accurate diagnosis and prognosis have been made regarding patients and that they will not recover cognitive and affective abilities given the degree of moral certitude possible in medicine.

Some people object to the description of patients as "vegetative" as though it indicates they are less than human. While the term could be understood with this connotation, it more exactly refers to the person's ability to function only at the biological level, not to a lack of personhood of the individual person. Cognitive-affective function, the foundation of any spiritual activity, is not possible for a person in PVS. According to the concept of the human person common in Catholic theology, the spirit or the soul of the person still maintains the radical power to perform human acts of cognitive-affective function but the actual performance of these acts is impossible due to dysfunction in that part of the body which is necessary for cognitive-affective function: the cerebral cortex.⁸

The First Opinion

Basically there are three opinions held by people in the Catholic community in regard to the use of AHN for patients in PVS.⁹ The first opinion looks upon the removal of AHN from a PVS patient as a serious violation of the right to life, and often implies that removal of AHN from a PVS patient is an act of euthanasia.¹⁰ This opinion seems to be based upon the fact that death will follow removal of AHN and that for some, any act from which death follows is an act of euthanasia. Proponents of this opinion maintain that only when a patient is in a "terminal condition" and in "imminent danger of death" may life support be removed.¹¹ As long as AHN continues to do the job for which it was designed, to keep the person alive, it should not be removed. This opinion seems to draw some support from a recent statement of Pope John Paul II in *Evangelium Vitae*, that life

support may be declared disproportionate or an excessive burden when death is clearly imminent or inevitable.¹² However, this text cannot be interpreted to allow foregoing life support only when death is imminent and inevitable because the statement in question is taken from the "Declaration on Euthanasia", which in accord with Catholic tradition, specifically allows withdrawal of life support even if death is not imminent and life support is judged to be disproportionate or imposes an excessive burden. The document specifically asks the question: "Is it necessary in all circumstances to have recourse to all possible remedies?" and then lists at least five situations other than the case of imminent and inevitable death, in which life support may be removed.¹³ People who hold this opinion frequently equate the removal of AHN with painfully "starving a patient to death" or with abandoning the patient or showing disrespect for life.¹⁴ But removing AHN from patients in PVS or in the last stages of an illness does not cause the pain of hunger and thirst as it would in a healthy person who is deprived of food and water.¹⁵ Moreover, people can show solidarity and love for loved ones by allowing them to die and praying for them when life support is no longer beneficial, more so than by prolonging their lives when it is not helpful for the patient. Finally, removing AHN does not mean that the direct moral cause of death is starvation or dehydration. Rather, the pathology which directly causes death is the dysfunction of the cerebral cortex. Because of this pathology, the patient is unable to eat and drink on his own. Up until the removal of AHN, the effects of this pathology have been circumvented by use of AHN. Just as a respirator circumvents ineffective function of the lungs, but may be removed if it does not offer hope of benefit or imposes an excessive burden, so removal of AHN merely allows the pathology in question to take its natural course. As Pope Pius XII stated in 1957, the foreseen death of a patient from whom life support is removed is an "indirect voluntary,"¹⁶ a term used by some manualist-theologians to signify the use of the principle of double effect.¹⁷ Some people argue that because the purpose of AHN "is not to effect a cure but rather to keep the person alive by providing nutrition one may not withdraw AHN on the basis that it is ineffective if, in fact, it does keep the patient alive."¹⁸ However, the same thing can frequently be said of a ventilator which often does not effect a cure yet is readily discontinued if it does not offer hope of benefit or imposes an excessive burden. Thus, the fact that AHN is designed to circumvent rather than cure a pathology is not relevant to the ethical discussion concerning its use.

Occasionally, the argument is offered by proponents of this first position that a feeding tube and nutrition are very inexpensive and comparatively easy for the medical professionals to install so they could never be considered an extraordinary means to prolong life.¹⁹ In other

words, this opinion tends to judge whether the means to prolong life are ordinary or extraordinary (morally imperative or morally free) in the abstract, without reference to the condition of the patient. As Kevin Wildes pointed out in a thorough study of the means to prolong life, this attitude is not in accord with Catholic tradition.²⁰ It dehumanizes the person because it neglects the needs of the person by concentrating on the medical therapy alone. This first opinion was popular when the Nancy Beth Cruzan case was in the news in the late 1980s. Then its popularity seemed to wane, perhaps as a result of several court decisions which allowed removal of AHN from PVS patients and the opinions expressed by several professional societies.²¹ But it seems to be gaining adherents once again as avid pro-life proponents seek to oppose any and all withdrawal of life support and persuade people to fill out their advance directives to insure that AHN will always be used, no matter what the circumstances.²² While this opinion is often invoked by people maintaining that they are fighting the movement toward euthanasia in the United States, others allege that such an absolutist position disposes for euthanasia because this opinion would allow withdrawal of life support only if death were imminent, no matter what the quality of function or the suffering of the individual patient.

This first opinion seems to be concerned with the physical effects of withdrawing life support, not with the moral object as such.²³ This difference in moral evaluation is well expressed by the statement of the Pro-Life Committee of the National Conference of Catholic Bishops (PLC):

We should not assume that all or most decisions to withhold or withdraw medically assisted nutrition and hydration are attempts to cause death. To be sure, any patient will die if nutrition and hydration are withheld. But sometimes, other causes are at work, for example, the patient may be imminently dying, whether feeding takes place or not, from an already existing terminal condition. *At other times, although the shortening of the patient's life is one foreseeable result of an omission, the real purpose of the omission was to relieve the patient of a particular procedure that is of limited usefulness to the patient or unreasonably burdensome for the patient and the patient's family or caregivers. This kind of decision should not be equated with a decision to kill or with suicide* (emphasis added).²⁴

Ultimately, the underlying conviction of people who hold this first opinion seems to be that AHN for PVS patients is not a medical device or medical treatment, but merely comfort or normal care which would be morally obligatory when physiologically effective.²⁵ The aforementioned

opinions of medical societies, as well as the medical expertise needed to install AHN, and the fact that AHN does nothing to increase the comfort of the patient contradicts this conviction.²⁶

The Second Opinion

The second opinion extant in the Catholic community does not prohibit the removal AHN from patients in PVS. However, as we shall see, in its interpretation of "hope of benefit" and "excessive burden," it does limit the criteria which may be used for removal. This opinion was expressed most authoritatively in 1992 by the PLC and is held by some theologians and philosophers,²⁷ but was never adopted by the Administrative Board of the National Conference of Catholic Bishops (NCCB) nor by the NCCB as a whole. It is of considerable importance within the Catholic community in the United States as a pastoral statement, even though the PLC does not promulgate doctrinal statements. While the document of the PLC "repeats solid principles," it also contains "contingent and conjectural elements," which mitigate its doctrinal authority.²⁸ As the PLC itself declared, the document states "the first word" which may be revised before the "last word" is spoken. Briefly, this opinion may be expressed in the words of the Committee:

.... it is our considered judgment that while legitimate Catholic debate continues, decisions concerning these patients (PVS) should be guided by a *presumption* in favor of medically assisted nutrition and hydration. A decision to discontinue such measures should be made in light of a careful assessment of the burdens and benefits of nutrition and hydration for the individual patient and his or her family and community. Such measures must not be withdrawn in order to cause death, but they may be withdrawn if they offer *no reasonable hope of sustaining life or pose excessive risks or burdens* (emphasis added).²⁹

There is no dispute in the United States Catholic community in regard to teaching and theology concerning the intention of removing life support. It must not be to kill the patient, but rather to stop doing something disproportionate (no hope of benefit) or to benefit the patient by removing a burdensome therapy (remove an excessive burden). In traditional Catholic theology, evidence that people act ethically when removing life support is drawn either from "no hope of benefit" or from "excessive burden." "No hope of benefit" simply means that the goods for which one seeks medical therapy are not forthcoming from the therapy; "excessive burden" means that any benefits forthcoming from use of a therapy are

outweighed significantly by the burdens. Burdens may be spiritual, psychic, and economic as well as physiological. These criteria are stated in the *Ethical and Religious Directives for Catholic Health Care Services* (ERD),³⁰ a document prepared by the United States Bishops to maintain ethical standards in the provision of health care in Catholic health care facilities. If the medical therapy offers hope of benefit and does not impose an excessive burden, it is called an ordinary or proportionate means of preserving life. If it either offers no hope of benefit or imposes an excessive burden, it is called an extraordinary or disproportionate means to prolong life.³¹

While there is agreement in theory concerning the general norms for removing life support, when applying the criteria to particular situations, the PLC and the theologians who agree with them adopt a narrow interpretation of "hope of benefit" and "excessive burden." They consider the prolongation of life in the PVS condition as an "intrinsic good" and a "great benefit."³² According to this interpretation, if life can be prolonged for PVS patients through the use of AHN, it must never be withdrawn or withheld on the grounds that it is not providing a benefit to the person. Thus, in the previously cited passage, the PLC translates "no hope of benefit" as "no reasonable hope of sustaining life." For practical purposes then, if the AHN is prolonging life, "doing its job" as some theologians maintain,³³ only the criterion of excessive burden may be used to withdraw life support. The notion of life being "an intrinsic and great good" is included in the PLC document and other statements of bishops and theologians but it seems to stem from the moral theory of Germain Grisez, which holds that human life as such is an incommensurable good, and that people who deny this assertion are professing dualism.³⁴ Both Ralph McInerney and Benedict Ashley, prominent Thomists, reject Grisez's interpretation because it misconstrues the notion of natural inclination and subordination of proximate goals to ultimate goals. Ashley observes: "the human body is human precisely because it is a body made for and used by intelligence. Why should it be dualism to unify the human body by subordinating the goods of the body to the good of the immaterial and contemplative intelligence?"³⁵

Insofar as excessive burden is concerned, the proponents of this second opinion make an effort to consider only the burden that might be connected directly with the use of AHN,³⁶ not the burden that might follow from the use of the therapy for the patient, the family or society, as is allowed in the ERD (Directives 56 and 57). Moreover, the Catholic tradition understands that "excessive burden" may arise from economic and psychic causes as well as from physiological causes. Overall then, the opinion expressed by the PLC and the theologians who agree with them is

rather limited insofar as removal of life support from PVS patients is concerned. Moreover, it is clear that many bishops in the United States do not agree with this opinion, especially when they are called upon to give guidance in specific cases.³⁷

While it does not correspond exactly to the theological presuppositions of the second opinion, and is more akin to the first opinion, there is a growing tendency among proponents of the second opinion to define AHN as a form of "normal or comfort care" not subject to the above-mentioned ethical criteria.³⁸ Normal care is described as care which is always required; for example, keeping the patient comfortable, changing bed clothes, and avoiding bed sores. According to proponents of this theory, AHN is not a medical procedure or device, because it is not utilized in order to prolong life but rather in order to keep the patient comfortable, or because each person has a right to food and water. This opinion is directly contrary to declarations of several medical societies and legal opinions which explicitly declare that AHN is a medical procedure.³⁹ Moreover, the use of AHN for all patients in the dying process has been called into question recently in prestigious medical journals.⁴⁰ Even if AHN were not a medical procedure, it does *de facto* prolong life, no matter what it is called. For this reason, it should be evaluated ethically according to the two aforementioned criteria: hope of benefit and degree of burden.

Recently, the Holy Father mentioned the PLC document in an *ad limina* address to bishops from the Western United States.⁴¹ This led some people to maintain that the Holy Father was proposing a clear teaching that AHN could not be removed from PVS patients because it offered "normal care."⁴² This is an overreaction to the papal statement. While the Holy Father seems to affirm the principles expressed by the PLC, especially the principle of not removing life support with the proximate intention of causing death (*finis operis*), it would be rash to maintain that he was correcting bishops who have affirmed the third opinion or approved the actions of their parishioners who acted in accord with the third opinion.⁴³ The Pope maintains that AHN should be provided "to all patients who need them." However, he offers no clarification as to how to assess necessity in the concrete situation. Clearly, holders of both the second and third opinions agree that AHN should be provided when ethically necessary. While not a definitive statement of doctrine then, the Pope's *ad limina* address affirms the principles stated in the PLC document and implies that the opinion of the Committee is "safe in practice" but it cannot be maintained that the third opinion is rejected.⁴⁴

Finally, the actions of several State Catholic Conferences question the rational consistency of the second opinion. Many states have advanced directives which allow persons through proxy decisions to decline the use

of AHN, if the person is ever in a state where he cannot make health care decisions for himself.⁴⁵ If there must be a presumption to prolong the life of a person in PVS unless there is evidence that prolonging life in this condition is an excessive burden, why is it that State Catholic Conferences, always under the direction of the bishops in the state, have accepted advance directive legislation without any serious objection?

The Third Opinion

The third opinion is held by many Catholic theologians and ethicists who work in clinical settings and by many medical societies who have studied the issue.⁴⁶ In addition, this opinion has been followed by some bishops who have been called upon to offer opinions in regard to well publicized cases in their dioceses.⁴⁷ The opinion follows the traditional admonition that the death of the patient must not be the proximate intention of the persons either requesting the removal of life support or removing it from the patient. But it also maintains that once a firm prognosis of permanent unconsciousness has been made, AHN may be removed. This third opinion uses both of the criteria for removing life support, originated by Catholic theologians at Salamanca, Spain, in the 16th century: namely, hope of benefit to the patient or excessive burden to the patient, his or her family, and to the community which is involved in caring for the patient.⁴⁸

The essential difference between the second and third opinions is that those who hold the third opinion maintain that continuing life support for people with a PVS diagnosis does not offer "hope of benefit" for the patient. Proponents of both the second and third opinion agree that the proximate intention of the people removing life support must not be to end the life of the patient. But the proponents of the third opinion maintain that the continued existence of the patient who is permanently unconscious offers objective evidence that life support may be removed because it is disproportionate or unnecessary.⁴⁹ Proponents of this position support their opinion by referring to the purpose of health care and the purpose of life. Health care seeks to enable people to strive for the purpose of life, not merely to function at the biological level.⁵⁰ Ultimately, the purpose in life is friendship with God.⁵¹ Recall in another era we would answer the Catechism question, "Why did God make you?", with the response, "To know Him, love Him, and be happy with Him in this life and the next." To know, love, and be happy requires cognitive-affective function. If a person does not have the potential for cognitive-affective function, it does not mean that God does not love him or her or that the person is no longer a friend of God. But it does mean that the person cannot pursue the friendship of God, the purpose of life, through his or her free actions.

Therefore, the moral imperative to help the person toward health and existence is no longer present if there is no potential for cognitive-affective function and treatment offers no palliative benefit. The truth of this explanation is confirmed by the care given to anencephalic infants in Catholic hospitals. Their lives could be prolonged, maybe even for a few years, but no care outside of comfort care is given because they do not have the capacity for cognitive-affective function. This manner of treatment has been approved by a recent statement of the Doctrine Committee of the NCCB in the United States.⁵²

St. Thomas Aquinas gives the foundation for declaring that friendship with God requires cognitive-affective function when he distinguishes between a human act (*actus humanus*) which requires the activity of the intellect and will, and acts of the body (*actus hominis*) which are accomplished by our autonomic nervous system (bodily functions), not under the direction of our intellect and will.⁵³ Our ultimate goal, the purpose of life, is acquired only through human acts, not through acts of the body which are independent of the intellect and will.⁵⁴ People who are not able to perform acts of cognitive-affective function because of some pathology are not less human, but the moral mandate to help them prolong their lives is no longer present because they will never again perform human acts, that is, acts proceeding directly from the intellect and will. Clearly people in this condition, as in the case of anencephalic infants, may not be directly put to death nor mistreated in any way, but life support that keeps them alive need not be continued because it does not offer them any hope of benefit.

Clinical experience attests to the fact that families have a very difficult time giving permission to remove life support from their loved ones, even if they are permanently unconscious. The decision is not made unless it is clear the life support is not beneficial or imposes a severe burden. As the statement of the PLC quoted above maintains: "...*although the shortening of the patient's life is one foreseeable result of an omission, the real purpose of the omission was to relieve the patient of a particular procedure that was of limited usefulness to the patient or unreasonably burdensome for the patient and the patient's family or caregivers (emphasis added).*"⁵⁵ When questioned, families affirm that because medical technology is no longer useful, their proximate intention is to discontinue an inappropriate therapy, thus contributing to the well-being of their loved ones. The foreseen death of the patient from whom life support is removed because it is not effective is "an indirect voluntary." In other words, when AHN is removed from a patient in PVS, the principle of double effect is invoked.⁵⁶ The act of removing a therapy or a medical device which is disproportionate or excessively burdensome is a good

moral act because the moral object of the act is to remove what has been judged to be an inappropriate treatment. However, the act has two effects, one foreseen and intended in the moral object; the other, foreseen but not intended as part of the moral object. In fact, if it were possible to achieve the first effect without the second one, the person acting would avoid placing the action from which the unwanted effect follows. Finally, this third opinion is based upon the belief that there is life after death, when, as the liturgy of the Church maintains in the preface for the Mass for the Dead, "life is changed, not ended." Thus, allowing a person to die when life support offers no hope of benefit to the patient or imposes an excessive burden is simply surrendering to God's Providence and accepting the fact that human life is not an absolute good. Proponents of this opinion do not ask whether life can be prolonged, but rather, should it be prolonged?

Conclusion

Given the various opinions, what opinions seem safe in practice? The first does not seem viable because it seems to prohibit the removal of AHN in all circumstances. As directives 56 and 57 of the ERD indicate, there are some situations in which life support may be removed. The second and third opinions seem viable insofar as the general principles for removing life support are concerned. People will judge which is the more fitting way to care for patients in PVS in accord with the rationale that we have explained for opinions two and three.

Do both the second and third opinions fall within the realm of Church teaching? It would seem that they do, because as the Bishops of the United States declared in the Ethical and Religious Directives: "The NCCB Committee on Pro-Life Activities...points out the necessary distinctions between questions already resolved by the Magisterium and those that require further reflection, *as for example, the morality of withdrawing medically assisted hydration and nutrition from a person who is in the condition which is recognized by physicians as the persistent vegetative state (PVS)* (emphasis added)."⁵⁷ All three opinions present in contemporary Catholicism in the United States insist that the intention to remove life support must not be to kill the patient. However, the second and third opinions contradict the first opinion because both allow for the withdrawal of life support in certain circumstances in accord with the traditional teaching of the Church. The second opinion, however, limits in practice the application of the traditional teaching by maintaining that life in PVS is a "great benefit" and that the burdens which would justify the removal of life support do not include the burdens which AHN imposes from its very nature. The third opinion is based upon the teleological

aspects of medicine and human life. If the purpose of human life can no longer be obtained, it seems that no hope of benefit will come from medical therapy. The difference between the second and third opinions seems to stem ultimately from different theological and philosophical anthropologies. As explained above, the third opinion would not conceive of life in a PVS condition as beneficial for the patient because he or she is no longer able to strive for the purpose of life and will not regain this ability. When this ability is present, or may be actualized in the future, then friends, family and society have an obligation to offer health care and life support to the debilitated person, if doing so does not impose an excessive burden.

The third opinion does not differ in principle from the second opinion. Both clearly view euthanasia as intrinsically evil. The opinions differ mainly in their assessment of what constitutes "hope of benefit." At times, the debate about the utilization of AHN for patients in PVS has been a contentious one within the Catholic community in the United States. However, much of the acrimony in the dispute could be eliminated by recognizing that the resolution of the debate hinges on an irenic examination and discussion of theological anthropology, including further delineation and understanding of what is beneficial for the human person based on the purpose and sanctity of human life.

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27. PLC, "Nutrition and Hydration," 705-12; Joseph Boyle, "A Case for Sometimes Tube-Feeding Patient," 189-99; William May "Tube Feeding and the 'Vegetative State' (Part I)," *Ethics and Medics* 23 (December, 1998): 1-2 and "Tube Feeding and the 'Vegetative State' (Part II)," *Ethics and Medics* 24 (January, 1999): 3-4.
28. CDF, "Instructions on the Ecclesial Vocation of the Theologian," n. 17. For full text, see *Origins* 20 (1990): 117-26.
29. PLC, "Nutrition and Hydration," 710.
30. National Conference of Catholic Bishops (NCCB), *Ethical and Religious Directives for Catholic Health Services (ERD)*, fifth printing, (Washington DC: United States Catholic Conference, 1995), 21-22 and Directive nos. 55-58.
31. *Ibid.*, Directive nos. 56 and 57.
32. William May "Tube Feeding and the 'Vegetative State' (Part I)," Germain Grisez, *Living a Christian Life*, 284-86, 524-26; and Bishop McHugh, "Artificially Assisted Nutrition and Hydration," *Origins* 19 (1989): 314-16.
33. Robert Barry, *Medical Ethics: Essays on Abortion and Euthanasia* (New York, NY: Peter Lang, 1989), 179-200.
34. Germain Grisez, *Christian Moral Principles*, Vol. 1 of *The Way of the Lord Jesus* (Chicago, IL: Franciscan Herald Press, 1983), 115-40; and "Should Nutrition and Hydration be Provided to Permanently Unconscious Persons?" *Issues in Law and Medicine* 5 (Fall, 1989): 173.
35. Ralph McInerny, "The Principles of Natural Law," *American Journal of Jurisprudence* 25 (1980): 1-15; and Benedict Ashley, "What is the End of the Human Person?" in *Moral Truth and Moral Tradition*, ed. Luke Gormally (Blackrock, Ireland: Four Court Press, 1994), 73. For further discussion of this debate, see Germain Grisez and John Finnis, "The Basic Principles of Natural Law: A Reply to Ralph McInerny," *American Journal of Jurisprudence* 26 (1981): 21-31; and William May, "Recent Moral Theology: Servais Pinckaers and Benedict Ashley," *The Thomist* 62 (1998): 130-31.
36. PLC, "Nutrition and Hydration," 707-08.
37. A representative sample would include: Texas Catholic Conference (16 of 18 bishops assenting), "On Withdrawing Artificial Nutrition and Hydration," *Origins* 20 (1990): 53-55; Bishop Gelineau, "On Removing Nutrition and Water from Comatose Woman," *Origins* 17 (1997): 545-47; Bishop Liebrecht, "The Nancy Beth Cruzan Case," *Origins* 90 (1990): 525-26; Bishop Kelly, "Hugh Finn Case," *Associated Press* (11 September 1998); and Oregon and Washington Bishops, "Living and Dying Well," *Origins* 21 (1991): 345ff.

38. Edward Richard, "Bioethical Magisterium on Normal Treatment," 5; William May, Robert Barry, Orville GRIESE, et al., "Feeding and Hydrating the Permanently Unconscious and Other Vulnerable Persons," *Issues in Law and Ethics* 3 (Winter, 1987): 207-17; and Robert Barry, "Feeding the Comatose and the Common Good," 1-30.

39. American Academy of Neurology, see note 3; and American Medical Association Council on Ethical and Judicial Affairs, see note 20. Also, new laws in Florida recognize explicitly that AHN is a medical device. "Seniority Section," *St. Petersburg Times* (27 July 1999).

40. T. Finucane, C. Christmas, K. Travis, "Tube Feeding in Patients with Advanced Dementia," *JAMA* October 13, 1999; 282:14: 1365-69; M. Gillick, "Rethinking the Role of Tube Feeding in Patients with Advanced Dementia," *NEJM*, January 20, 2000; 342:3:206-10.

41. The pertinent text reads: "...a great teaching is needed to clarify the substantive moral difference between discontinuing medical procedures that may be burdensome, dangerous or disproportionate to the expected outcome...and taking away the ordinary means of preserving life such as feeding, hydration and normal medical care. The statement of the U.S. bishops' pro-life committee, 'Nutrition and Hydration: Moral and Pastoral Considerations,' rightly emphasizes that the omission of nutrition and hydration *intended to cause a patient's death* must be rejected and that, while giving careful consideration to all factors involved, the presumption should be in favor of providing medically assisted nutrition and hydration to all patients *who need them* (emphases added)," John Paul II, "Building a Culture of Life," *Origins* 28 (1998): 316. One notes the careful distinction between normal care versus feeding and hydration as well as the distinction between medically assisted nutrition and hydration versus feeding and hydration.

42. Cf., Edward Richard, "Bioethical Magisterium on Normal Treatment," 5; see also unsigned editorial, "Feeding and Hydration of Patients," *St. Louis Review* (16 October 1998).

43. Cf., note 36.

44. The Pope could have easily confirmed the Pro-Life Committee's conclusion by quoting it verbatim. His failure to do so as well as his failure to mention the condition of PVS suggests that the issue remains unresolved because of the pastoral caution generally used by the Magisterium when offering advice on specific applications of agreed upon norms and principles. Cf., Richard McCormick, "'Moral Considerations' Ill Considered," *America* 166 (March 14, 1992): 210-14, esp. 211.

45. Most states permit individuals to refuse artificial nutrition and hydration through Living Wills or Durable Power of Attorney. Cf., *Artificial Nutrition and*

Hydration in Medical Durable Power of Attorney Statutes (New York, NY: Choice in Dying, 1993).

46. John Paris, "Hugh Finn's 'Right to Die,'" 13-15; Richard McCormick, " 'Moral Considerations'," 210-14; Dennis Brodeur, "The Ethics of Cruzan," *Health Progress* 71 (October 1990): 42-47; and Kevin O'Rourke, "Should Nutrition and Hydration be Provided to Permanently Unconscious and Other Mentally Disabled Persons," *Issues in Law and Medicine* 5 (1989): 181-96. Cf., note 20 for medical societies that approve this practice.

47. cf., note 36.

48. Daniel Cronin, "Moral Law in Regard to the Ordinary and Extraordinary Means of Conserving Life," in *Conserving Human Life*, ed. Russell Smith (Braintree, MA: Pope John XXIII Center, 1989), 33ff.

49. Archdiocese of Chicago, "Chicago Commission Speaks Out on Nutrition and Hydration," *Health Progress* 68 (December, 1987): 35-36, 68.

50. Edmund Pellegrino and David Thomasma, *For the Patient's Good: The Restoration of Beneficence in Health Care* (New York, NY: Oxford University Press, 1988), 80.

51. *Catechism of the Catholic Church (English Translation)*, 2nd ed. Libreria Editrice Vaticana, 1997, n.1.

52. NCCB Doctrine Committee, "Moral Principles Concerning Infants with Anencephaly," 26 *Origins* (1996): 276; and Kevin O'Rourke, "Ethical Opinions in Regard to the Question of Early Delivery of Anencephalic Infants," *Linacre Quarterly* 63 (Aug., 1996): 55-59.

53. Thomas Aquinas, *Summa Theologiae*, I-II, q. 1, a. 1.

54. *Ibid.*, I-II, q. 5, a. 1.

55. PLC, "Nutrition and Hydration," 707.

56. Cf., Benedict Ashley and Kevin O'Rourke, *Health Care Ethics: A Theological Analysis*, 4th Edition (Washington, DC: Georgetown University Press, 1997), 191-92.

57. NCCB, *ERD*, Introduction to Part Five, 22.