

The Linacre Quarterly

Volume 73 | Number 2

Article 2

May 2006

A Catholic Perspective on the Ethics of Artificially Providing Food and Water

Jorge L.A. Garcia

Follow this and additional works at: <http://epublications.marquette.edu/lnq>

Recommended Citation

Garcia, Jorge L.A. (2006) "A Catholic Perspective on the Ethics of Artificially Providing Food and Water," *The Linacre Quarterly*: Vol. 73 : No. 2 , Article 2.

Available at: <http://epublications.marquette.edu/lnq/vol73/iss2/2>

A Catholic Perspective on the Ethics of Artificially Providing Food and Water

by

Professor Jorge L.A. Garcia

The author is a professor of philosophy at Boston College. The author wishes to thank H. Tristram Engelhardt, Dr. Andrew McCarthy, Kevin McDonnell, Mark Sentesy, David Solomon, Christopher Tollefsen, Paul Weithman and the staff of the 20th Notre Dame Medical Ethics Conference for their kind assistance.

In the short time since the late Pope John Paul II, now designated John Paul the Great, delivered his controversial March, 2004 address on the morals of providing, withholding, declining and discontinuing tube-feeding of persons in the condition often called "persistent vegetative state," a number of cases have arisen and interpretations offered of the papal statement, some of them seriously affecting patient care.¹ I wish here to offer a reading of the papal address that is more permissive than some in the options it preserves but, I think, faithful to the text and the wider tradition of Catholic moral reasoning in medical ethics. Much of my discussion will focus on the more general topic of assisted food and drink, rather than on the special issues raised by the condition misleadingly called "persistent vegetative state."

I hasten to state that I am not a moral theologian, nor a theologian of any sort. Rather, I wish to offer reasons why the recent statement might, when construed within the larger context of Christian thought on ethical issues in medical practice, reasonably be judged consistent with that thought and with a position on responsible discretionary interventions with such patients that I find sensible and attractive. My proposed interpretation is offered as provisional, contingent on further exploration of these issues in the light of religious and secular moral inquiry. Moreover, we need to be sensitive to the fact that Pope John Paul II's March, 2004 allocution is part of a tradition periodically developed and refined. Future doctrinal statements may clarify the tradition's implications, rendering obsolete

some of today's judgments about what Catholic medical ethics requires, recommends, and permits.

I will proceed by first focusing on several key phrases in the papal statement, indicating for each how it might reasonably be seen to cohere with traditional Catholic ethical inquiry and moral common sense. In later sections, I relate the recent allocution to a number of recent, chiefly secular bioethical discussions of related issues, especially those of euthanasia and care of the incompetent.

I. Some Key Passages

Certain passages in the papal text have engendered much controversy and elicited criticism. We begin by examining some of them in this section. In the next, I offer interpretations of these texts to clarify them and suggest that many of the criticisms are misguided.

"The sick person in a vegetative state, awaiting recovery or a natural end, still has a right to basic health care (nutrition, hydration, cleanliness, warmth, etc....and) the right to appropriate rehabilitative care..."

"I should like particularly to underline how the administration of water and food, even when provided by artificial means, always represents a natural means of preserving life, not a medical act. Its use, furthermore, should be considered in principle, ordinary and proportionate, and as such morally obligatory, insofar as it seems to have attained its proper finality, which in the present case consists in providing nourishment to the patient and alleviation of his suffering.

"The evaluation of probabilities, founded on waning hopes for recovery when the vegetative state is prolonged beyond a year, cannot ethically justify the cessation or interruption of minimal care for the patient, including nutrition and hydration. Death by starvation or dehydration is, in fact, the only possible outcome as a result of their withdrawal. In this sense it ends up becoming, if done knowingly and willingly, true and proper euthanasia by omission."

Significantly, the pope quotes from his own 1995 encyclical *Evangelium Vitae*: "By euthanasia in the true and proper sense must be understood an action or omission which by its very nature and intention brings about death with the purpose of eliminating all pain."

"[N]o evaluation of costs can outweigh the value of the fundamental good which we are trying to protect, that of human life. Moreover, to admit that a decision regarding a man's life can be based on the external acknowledgment of its quality, is the same as acknowledging that increasing and decreasing levels of quality of life, and therefore of human dignity, can be attributed from an external perspective to any subject, thus introducing into social relations a discriminatory and eugenic principle."

II. Some Interpretive Suggestions

John Paul II's talk was given to an audience at a meeting organized by the Pontifical Academy for Life and the International Federation of Catholic Medical Associations. This audience, he could assume, would be familiar with Catholic training in medical ethics and would not need to have all relevant exceptions and context spelled out for them.²

A) John Paul II describes providing artificial nutrition and hydration (hereafter, ANH) as both an "artificial means" and "a natural means of preserving life" (para. 4). This is apt to cause confusion. I think the passage is best read as indicating that ANH is an artificial way of doing a natural thing, as would be using a cell phone to call for help when trapped in a dangerous situation.

B) The papal statement maintains that ANH is "not a medical act" (para. 4). Again, this is perplexing. It is, after all, a procedure performed by medical personnel using medical equipment in a medical setting. Some even prefer the term "medically assisted nutrition and hydration (MANH)" to "artificial nutrition and hydration," which I use here.³ In what respect is it, then, not a medical act?⁴ I suggest that the point is that providing nutrition is not a *healing, therapeutic* or *disease-preventive* intervention. It has much, and arguably more, in common with what is commonly described as nursing care, such as keeping a patient clean and warm. My colleague, the eminent theologian Lisa Sowle Cahill, compares ending ANH to removing respirators, and certainly there are important similarities.⁵ Still, there are also differences that may matter. Breathing is naturally an involuntary motion, what followers of Aquinas sometimes call "an act of man" rather than a human action. In contrast, food and drink always enter our bodies through some agent's voluntary action, usually one's own.⁶ That indicates an interesting and relevant way in which receiving ANH is closer to the natural and ordinary means of getting food and drink than is being on a respirator to natural and ordinary breathing. The fact that, in ANH, the means and setting of supplying food and drink are more technological does not suffice to make their provision narrowly *medicinal* rather than nutritive care.

Might it be correctly said that inserting and maintaining the feeding tube are medical acts, even if the feeding and watering are not?⁷ Perhaps so, though this claim seems to rely on a dubious ontology of human action, according to which inserting and maintaining the tube that feeds the patient are somehow different actions from that of feeding her. If the feeding is not this, one wonders, what is it? In any case, I think the larger point is that

little depends on this classificatory matter. Some people think it important because they reason that, since the language of "ordinary means" and "extraordinary means" comes from medical ethics, if ANH is not medical, this distinction cannot apply to it, and thus no purchase is afforded the claim that it may sometimes be morally optional because extraordinary. This, however, is a *non sequitur*. If providing someone food and drink is excessively burdensome to her or others, it is not morally obligatory, regardless of whether the provision would be "a medical act" and whether or not it fits some restricted technical definition of an "extraordinary means."

C) What of the address's explicit claims that ANH "should be considered in principle ordinary and proportionate and as such morally obligatory" (para. 4)? Is withholding ANH or even discontinuing it, then, never permitted?⁸ That is not the only way to construe this claim, and I am not convinced that it is the best. First, compare the ordinary statement: What you borrow you ought in principle to return. Here, "in principle" means such return is a duty normally considered in isolation and by itself (and *not* in the sense in which medieval thinkers used the term *in se*), in the abstract, in general. Adapting this use here could allow that ANH might still become extraordinary and disproportionate in some circumstances, and be licitly withheld or ended when it has. To be sure, the text admits of a stricter reading, supporting a more stringent rule. My suggestion is that the new statement on ANH and persistent vegetative state (hereafter, PVS) be read as continuous with traditional Catholic thinking in health care ethics, so that considerations of proportion are relevant and possibly dispositive, so long as the action is not of a type that in virtue of its nature can never be justified, is *malum in se*.⁹ But should the recent papal statement be read precisely as branding withdrawal of (effective) ANH as *malum in se*? Again, it admits of such a reading, but at this point and waiting further clarification, I think that a looser reading plausible, available, and open.

A year after the papal allocution, the National Catholic Bioethics Center in the USA announced its position that, "Food and water should be provided for all patients who suffer PVS unless it fails to sustain life or causes suffering," insisting that "(r)emoval of food and water is permissible only when they no longer attain the ends for which they are provided."¹⁰ However, it is not clear these two claims are themselves fully consistent. What of the case where ANH is not futile but attains its end of prolonging life, yet does so only by causing some burden so substantial as to be disproportionate? PVS may rule out the patient's feeling pain, but this is not the only form that a disproportionate burden may take.¹¹ The US Bishops' Conference has defined "disproportionate means" as measures "that in the patient's judgment do not offer a reasonable hope of benefit or

entail an excessive burden, or impose excessive expense...¹² Of course, a PVS patient is in no position herself to judge “benefits” to be “reasonable” or a “burden... excessive.” As Father Ford, of Australia’s Chisholm Centre for Healthcare Ethics, affirms, such patients “are unconscious, unaware of themselves or their environment” and because “awake but not conscious,” they are unable to show their wishes.¹³ Nevertheless, it is not clear that morally ending (or withholding) ANH requires that the patient must make this judgment about, and at the time of, a proposed intervention. It may sometimes be enough that the burdens of initiating or continuing ANH go beyond some reasonable standard that the patient has endorsed previously and in the abstract, especially in a carefully drafted and reflectively informed advance directive.¹⁴

How might her receiving ANH burden someone, specifically a PVS patient and her loved ones? Even if pain and discomfort are not issues for them, which can be questioned, and the expense is normally but not always modest, the toll in infections and other physiological complications may become so great that she could reasonably decline to continue despite the lethal result. Certainly, the costs to caregivers in time, stress, and fatigue can be so substantial it is morally permissible for them to decline further provision even in the face of the patient’s likely death.

Does all this evacuate the papal injunction of its point, perhaps even content? Not at all. The point is that nourishing those unable to eat is valuable and justified quite independently of their “quality of life” or prospects for recovery. It should be the ordinary (here meaning typical, normal) thing to do, in no need of further justification. This is a truth it is important to assert in our time, when even some scholars in Christian medical ethics are wont to reject, sometimes deriding it as “vitalism,” the claim that anyone’s life is valuable in a way that warrants protection regardless of her disability, illness, etc. To the contrary, it is discontinuing such care that will always require special justification. That is not to say, however, that such justification can never be given, even when ANH prolongs life, and I do not read the papal text as excluding that possibility *tout court*. I return to both these points below.

D) The 2004 address does allow that ANH might permissibly be withdrawn when it cannot achieve its “proper finality” (para. 4). Here, as the papal text makes clear, what is important is that the ends relevantly appropriate to the provision of food and water are nourishment and alleviating discomfort. Tubal delivery that cannot achieve this goal is futile and, at best, optional.

To be sure, there are problems in the offing at this point. Some insist that determinations of a form of treatment’s futility themselves presuppose judgments of a patient’s quality of life. Others distinguish such “qualitative

futility” from a more empirical “physiological futility.” To be sure, judgments that some type of care is futile are sometimes abused, used merely to camouflage the view that someone’s life is not worth saving. Likewise, some determinations of futility do depend on evaluations of evidence. And efforts to eliminate any room for subjective judgment or assessment of evidence can have the effect of eliminating virtually any legitimate scope for considerations of futility.¹⁵ For all that, it seems to me that a generally serviceable, attractive, reasonable, and objective account of futility can be given. Often we can make do with an account that holds a form of care for a type of illness to be futile when it has not achieved its more immediate physiological goals to any appreciable extent in the last hundred suitable patients within a region.¹⁶

Eating and drinking usually bring someone many advantages besides deliverance from hunger and thirst, of course, and they are often undertaken with these results chiefly in mind – pleasures of the palate, convivial enjoyment, a sense of one’s welfare being furthered, the interpersonal bonding that can be both manifested and cemented by sharing goods. The point is that the “proper finality” of eating is achieved in nourishment in the sense that this is its chief function, *telos*, point in nature/biology, though not necessarily the eating agent’s foremost aim, motivating thought, or conscious and adopted personal objective. ANH that doesn’t nourish and hydrate is futile treatment in the relevant sense, the one, as we saw, sometimes called physiologically futile.

E) The pope stresses that “evaluation of probabilities... cannot ethically justify the cessation or interruption of minimal care for the patient, including (even artificial) nutrition and hydration” (para. 5). Must ANH, therefore, be started and maintained no matter what side effects are likely? I do not think the statement should be interpreted that narrowly. It is saying that evaluation of the probability of the patient’s *recovery* is not necessary in order to make a determination of the medical and moral necessity of ANH. That is because such contingency would improperly suggest that the value of the patient’s life hinges on its “quality”, specifically, on the likelihood of her substantially recovering. That is false. The patient’s life is valuable, just as graced with dignity as yours or mine, irrespective of her health. Nevertheless, the likelihood of both the nutritive *effectiveness* of ANH and of various untoward side-effects remains morally always relevant, and they should be continually monitored and assessed. I see nothing in the address that gainsays that.

F) What of the text’s excluding the possibility that our “evaluation of costs can outweigh the value of” human life, explicitly ruling out appeal to any “external acknowledgment of its quality... as acknowledging that

increasing and decreasing levels of quality of life can be attributed from an external perspective to any subject," which latter step is described as "introducing into social relations a discriminatory and eugenic principle?" (para. 5,6) There are several important and valid points made here. First, the sick and disabled have a serious (even equal) claim on our help. Second, only the person herself can determine at what point the burden of a form of intervention (whether or not it properly counts as a medical treatment) is too much for her. Presumably, a duly designated surrogate can try to determine and apply the patient's wishes, but none of us, separately or collectively, may substitute our judgment on what sort of life is worth living or saving.

That is not to say, of course, that the subject's own judgment is infallible, nor that it should always be the conclusive consideration. The papal statement is careful to indicate an asymmetry here. No one but the patient herself may properly terminate ANH on the grounds that its burdens to the patient (pain, discomfort, expense, intrusiveness, restrictions, inconvenience to and deprivation of others, especially loved ones) have become disproportionate to its benefits to her (continued life). However, that does not mean that the patient must have the last word, no matter what it is. On the contrary, the pope does not rule out our relying on our own best judgment, rather than the patient's, when we think that ANH's benefits to her outweigh its burdens. This may seem unfair, and the thoughtless will complain that it is "cruel." However, it is not unfair, it is just asymmetrical, and the implicit guideline is that we need to take care to err, if sometimes we must, always on the side of life. It matters crucially *why* (the reasons for which) the medical team withdraws care and, in the case of the patient herself, it matters crucially *why* she asks that it be withdrawn.¹⁷ As Kant, the father of modern autonomy, affirmed, not every preference is to be honored but only those wherein the agent acts free from pathological preferences and out of respect for her own and others' inherent dignity as persons.¹⁸ The patient whose choice to end ANH or other care is a choice for death over life ought not to be abetted in this decision. In fact, this sort of death-wish, and its accompanying act of self-degradation, is one of the few places where the misused notion of "death without dignity" might find legitimate application. Privileging life over autonomy, as the pope here does, may displease some, but it is not an unreasonable prioritization. It is just the opposite, in fact, and plainly has nothing whatever of the character of genuine cruelty.

III. Withholding ANH in the Context of Euthanasia

We should now consider the papal claim that withdrawing ANH, thereby condemning the patient to "death by starvation or dehydration... as

the only possible outcome... ends up becoming, if done knowingly and willingly, true and proper euthanasia by omission." (para.4) This is quite strongly worded. What is he saying here? Recall that John Paul II is careful in this address to quote from an earlier document where he sought to define euthanasia. There, he wrote that: "by euthanasia in the true and proper sense must be understood an action or omission which by its very nature and intention brings about death with the purpose of eliminating all pain." (*Evangelium Vitae*, para. 65)

This makes it clear that, as this pope understands the term, intention is a necessary condition for euthanasia, along with result. Of course, intentions should neither be restricted nor imputed artificially or in a contrived way. We also need to remember that means count crucially. We will often need to ask, how does an agent reasonably mean/plan (i.e., have it in mind) to get from her course of conduct *C* to her envisioned resultant state *S1* if not through the intermediary (means) step of result *S2*? As indicated in this account, it constitutes euthanasia, morally and in fact, when an agent's relevant course of conduct is self-restraining – that is, omissive – but nevertheless routed to its planned, targeted resultant state through the intermediary step of the patient's death. Again, it matters crucially *why* (the reasons for which) she withdraws care. And, in cases where the patient can voice her wishes, it matters crucially the reasons for which she asks that it be withdrawn. Those in PVS are, of course, unable at the time of care to voice, or even have, such preferences. However, they are not the only such patients, and it can be instructive for us to widen our scope and consider what people are saying about withdrawing life-sustaining treatment from, and even actively putting to death, neonates and other infants – especially those with severe mental deficiencies.

Stephen Pinker, the prolific proponent and popularizer of so-called evolutionary psychology, wrote a controversial New York Times essay where he claimed, "It seems obvious that we need a clear boundary to confer personhood on a human being and grant it a right to life. Otherwise, we approach a slippery slope that ends in the disposal of inconvenient people...(To recognize a right to life in all but only) members of our own species, *Homo sapiens*,... is simply chauvinism; a person of one race could just as easily say that people of another race have no right to life. No, the right to life must come, the moral philosophers say, from morally significant traits that we humans happen to possess... having a unique sequence of experiences that defines us as individuals and connects us to other people,... an ability to reflect upon ourselves as a continuous locus of consciousness, to form and savor plans for the future, to dread death and to express the choice not to die. And there's the rub: our immature (human) neonates don't possess these traits any more than mice do."¹⁹

I think Pinker's implicit comparison of the differences between White and Black people to those between the human and the subhuman racially offensive. Moreover, we do not "confer personhood on" people, nor "grant it" a moral right – note the term "it" – but rather recognize (acknowledge) their personhood and appreciate the rights that it grounds. Pinker notes that very few mothers who kill their one-day-old children (what he calls "neonaticide" as distinct from other "filicide", that is, the killing of offspring) are tried, convicted, and imprisoned. He infers from this that we empathize with the very young victims. (He cites a study indicating that of 300 women charged with such crimes in the USA and Britain, none spent more than one night in jail.) Pinker explains this differential concern by speculating that evolution has equipped us to feel a certain detachment until the child shows himself or herself capable of survival and thus a good investment of time and attention. However, Pinker himself notes that these baby-killers are usually very young, unmarried, alone, poor, and desperate. That suggests a different explanation for society's clemency: it may be rooted more in our greater sympathy for the killers than in our lesser sympathy for their victims. Finally, it is true neither that we "happen" to possess personal attributes nor that only those who in fact possess them, or possess them at a certain time of their lives, are persons. Rather, these qualities are most plausibly seen as defining personhood in that a human person is a being that by its natural inclination properly and naturally tends to develop them. When a human being is not yet at the stage where they have developed, or is at the appropriate stage but is such that some internal or external misfortunes have thwarted their development (or ended them) these facts do not deprive her of personhood, causally or conceptually. In fact, it only compounds her mischance, and literally adds insult to injury, if we take this disability as grounds further to deprive her even of social protections and personal respect.

Barbara Smoker, former president of Britain's National Secular Society, writes in a publication of the Council for Democratic and Secular Humanism, "I strongly feel that it is cruel, and therefore immoral, to preserve a baby's life when there are such severe handicaps that chances of happiness are manifestly low. For life can, of course, be far worse than death... (Acting) to starve seriously defective neonates to death – giving them only water, not milk... is certainly better than keeping them alive – but not as merciful as a quick, lethal injection... Since we now have a social duty to limit our families, it is only sensible to limit them to those with a reasonable prospect of a normal human life... A newborn baby has very limited awareness, no idea of any future, and no real stake in life, (whereas, in contrast,) an older child has become a real little person, with personal relationships, a sense of his or her own identity, and an idea of purpose – the very things that give human beings human rights and status."²⁰

What we need to remember, in the face of Smoker's remarks, is that the principal way in which human life is valuable is rooted in the status and dignity of human personhood and does not derive from its usefulness for achieving happiness, having an idea of the future, and so on. Newborn babies are *already* and *intrinsically* persons, albeit little ones, and that status does not depend on what level of development they have achieved or will later achieve. H. Lagercrantz opines that "it is wrong to ask if euthanasia of infants should be legal. It is better to retain respect for a personal life defined as a human individual with consciousness or the potential to become conscious. Having set his definition like this, he feels entitled to say, with regard to deliberately withholding resuscitation and treatment from certain severely encephalopathological children "with a very limited ability to develop a reasonable level of consciousness," that he "do(es) not regard this as euthanasia because the infant is not a conscious, or potentially conscious, person."²¹

Garret Keizer, an essayist who sometimes writes for the leftist American political magazine *The Nation*, believes he has uncovered what really motivates those who wish to protect life and medicine from the professional deformity that he and others call physician-assisted suicide. "The right talks about protecting life and tradition, but on some level... it is mostly interested in protecting pain. The first is theological: the belief that pain holds the meaning of life... The second reason... is political: the belief that pain is fundamental to justice."²²

Keizer offers little reason for imputing this odd idea to his adversaries, and it seems like mere unfairness. To be sure, many religious people remind us that suffering is not an unalloyed ill and even biology shows its normal usefulness. They also know that deserved suffering is a necessary part of criminal justice, though most religious people in the West are content these days to restrict the desirable types of suffering to the frustrations and restrictions of fines, incarceration and, at most, relatively painless execution. More to the point, one would certainly have difficulty locating a reputable religious ethicist who thinks that medicine has a legitimate role in increasing, maximizing, prolonging, or enabling patients' pain. So, Keizer's claim is merely mean-spirited fancy.

Against what he imagines to be his adversaries' fixation on "protecting pain," Keizer wants to make his stand with liberal democracy. "PAS (physician-assisted suicide) rests on two principles that are central to a liberal society. The first is that we are owners of our own lives... The second principle... is that we are collective owners of the culture we produce collectively. The debate over PAS is... about who owns the medicine... And one thing more about the relevance of a Death with Dignity law to our democracy: we are free to try it out."²³

Keizer's odd, left-libertarian view is rife with bad metaphors of ownership: owning our selves, owning medicine. It is unseemly for anyone to make so much depend on economic analogies, particularly someone on the Left. In any case, there is little substance to his reasoning, since it is difficult to make sense of his idea of owning ourselves – if this entitles us to kill ourselves, does it not also entitle us to sell ourselves, even to give ourselves away to others in permanent bondage? But what sense can be made of self-alienation? And how could it be a matter of right? I cannot only destroy, sell, or give away my couch legally, I can also rip it up when I feel like it. And I can do any of these merely according to my passing caprice in the eyes of the law. Does Keizer's defense of PAS also bravely guarantee our moral right to deface, even mutilate ourselves simply on the basis of a passing fancy? And should this entitlement also be legally encoded? If not, how and on what basis are these moral lines to be drawn? What sort of liberalism is it that could so casually commit itself to whimsical enslavement and mutilation? While John Locke spins in his grave, we would do well to remember this fact: those patients who exercise their Keizer-granted right to "try...out" PAS can never learn from their experiment's failure. It is doubtful that this is what Mill had in mind in talking of the marketplace of ideas.

Keizer also notices that many disabled people, and those who love them, are starting to notice the implications of condoning infanticide and mercy-killing for people who can no longer take care of themselves, ambulate, and so on. Some do not like those implications, and are becoming more vocal in expressing their misgivings. "Groups like Not Dead Yet," he observes, "view any laws for assisted death as a threat to the very existence of the disabled. At least they claim to. After reading some of their literature, I suspect that what they see is not as much a threat as an insult. 'Death with Dignity' becomes a loaded term in the presence of Life with Disability. Complaints about the 'indignities' of terminal illness – loss of control over bathroom functions, complete lack of mobility – are naturally going to seem offensive to those who have struggled to assert their dignity under similar conditions."²⁴ Of course, the insult to the disabled in this nasty rhetoric is not merely perceived; it is inherent in much talk of "death with dignity."

John Robertson, an expert in issues of biomedical law, strains to justify his strange view that parents ought to be legally empowered to make care decisions because of what appears to constitute a plain conflict of interest. "Because parents (and other children) will bear the burdens of caring for the child with severe impairments, they should have the right to refuse resuscitation or treatment in... (severe) cases."²⁵ He continues, "If one lacks altogether the capacity for meaningful symbolic interaction, then one lacks the characteristics that make humans the object of moral duties..."

(T)he mental disability in such cases is so extreme, so far from those cases in which children may be said to have valid interests in living, that they arguably do not threaten to harm the important values underlying the injunction against quality of life assessments in cases of disability."²⁶

However, we should reject Robertson's claim that disabled babies lack relationship. Rather they already *are* related to us as somebody's son or daughter, grandchild, brother, sister, nephew, niece, etc. The question is how *we* respond to them – living up to (or failing in) these relationships. The same holds true for PVS patients.

This shift from concern to avoid burden on patients (especially, their pain), to avoiding burden on parents (who Robertson, oddly, wants to empower to make decisions precisely because of their conflict of interest), shows that not all the impetus for infanticide is really mercy-killing, killing from (supposed) mercy for the patient. It also raises the question: which putative justification will come next? Avoiding burden *to society*? People who point out that the last century's chief advocates of euthanasia were in the Third Reich are nowadays denounced in high dudgeon. We have become accustomed to hearing that things are entirely different now, because the Reich supported euthanasia for the supposed good of society while the current trend appeals to individual autonomy and dignity. But as the rationale for infanticide shifts from avoiding the patient's pain to respecting her wishes, and now to enabling her potential caregivers to spare themselves expense and trouble, just how far are we from the Nazis' rationale for euthanasia?

Finally, consider Eduard Verhagen. Dr. Verhagen is clinical director of the Pediatric Clinic in the University Hospital of Groningen, a Dutch hospital whose physicians have a policy of sometime performing mercy killings on terminally ill newborns. In a recent NPR interview about his clinics' activities, he said, "(W)e felt that in these children the most humane course of action would be to allow the child to die, and even actively assist them in their death... (F)rom a medical point of view, it is very important to be strict on the protection of life. And in extreme cases, the best way to protect life is to sometimes assist a little bit in death."²⁷

I will not belabor the nasty absurdities of human infanticide and protecting life (whose? from what? one wonders) by helping "a little bit in death." One important lesson from reflecting on the disgraceful statements I have discussed, and it would be easy to multiply such examples, is that we all need to learn to accept and value our common dependence, and recognize that there is no indignity in it, while it is manifestly degrading to judge some people to have lives worth neither saving nor living.²⁸

IV. Withholding ANH: Intervention and Its Discontents

Bearing those truths in mind can help us act more responsibly in making decisions about starting and discontinuing ANH. These decisions can get especially complicated with patients in PVS. We need to remember, for example, that diagnosis of PVS can be quite unreliable. Dr. Allen Counter reports that a 32-year-old woman whose doctors concluded that she, while "unresponsive to sensory stimuli, devoid of any intellectual function, and in a persistent vegetative state," consistently turned towards a music box playing in her room, and "began to smile and make sounds, as if she were enjoying" it.²⁹ He reports that he found himself "emotionally moved by her struggle for human definition through the single modality of hearing," that her doctors began responding to her more personally ("in some cases, holding her hand and trying to speak with her"), and that she continued to enjoy the music for some years. He concludes that "Her case was a reminder of how much we do not understand about the brain, and that even people in an apparent vegetative state may have ways of connecting to the world around them."³⁰

For all that, there can be reasons to withhold or discontinue ANH that are neither rooted in nor routed through the euthanasist's aim of "eliminating all (the patient's) pain" through her death. Dr. Muriel Gillick holds that feeding and watering by tube are "seldom warranted for patients in the final stage of dementia," because they have "few if any benefits and there is considerable potential for harm."³¹ She bases this conclusion on evidence that ANH has not been shown to lead to longer lives as compared with those who do not receive it, can cause diarrhea and nausea (so that neither nutrition nor hydration really results), and often leads to infections. In addition, demented patients frequently behave so as to pull out the tubes and need to be restrained, causing distress, fear, and diminished autonomy.³² Moreover, ANH provides neither the felt satisfaction of eating nor the social interaction of being spoon-fed. Gillick's views have been controverted and I certainly possess neither the knowledge nor the expertise to make a judgment.³³ My point is that the factors she cites are relevant, not excluded as such. Indeed, even the magnitude of financial costs to the patient and her family can be relevant, though this would be less true in a more just system of health care allocation.³⁴

The US Catholic Bishops have stated that, while "there should be a presumption in favor of providing nutrition and hydration to all patients, including patients who require medically assisted nutrition and hydration," such intervention is morally required only when it "is of sufficient benefit to outweigh the burdens involved (by its provision) to the patient."³⁵ Indeed, the burdens to others, e.g., relatives, can also be legitimately be considered. Robert Orr reminds us that "For... years, traditional moral

theology distinguished between ordinary and extraordinary means of saving life. Ordinary means were those that were not too painful or burdensome for the patient, were not too expensive, and had a reasonable chance of working.³⁶ Other measures involving "undue burden(.) were extraordinary and thus optional." The distinguished Protestant ethicist Gilbert Meilander rightly affirms that "we may refuse treatments that are either useless or excessively burdensome. In doing so, we choose not death but one among several lives open to us." His point is that sometimes, in withholding or discontinuing ANH, we act licitly because all that "we aim to dispense with (is) the treatment, not the life." In contrast, "if I decide not to treat because I think a person's life is useless, then I am taking aim not at the treatment but at the life." In this context, it is worth noting Father Ford's claim that "to prolong indefinitely the life of a patient in a permanent unconscious state does not seem to respect (her life's inherent) worth" and his alarming suggestion, cast as a question, that "subject(ing someone) to years of unconscious life sustained by MANH (medically assisted nutrition and hydration)" shows a "lack of respect for (that) patient's inherent dignity."³⁷ I find it difficult to interpret this statement in a way that does not imply that it is such a life itself that is being targeted for termination because somehow unworthy, rather than the treatment that is being terminated *despite* and *not because of* the fact that doing so shortens the patient's life.

Even the idea of accepting some undesirable side effects of actions taken for good ends is complicated. We should not take too literally the metaphor of "weighing," Meilander sagely observes. "On what scale one 'weighs' benefits and burdens is a question almost impossible to answer. Even more doubtful is whether we can 'weigh' them for someone else. My own view is that when we make these decisions for ourselves, we are not weighing anything. We are deciding what sort of person we will be and what sort of life will be ours. We are making not a *discovery* but a *decision*." He cautions against being "too quick to assume that feeding tubes are 'treatment' rather than standard nursing care... It is hard to see why such services as turning a patient regularly and giving alcohol rubs are standard nursing care while feeding is not."³⁸ Meilander's trenchant discussion reminds us of our moral tradition's familiar insight that, as Father Ford nicely summarizes it, "Human life is a gift of God; it is a basic good of the person and not merely a means to other goods."

V. Conclusion

I have here tried to offer an interpretation and partial defense of the recent papal statement on ANH and PVS, placing this form of care and this condition in the larger contexts of recent discussion of care option, and

euthanasia for other persons who have diminished or unrealized capacities, especially newborns. Mine can be seen as a kind of middle view between those who deem the lives of some unworthy of prolongation on the one hand and, on the other hand, an unconditional requirement to administer food and water artificially, provided only that it nourishes and hydrates, no matter how much doing so burdens the patient and her family and others. That is not to say I find the two alternatives equal. The more restrictive is a plausible, serious position, clearly consistent with responsible Christian thinking in medical ethics. In contrast, those who deem disabled lives unworthy of saving are spokespersons for what John Paul II repeatedly and trenchantly labeled an "anti-life culture" or, more starkly an "anti-culture."³⁹

References

1. John Paul II, 2004. This address was delivered to an International Congress sponsored by the Pontifical Academy for Life and the World Federation of Catholic Medical Associations.
2. I have been told that the papal address was printed and delivered in Italian, and hastily translated by unknown staff. The doctrinal status of this papal statement is unclear. My colleague Father Himes casts doubt on the idea that it adds to "the official teaching of the Church," noting that it was "one papal speech to a special audience... never promulgated to the universal church, nor were episcopal conferences ever told to revise their local hospital directives" to bring them into conformity with new teaching. (Himes, 2005, p. 8) If I am correct that the statement does not really advance what Himes characterizes as "a novel position" but only builds on, clarifies, and develops a more familiar ethical stance, then the issue is not crucial. We should note, however, that in an age when even papal statements to local groups are quickly posted on the Vatican website in several translations, the distinction between private remarks and what is universally announced may no longer be so sharp.
3. See Ford, 2004.
4. Cahill claims the 2004 address is "marked by non sequiturs and inconsistencies," immediately offering by way of illustration, "For one thing, it is hard to see how tube feeding can flatly be judged 'not a medical act.'" (Cahill, 2005, p. 16)
5. Cahill, 2005, pp. 16-17.
6. Watt nicely makes a related point, while combating Father Ford's appeal to similarities between ANH and respirators. "Giving food and drink is... part of non-medical, everyday care for many people, in a way that 'oxygenating' people is (at least after birth). Infants and toddlers are routinely spoon-fed, as are disabled people of all

ages. Tube-feeding is a low-tech extension of this kind of assistance; like the use of catheters, it is basic nursing care... In any case, PVS patients often retain some ability to swallow, so that spoon-feeding would presumably need to replace the more convenient tube-feeding if that were withdrawn." (Watt, 2004; contrast Ford, 2004; "Both [ANH and respirators], after all, use a medical procedure; in both cases death is the natural outcome unless ventilation or MANH is continued. Air and food are equally necessary for the maintenance of spontaneous life. If the ventilator may be ethically withdrawn, why not also MANH?")

7. Australia's bishops suggested this in Australian Conference of Catholic Bishops, 2003.

8. Never permitted, except in the situation described in the following paragraph where ANH does not achieve its "proper finality" of nourishing the patient and therein palliating her discomfort.

9. The consensus statement issued on this document by a 2004 Colloquium of the Canadian Catholic Bioethics Institute stresses this. The signatories affirm: "The papal speech needs to be understood in the context of the Catholic tradition. The words 'in principle' (in the passage cited) do not mean 'absolute' in the sense of 'exceptionless' but allow consideration of other duties that might apply." Their proposed gloss on the pope's statement seems to me well crafted and reasonable: "For unresponsive patients to whom ANH can be delivered without being in itself in conflict with other grave responsibilities or overly burdensome, costly or otherwise complicated, ANH should be considered ordinary and proportionate, and, as such, morally obligatory." They continue, "Treatments cannot be classified ahead of time as (inherently) ordinary or extraordinary. Reference must be made to the wishes and values of the patient, his or her condition, and the availability of health care in the given context. ... Extraordinary treatments are those that do involve excessive pain, expense, or other burdens." That determination is situation-based. (Canadian Catholic Bioethics Institute, 2004, para. 5, 7). In contrast, Cahill too confidently asserts that "the (papal) speech is not consistent with prior well-established papal teaching." (Cahill, 2005, p. 17) I seek a reading of the allocution that enables us to resist that extreme and implausible judgment.

10. See National Catholic Bioethics Center, 2005.

11. I say that PVS only "may rule out the patient's experiencing pain" because the matter has been controverted. Ford reports that the Congress to whom the pope made his March 2004 remarks also "heard evidence that some PVS patients had minimal consciousness, and that there was a possibility they could experience pain." As Ford notes, if and insofar as she can experience discomfort, the possibility is raised that ANH may be morally optional, discretionary, for a PVS patient on the grounds that the pain it causes her constitutes an excessive burden. (Ford, 2004) My point is that, even in the absence of any possibility of pain, considerations of ANH's excessive and disproportionate burden may come into play because of the expense it runs the patient, her family, or others. In the last sections of this essay, I raise some ethical worries

properly arising from recent theorists' emphasis on the social cost of sustaining life.

12. See United States Conference of Catholic Bishops, 2001.

13. Ford, 2004. A joint statement from the International Congress that the pope addressed describes a vegetative state as "a state of unresponsiveness, currently defined as a condition marked by: a state of vigilance, some alternation of sleep/wake cycles, absence of signs of awareness of self and surroundings, lack of behavioural responses to stimuli from the environment, (and) maintenance of autonomic and other brain functions." (International Congress, 2004, para. 1) What is important for our purposes is that characterizing the state in this way, chiefly by observed operations and (lack of) responses, leaves open the possibility that such a patient may experience pain in her inner life though she does not manifest typical behavior.

14. To say this is not necessarily to endorse the confused counterfactuals that muddle much of today's debate. Plainly, there can be little sense to questions about what the PVS patient "would have wanted." This subjunctive indicates that the desire is conditioned on some situation. But what could it be? It is laughable to inquire whether she would or would not want (like?) being in PVS if she were in that condition (of a lack of awareness) and aware of it. Is it, then, that what matters is whether she would opt for a PVS life if described to her? But why should such a preference, essentially uninformed by any experience, be what counts?

15. Bailey quotes a definition according to which "a particular medical treatment (is) futile if that treatment is incapable of accomplishing any of the specific goals of treatment." (Bailey, 2004, pp. 78-79) The "any" here is supposed to eliminate subjective judgments but, as Bailey sees, the account remains problematic. If the definition is meant to pick out only such treatments as *undeniably* have *no* chance of accomplishing any of their goals *to any extent*, it is so narrow as to have almost no application. If it is meant less restrictively, then room remains for judgments of likelihood and assessments of evidence. "(I)t will be rare, if not impossible, that the evidence will demonstrate that the particular intervention to be (sic) ineffective 100% of the time. What if statistical evidence shows that a particular intervention will succeed in achieving its goal 1% of the time? Strictly speaking, this intervention cannot then be labeled physiologically futile." (Bailey, 2004, p. 80)

16. Here I draw on the account offered in Schneiderman and Capron as amended by Bailey and further modified. (See Schneiderman and Capron, 2000, and Bailey, 2004) I depart from Bailey, however, in holding that what matters for a (somatic) treatment's futility or efficacy is not whether it achieves its overall goal of effecting the patient's recovery but whether it makes the (causally) more immediate and smaller-scale physiological changes that it is hoped will contribute to her recovery.

17. "Health care professionals may be confronted by patients who, with suicidal wishes, refuse ordinary life-sustaining care. Such patients must be treated with concern for their dignity and well-being. Health care professionals should do their best

to protect the life and health of the patient while recognizing there may be legal and professional limits to their ability to intervene... (Nevertheless, a) Catholic health care professional should not cooperate in implementing a suicidal directive." (Canadian Catholic Bioethics Institute, 2004, para. 12, 20).

18. There are, thus, innocent mistakes that the patient might make, overestimating the suffering a treatment will cause (or its probability). Such failings in judging and reasoning are not normally culpable, even when born of emotional distortions, such as fear. Of course, controllable but uncontrolled, fear, when excessive (or insufficient), can be a type of moral vice that can morally contaminate the judgments and decisions it shapes. Further, the patient may judge treatment too burdensome simply because she viciously despises a life of dependency, counting it as no benefit at all. Not all mistakes, then, about whether a mode of treatment's costs are too great, will be innocent. I am grateful to Prof. Tollefsen for turning my attention to some of these points.

19. Pinker, 1997. Pinker does not specify which are "*the* moral philosophers" who root human rights in what "happens" to be true of us but, unfortunately, there is no shortage of such thinkers who deny to humanity inherent dignity and restrict rights to those who have reached a certain level of development and accomplishment.

20. Smoker, 2003.

21. Lagerkrantz, 2004.

22. Keizer, 2005, p. 55.

23. Keizer, 2005, p. 61

24. Keizer, 2005, p. 52

25. Robertson, 2004, p. 36.

26. Robertson, 2004, p. 37.

27. Montagne, 2004.

28. See MacIntyre, 1999.

29. Counter, 2005, p. E1.

30. Counter, 2005, p. E2.

31. Gillick, 2000, p. 209.

32. The Canadian statement pertinently reminds us that "Some restraints may

constitute an assault on human dignity... Restraints can also lead to complications such as pressure sores." (Canadian Catholic Bioethics Institutes, 2004, para. 15).

33. For the controversy, see Vollmann, et al., 2000.

34. The Canadian statement is again helpful on this point. "While recognizing that it is impossible to place monetary value on human life, the cost of treatment can be a morally relevant factor in health care decisions, especially if patients or their families have to bear the entire economic burden." (Canadian Catholic Bioethics Institute, 2004, para. 9).

35. USCCB, 2001.

36. Orr and Meilander, 2004.

37. Ford, 2004. Similarly, Cahill is careful to distance herself from those who claim "that continued life would be a benefit no matter what its condition," and maintains that "it could reasonably be argued that 15 or more years of existence in a "vegetative" state neither serves human dignity nor presents a fate that most reasonable people would obviously prefer to death." (Cahill, 2005, pp. 16, 17) I think it incoherent to deny that life is always a benefit to a human being and can discern no disservice to human dignity in preserving a human life, in which dignity inheres as such and irrespective of the blocking of many normal capacities. On the contrary, to deem such a life as beneath preservation is to deny its inherent status. Whether many reasonable people would prefer death to a long life in PVS is morally irrelevant, since they may seek escape in death out of despair and incomprehension before the prospect of such a limited existence. Even reasonable people, of course, form some preferences from irrational parts of the self.

Cahill suggests the chief issue is whether John Paul II's 2004 allocution "settles" the question in favor of *always* using artificial nutrition." However, this threatens to mislead. She herself notes that Richard Doerflinger, a spokesperson for the U.S. bishops on pro-life matters, denies that the statement "declared an absolute moral obligation to provide assisted feeding in *all* cases." (Cahill, 2004, pp. 16, 17; emphasis added) The papal statement explicitly repudiates ANH in cases where it is ineffective. Rather, the controversy today is, as Father Ford puts it, over the range of remaining discretion, what "wriggle room is now left for doctors in Catholic hospitals to continue to make decisions (about ANH for PVS patients) on a case-by-case basis." (Ford, 2004)

38. Orr and Meilander, 2004.

39. For one such reference to our "anti-life culture," see John Paul II's 1981 Apostolic Exhortation, *Familiaris Consortio*, sec. 30. For "anti-culture," see his 1984 Address to the Pontifical Council for Culture, cited at Dulles, 1999, p. 123.

Bibliography

Australian Conference of Catholic Bishops, "Briefing Note on the Obligation to Provide Nutrition and Hydration." Available at: www.acbc.catholic.org.au/pdf/040903_briefing_note.pdf.

Bailey, Susan. "The Concept of Futility in Health Care Decision Making." *Nursing Ethics* 11 (2004): 77-83.

Cahill, Lisa Sowle. "Catholicism, Death and Modern Medicine." *America*, April 25, 2005, pp. 14-17.

Canadian Catholic Bioethics Institute, "Reflection on Artificial Nutrition and Hydration," consensus statement of a Canadian Catholic Bioethics Institute colloquium in Toronto, June 14-17, 2005.

Counter, Dr. S. Allan. "Music Stirred Her Damaged Brain." *Boston Globe*. March 29, 2005, pp. E1-E2.

Dulles, Avery, S.J. *The Splendor of Faith*. New York, Crossroad, 1999.

Ford, Norman. "Impacts of Papal Teaching on Vegetative Patients in Catholic Hospitals." Available at the Australian website, Onlineopinion.com.au/print.asp?article=2219 Originally published in *The Tablet*, 1 May 2004.

Gillick, Muriel, M.D. "Rethinking the Role of Tube Feeding in Patients with Advanced Dementia." *New England Journal of Medicine*. Vol. 342, no. 3 (January 20, 2000): 206-210.

Grubb, Andrew, et al. "Survey of British Clinicians' Views on the Management of Patients in Persistent Vegetative State." *Lancet* 348 (1996): 35-40.

Himes, Kenneth, O.F.M. "To Inspire and Inform." *America*, June 6-13, 2005, pp. 7-10.

International Congress on Life-Sustaining treatments and Vegetative State: Scientific Advances and Ethical Dilemmas. "Joint Statement." March 10-17, 2004.

John Paul II. "Address to Participants in an International Congress on Life-Sustaining Treatments and Vegetative State." March 20, 2004.

Keizer, Garret. "Life Everlasting." *Harper's*. February 2005, pp. 53-61.

Lagerkrantz, H. "Should Euthanasia Be Legal?" *Archives of Disease in Childhood. Fetal and Neonatal Edition*. 89 (January, 2004): p. F2.

MacIntyre, Alasdair. *Dependent Rational Animals: Why Human Beings Need the Virtues*. London: Duckworth, 1999.

Montagne, Renée. "Interview with Dr. Eduard Verhagen." National Public Radio, December 1, 2004.

National Catholic Bioethics Center. "The Case of Terry Schiavo." Press release of March 18, 2005 available at nbccenter.org/press/05-03-18-Schiavo.html.

Orr, Robert and Gilbert Meilander. "Ethics and Life's Ending: An Exchange." *First Things* 145 (August/September 2004): 31-37.

Pinker, Stephen. "Why They Kill Their Newborns." *New York Times*, November 2, 1997.

Robertson, John. "Extreme Prematurity and Parental Rights After *Baby Doe*." *Hastings Center Report* July-August 2004, pp. 32-39.

Schneiderman, L.J., et al. "Medical Futility: Response to Critiques." *Annals of Internal Medicine*. 125 (1996): 669-674.

Smøker, Barbara. "On Advocating Infant Euthanasia." (Op-Ed) *Free Inquiry* 24 (December 2003): pp. 17-18.

United States Conference of Catholic Bishops. "Ethical and Religious Directives for Catholic Health Care Services," fourth edition. Washington: United States Conference of Catholic Bishops, 2001.

Vollmann, Jochen, M.D., Ph.D., et al. "Correspondence." *New England Journal of Medicine*, vol. 342, no. 23 (June 8, 2000): 1755-1756.

Watt, Helen. "In Defense of Just being." Available at the Australian website: Onlineopinion.com.au/print.asp?article=2294. Originally published in *The Tablet*, 1 May 2004.