The death of Terri Schiavo in Florida on March 31, 2005, brought into high relief many of the central questions concerning the care and treatment of patients in the persistent vegetative state (PVS). At the center of the Catholic discussion of this contentious issue has been whether the provision of food and water is an extraordinary means of conserving life when a patient no longer has any measurable cognitive-affective abilities. Although my own work on the topic of artificially assisted hydration and nutrition (AAHN) is involved with the question of whether such patients are indeed incapable of awareness of themselves and others, that issue is not addressed here.¹ This article will consider the topic of ordinary and extraordinary means as the background for the larger discussion within the Church over the appropriate care of PVS patients. After a survey of key historical ideas in the development of this distinction, I conclude with some comments on how the distinction between ordinary and extraordinary treatment helped the bishops and the Church’s magisterium to arrive at the conclusion that the provision of food and water is morally obligatory, in most cases, for those who are in the PVS.

Ordinary and Extraordinary Means of Preserving Life

Catholic teaching regarding human life starts from more general principles that delineate the ultimate nature of the human person, and then moves to more specific principles aimed at safeguarding human dignity and caring for human life within the bounds of health care. Because human life is a precious gift of God, the positive requirements incumbent upon the human person demand that he assume a reasonable degree of care for his life; however, because human life is not an absolute good to be maintained at all costs, there are equally important limits to this duty. The efforts of the Church throughout its history to outline the duty and limits of caring for human life has resulted in a solid moral tradition that advocates the use of all ordinary means to preserve life, along with a right to forgo any extraordinary means to preserve life.

The vitally important address by Pope Pius XII in 1957 to a group of Catholic physicians and anesthesiologists gave a succinct statement of the Church’s position regarding the ordinary and extraordinary means of conserving life. The Pope stated:

[N]ormally one is held to use only ordinary means—according to circumstances of persons, places, times, and culture—that is to say, means that do not involve any grave burden for oneself or another. A more strict obligation would be too burdensome for most men and would render the attainment of the higher, more important good too difficult. Life, health, all temporal activities, are in fact subordinated to spiritual ends. On the other hand, one is not forbidden to take more than the strictly necessary steps to preserve life and health, as long as he does not fail in some more serious duty.2

In 1958, the theological study by Daniel Cronin constructed a comprehensive analysis of the Church’s moral tradition pertaining to the ordinary and extraordinary means of conserving human life.3 The treatment of this subject in my article will present a representative selection of the theologians who clarified the major tenets of the obligations and limits correlative to the preservation of life. The brief examination of the principles governing the care of human life will provide both a glimpse into the course of historical development of the Catholic moral tradition and an important reference point for the arguments used to promote the provision or withholding of AAHN to the PVS patient, which will be discussed later.

2 Pius XII, “The Prolongation of Life: Allocution to the International Congress of Anesthesiologists” (November 24, 1957), The Pope Speaks 4.4 (1958): 395–398. While this statement by the Pope only addressed the broad strokes of the Church’s position on the ordinary and extraordinary means of conserving life, it did have implications for the PVS patient. Some moral theologians, most notably Rev. Kevin D. O’Rourke O.P., used the statement of the Pope regarding “the attainment of the higher, more important good” to conclude that in the case of a permanently unconscious patient, hydration and nutrition could be forgone. This is discussed in a later section, below.

Historical Roots and Use of the Terms

In the course of his research, Cronin discovered that the seeds upon which the ordinary and extraordinary means of preserving life would later grow were to be found in the treatises of St. Thomas Aquinas, particularly in his treatment of suicide and bodily mutilation. Of significant value for later theologians, who more thoroughly addressed the demands and limits of a human person’s responsibility to preserve his life, was this statement of St. Thomas: “A man has the obligation to sustain his body, otherwise he would be a killer of himself … by precept, therefore, he is bound to nourish his body and likewise, we are bound to all the other items without which the body cannot live.”

While this statement did not specifically delineate the precise elements that make up the obligation to preserve life, or even mention the instances and circumstances which would limit this duty, it did clearly maintain that the responsibility to preserve human life does exist and that it is a serious obligation, or else a person “would be a killer of himself.” St. Thomas’s broad statement on the somewhat tangential issue of suicide could be regarded as the kernel of what would become a significant moral study on the care of human life. From this point forward, as human needs have demanded, other theologians have built upon, and slowly developed, more specific duties and limits to the obligation noted by St. Thomas.

The theologians of the sixteenth century, especially Francisco de Vitoria (d. 1546) and Dominic Soto, O.P. (d. 1560), provided the next advances in the moral growth of the specific requirements to preserve human life. In Cronin’s assessment, the contribution of Vitoria involved the specific obligation of the human person to eat food and thus sustain life, which Vitoria based primarily upon the human person’s natural inclination to self-conservation. Of equal importance to the positive requirement of taking food to preserve life were the limits he placed upon that obligation:

Thirdly, I would say that if the depression of spirit is so low and there is present such consternation in the appetitive power that only with the greatest of effort and as though by means of a certain torture, can the sick man take food, right away that is reckoned in a certain impossibility, and therefore he is excused, at least from mortal sin, especially where there is little hope of life, or none at all.

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In this paragraph, Vitoria demonstrated an understanding that the duty to preserve life by taking food was not an absolute obligation, and, in so doing, he established the rudimentary threads that acknowledged the existence of circumstances where impossibility or extreme difficulty interfered with compliance with the positive obligation of conserving life. Other factors delineated by Vitoria that mitigated the duty to preserve life have been noted by John Connery, S.J., who states, “one is not obliged to use foods which are the best, the most expensive or the most exquisite. Neither is one bound to live in the healthiest climate … those who refuse to take some particular medicine are not to be condemned since one can rarely be certain that it will work.” One can notice, therefore, that the scope of the obligation to conserve life is fixed at reasonable measures, with common foods, in normal settings, and with medicines that are known to be effective.

Dominic Soto, O.P., offered little in the way of innovation in any sense that built upon Aquinas and Vitoria, but he was the first to address some of the duties and limits pertaining to surgery, in particular those surrounding acceptance of amputation. Connery notes that Soto asks “whether one is bound to undergo amputation of an arm or leg to preserve or prolong life. His answer is that no one could force a patient to undergo such torture.” Before the advent of reliable anesthetics, the question of what could reasonably be asked of a patient in terms of mutilation or amputation was frequently discussed, and the common opinion concluded that such a course was usually beyond the level required to preserve life, because of the great pain involved. Regarding the pain of overbearing shame, both Leonardus Lessius and Gabriel of St. Vincent concurred that an experience of excessive shame or abhorrence related to a medical procedure could also be more than a person should be asked to bear, and thus a reasonable cause to forgo the treatment. In this instance, both theologians were specifically referring to the care of female patients by male physicians.


9 Connery, “Prolonging Life,” 153; Connery quotes Dominic Soto, O.P., *De Iustititia et Iure* (Venice 1568), Lib. 5, q. 2, a.1.


11 L. Lessius, *De Iustititia et Iure*, Lib. IV, Cap.3, dub. 8, n. 60. He commented that “women, especially virgins, are not bound to accept from men medical treatment of this type in the more secret parts … The reason is because no one is held to accept a cure which he abhors no less than the disease itself or death.” See also Gabrielis a St. Vincentio, *De Iustititia et Iure* (Rome: Mancini, 1663) disp. 6 de restitutione, q. 6, n. 86. Other theologians contradicted this position. See also Vincent Patuzzi, *Ethica Christiana sive
Juan Cardinal de Lugo (d. 1660) provided the next significant addition to the moral tradition regarding ordinary and extraordinary means of conserving life. The moral theology of de Lugo offered several nuances that were not so much highly innovative as they were subtle insights and clarifications serving to broaden the Catholic moral tradition regarding the lengths and limits of conserving life. A particularly interesting contribution found in de Lugo’s moral theology involved a deeper understanding of extraordinary means. Instead of automatically accepting the extraordinary status of an amputation, a procedure that would likely save a person’s life but would entail intense pain, de Lugo took a different tack. Thomas O’Donnell, S.J., remarked that “De Lugo himself does not presuppose the extraordinary difficulty of a leg amputation, as Alphonsus [Saint Alphonsus Liguori] seems to do.”12 De Lugo stated, “He must permit this cure when the doctors judge it necessary, and when it can happen without intense pain; not, if it is accompanied by very bitter pain; because a man is not bound to employ extraordinary and difficult means to conserve his life.”13

In this statement, de Lugo shrewdly observed that the difficulty presented in the amputation procedure lay primarily with the significant amount of pain that often accompanied it and not necessarily with the amputation procedure itself. Hence, the extraordinary nature of an amputation, de Lugo realized, lay in the overwhelming pain, and not necessarily in the amputation itself. In a case in which the obscuring blanket of pain was removed, the amputation procedure could constitute an ordinary means of conserving life.

A second vital contribution which Cardinal de Lugo provided for the Catholic moral tradition was a greater clarification of the distinction between the positive formulation of the obligations necessary to preserve life (namely, the ordinary means of preserving life) and the negative formulation of the actions a person was not required to perform in order to preserve his life (namely, the extraordinary means of preserving life). Cronin’s assessment of de Lugo showed the latter’s firm conviction that the positive requirements to preserve the great good of human life using ordinary means were absolutely necessary, and a refusal to use them was the moral equivalent to suicide. De Lugo made his conviction clear in the following paragraph:

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12 Thomas J. O’Donnell, S.J., Medicine and Christian Morality, 3rd ed. (NY: Alba House, 1996), 56. O’Donnell credited De Lugo for seeing past the barrier of intense pain from amputation to a future time when, due to proper anesthetics, pain would no longer be a significant factor in such a procedure. See also Atkinson, “Theological History of Catholic Teaching on Prolonging Life,” 101. Atkinson commented that “the question at issue here is whether certain mutilations can become obligatory, as being necessary for life or health. De Lugo holds that such a mutilation is obligatory, provided that it can be accomplished without intense pain.”

[A] man must guard his life by ordinary means against dangers and death coming from natural causes … because the one who neglects the ordinary means seems to neglect his life and therefore to act negligently in the administration of it, and he who does not employ the ordinary means which nature has provided for the ordinary conservation of life is considered morally to will his death.14

De Lugo then examined the limits of the human person’s responsibility to conserve his life. He offered a clear distinction between the death of a person because of inadequate use of the ordinary means (which was a moral violation) and the death of a person resulting from a decision not to use an extraordinary means (which was not a moral violation). De Lugo reasoned that a human person’s life was not the greatest good, namely, something to be preserved at all costs; hence, a decision to only use ordinary means is morally acceptable. He stated that one

is not held to the extraordinary and difficult means … the “bonum” of his life is not of such great moment … that its conservation must be effected with extraordinary diligence: it is one thing not to neglect and rashly throw it away, to which a man is bound: it is another, however, to seek after it and retain it by exquisite means as it is escaping away from him, to which he is not held; neither is he on that account considered morally to will or seek his death.15

His analysis of the extraordinary means considered the various options available to prolong one’s life, ranging from the use of expensive foods and medicines to the taking or abstaining from wine,16 all of which he deemed not morally obligatory.

In the midst of this treatment of the extraordinary means, however, a third important contribution of de Lugo emerged. He introduced the concept of proportional benefit, in which, within the domain of an ordinary means of preserving life, circumstances could exist which effectively rendered such a means extraordinary. Using the example of a man surrounded by fire and facing certain death by that fire, de Lugo illustrated the concept of proportional benefit.17 The man in the fire has at hand, in de Lugo’s scenario, enough water to extinguish part of the fire, but not all of it, and if he used the water to quench some of the fire, his certain death would be delayed only a short time. In this case, the crucial element that determines proportional benefit is whether or not there exists a reasonable hope of recovery or continued life for an extended period of time, not simply a few extra moments. Ultimately, de Lugo reasoned that if a proposed action, medicine, or food, even if ordinary in itself, provided no significant assistance to the preservation of life, i.e., no proportional benefit, such a means was extraordinary and, therefore, nonobligatory. In short, the principle that emerged from this new theological insight was one that would have significant ramifications for moralists who later assessed the proportional benefit of providing AAHN to PVS patients: namely, that no one was obligated to employ a useless means.18

14 Ibid., in Cronin, The Moral Law, 63.
15 Ibid., in Cronin, The Moral Law, 63–64.
17 De Lugo, Disputationes Scholasticae et Morales, n. 30.
18 Connery, “Prolonging Life,” 155. Richard A. McCormick, S.J., among other Catholic theologians, argued from this position regarding the provision of AAHN to PVS pa-
The next addition which honed the Catholic moral tradition regarding ordinary and extraordinary means involved an assessment regarding the level of pain required before a means became extraordinary. The seventeenth century theologian H. Tournely posed the question of the person who did not want to undergo treatment that entailed suffering even moderate pain to conserve his life, and asked if such an individual could be forced to undergo such treatment. He responded, as later theologians also did, that a treatment involving extreme pain did not impose an obligation on a person. However, a person did have the duty to accept a proposed treatment offering only moderate pain, and he could be forced to submit to it by those caring for him. Tournely concluded that the suffering of moderate pain with such treatment did not contain a moral impossibility, and thus it would constitute an obligatory means to conserve a person’s life. This determination would be particularly useful in the modern health-care arena, in which the availability of effective anesthetics can reduce nearly all pain to manageable levels.

By the middle of the nineteenth century, speculation began regarding the use of induced sleep to relieve the intense pain of amputations and other surgeries. John Gury and other theologians questioned the obligation of a person to accept an operation if the experience of pain would be absent due to some form of artificially induced sleep. While the advent of anesthesia would provide the benefit of eliminating or greatly reducing the pain associated with medical treatments of this type, Gury ultimately concluded that the unknown dangers of an induced sleep, the loss of reason for an extended period of time, and the overall uncertainty of the sleep-inducing procedure made it an extraordinary means of conserving life. The use and reliability of anesthetics aside, late-nineteenth-century theologians also considered the major surgery of amputation likely to constitute an extraordinary means, because of the difficulty inherent in living with its after-effects, i.e., subjective repugnance, in addition to the surgery itself. Gerald Kelly quotes Palmieri, who said:

In his book *The Critical Calling*, McCormick presented the reasoning of Daniel Callahan. McCormick remarked that “when all is said and done … Callahan allows cessation of nutrition-hydration for those frail elderly who are ‘imminently dying’ and for those who are ‘not dying but are irreversibly comatose, utterly vegetative.’ For this latter category, nutrition and hydration simply confer no benefit. ‘There is no meaningful life of any kind—it is a mere body only, not an embodied person. Thus there is nothing left that would deprive such a patient of something valuable.’” Richard A. McCormick, S.J., *The Critical Calling: Reflections on Moral Dilemmas since Vatican II* (Washington, DC: Georgetown University Press, 1989), 377.


Theologians are speaking of the intense pains of amputation. But what if the use of an anesthetic removes the pain? Could we not still say that the serious inconvenience of living with a mutilated body would just as readily excuse the patient from undergoing the amputation as would the very intense pains that last only a short time?\(^{21}\)

The hesitancy among early twentieth century moral theologians to acknowledge the effectiveness and reliability of anesthetics slowly gave way to a gradual acceptance of their advantages, largely through the efforts of Dr. C. Capellmann, who promoted the advances of medical science at that time and applied the tenets of moral theology to them.\(^{22}\) The result was that the status of certain operations like amputation, which nearly always were accorded extraordinary status due to pain or difficulty, became less automatically pronounced as such. The theological assessment of H. Noldin and A. Schmitt in 1941 illustrated this modification in thought:

> Today the suffering is vastly decreased through narcotics, the danger of infection is very remote, and moreover success is more frequent and assured, and even for amputated members, there are artificial limbs—and therefore, at least where certain danger of death would very probably be avoided through an operation, it does not seem that it can be called an extraordinary means, unless there is great subjective horror of it.\(^{23}\)

Up to this point, the general consensus of moral theologians was that man is obliged to take the ordinary means to preserve his life, but is not obliged to use extraordinary means, unless some demand of the common good enters into the picture. All agreed that means which would involve extreme pain, significant danger of death, excessive expense, or great subjective repugnance were to be classified as extraordinary.\(^{24}\)

However, by the middle of the twentieth century, the rapid growth of available treatments in the medical field, the advent of more readily obtainable medicines, and improved medical facilities brought about a transformation in the character of health care. Of particular note were the advances made through use of artificial life-support technology. Modern medical techniques required theologians to speculate on the new moral questions raised by advanced medical technology, as well as on the increasing complexity their use caused for the determination of ordinary and extraordinary means of conserving life.

Gerald Kelly, S.J., in his timely 1950 article, “The Duty of Using Artificial Means of Preserving Life,” drew attention to the critical issues and questions posed by modern medical advances, with specific emphasis on artificial life-sustaining technology and the impact it had on the ordinary and extraordinary means of conserving life.


human life. Interestingly, Kelly’s assessment of the challenges confronting moral theology by 1950s medical care could, with a few additions, easily be reiterated today. He commented:

Our age abounds in artificial means of preserving life: e.g., incubators, blood transfusion, oxygen tents and masks, iron lungs, highly technical operations, insulin, and various other stimulants and medications. The formulation of some definite rules concerning the duty of using these artificial means is not merely intriguing speculation; it is also—if I may judge from the many questions asked me—a practical necessity.25

Moral theologians in the latter half of the twentieth century have been faced with the daunting task of applying the Catholic moral tradition regarding the preservation of human life within the context of the many stunning advances in medical technology, particularly the provision of artificial life support. In a few instances, notably in the early part of the twentieth century, a position had been put forward which stipulated that anything not natural was automatically extraordinary, and therefore a nonobligatory means of conserving human life.26 This determination, however, seemed to be somewhat simplistic, given the ease of obtaining and using some artificially produced medicines and procedures. O’Donnell commented that

It would lead to a position wherein the modern antibiotics, by the mere fact that they are artificially produced and administered, would be considered extraordinary means of preserving life. Moreover, although we must note and remember for future consideration that there is a valid distinction between natural and artificial means, still the artificial is not to be considered as wholly distinct from the natural. The advances of modern science are due fundamentally to the development of the natural potentialities of civilized man living in society, with each generation building on the discoveries and achievements of the last, as is evidently in accord with the rational nature of man. Thus it is inauspicious to say that surgery, intravenous feeding, radiation therapy, and the like, are extraordinary means, because they are, in themselves, artificial and unnatural. They are not properly considered in themselves, but rather must be viewed in their historical context.27

Kelly supported a proposal that classified all artificial means of sustaining life as a remedy for a particular disease or illness. The distinguishing characteristic of a remedy was that an individual might employ it as a useful means toward recovering


26 See Joseph B. McAllister, Ethics, with Special Application to the Medical and Nursing Professions, 2nd ed. (Philadelphia, PA: W. B. Saunders, 1955), 175. See also Cronin, The Moral Law, 91. A contradictory position can be found as far back as Francisco de Vitoria. Daniel Cronin wrote that Vitoria understood that “medicines and drugs—in fact artificial means in general—are intended by nature to supplement the natural means of conserving life. They are intended to help man to conserve his life when the use of merely natural means, such as food, sunshine, rest, etc., are not sufficient because of the individual’s physical condition.” In this way, according to Cronin’s assessment of Vitoria, artificial means could be obligatory.

from or halting a disease. However, a person incurred no obligation to use a remedy unless it offered a “reasonable hope of success” pertaining to the cure or alleviation of some aspect of a disease.28 The example he used was a person breathing with supplemental oxygen. He remarked that “It is one thing to use oxygen to bring a person through a crisis; it is another thing to use it merely to prolong life when hope for recovery is practically negligible.”29 The heart of Kelly’s position pertaining to artificial means of preserving life concluded that, based upon a “prudent, human evaluation,” the degree to which a particular means cured or controlled a disease determined whether it was ordinary or extraordinary. Simply because a means to preserve life was not completely natural did not mean that it automatically became extraordinary.30 Cronin agreed. He remarked that, “the terms artificial means and extraordinary means are not coextensive. An artificial means can be an ordinary means of conserving life.”31

To conclude this brief historical overview, it can be noted that Gerald Kelly provided a helpful definition of the ordinary and extraordinary means of conserving life. His definition formulated the ordinary and extraordinary means in such a way that each was completely exclusive from the other. Atkinson summarized Kelly, saying,

In other words, to call a means nonobligatory one must, using Kelly’s new definitions, call the means extraordinary. Ordinary = obligatory, extraordinary = per se optional, and these two equations are justified by reducing the obligatory nature of means to their being easily obtained and employed and their offering reasonable hope of benefit.32

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28 Kelly, “The Duty of Using Artificial Means of Preserving Life,” 213–214. John Connery questioned the use of the phrase “reasonable hope of success” used by Kelly. He said: “The question I would raise, tying this point to the previous one is this: Could one ever in the case of terminal illness, even though someone were not a grave burden, discontinue feeding him because there was not a ‘reasonable hope of success’ if he were fed normally? While most would consider this to be active euthanasia, it would seem possible to accept it within traditional Catholic thought, i.e., if natural means can sometimes be extraordinary, and extraordinary means are determined at times by usefulness, why not discontinue natural means if they are useless?” in Connery, “Prolonging Life,” 222.


31 Cronin, The Moral Law, 94. He further stated: “God intends the development of science for the good of man. When science can provide a means of conserving man’s life which can be a supplement to a natural means, then this artificial means would seem to be obligatory. It is true, however, that whereas natural means in general are ordinary means, artificial means of conserving life can quite often be extraordinary means and thus not obligatory. When artificial means are ordinary means, then they are obligatory.”

In this way, Kelly sought to reduce ambiguities that might affect the practical application of it in a moral determination. For him, the ordinary and extraordinary means were best defined in the following way:

Ordinary means are all medicines, treatments, and operations, which offer a reasonable hope of benefit and which can be obtained and used without excessive expense, pain, or other inconvenience.

Extraordinary means are all medicines, treatments and operations, which cannot be obtained or used without excessive expense, pain, or other inconvenience, or which, if used, would not offer a reasonable hope of benefit.33

These definitions were the result of the four-hundred-year tradition of the Church, and at the same time, they possessed the capacity to assess the techniques and treatments of modern medicine.

Clarifying the Ordinary and Extraordinary Means

The work of Cronin further sharpened the distinction between ordinary and extraordinary means of conserving life and even more completely illustrated the importance of the individual in his fullness (i.e., to include physical condition, mental and emotional state, etc.) as the integral cog in these determinations. In assessing Kelly’s definitions, Cronin concluded that they seemed too focused upon clinical procedures, and thus were not broad enough to include other means of conserving life. In Cronin’s estimation, it was also incumbent upon a comprehensive definition to include the concept of reasonable difficulty when weighing ordinary means, thereby demonstrating the belief that while a moral impossibility makes a particular action extraordinary, a reasonable difficulty did not. Finally, the addition of the other major elements that make up ordinary and extraordinary means enabled him to formulate the following definitions:

Ordinary means of conserving life are those means commonly used in given circumstances, which this individual in his present physical, psychological and economic condition can reasonably employ with definite hope of proportional benefit.

Extraordinary means of conserving life are those means not commonly used in given circumstances, or those means in common use which this individual in his present physical, psychological and economic condition cannot reasonably employ, or if he can, will not give him definite hope of proportionate benefit.34

introduces the principle of totality into the discussion and maintains that perhaps we should consider the patient’s total condition before we decide whether a given means is ordinary or extraordinary. Thus, for example, he sees the possibility of a diabetic with terminal cancer not taking insulin as perhaps an extraordinary means. He also emphasizes that we must consider the rights and duties of relatives and physicians when evaluating whether a given means of conserving life is ordinary or extraordinary.”


Cronin was quick to point out that these definitions were not absolute norms. Accordingly, the individual person was the only one with the ability to accurately assess the benefits or burdens of a particular means, for the simple reason that each person experienced the effects of a particular treatment, operation, or medicine differently. What might be an ordinary means of conserving life for one person could be extraordinary for someone else. Kelly noticed this problem earlier when he remarked that:

The foregoing definitions do not avoid all difficulties. There is always difficulty in estimating such factors as “excessive,” “reasonable hope,” “proportional benefit,” and so forth. But this difficulty seems inherent in all attempts to make human estimates, and it is doubtful that we can ever attain to a formulation that will entirely remove this problem.

Cronin did, however, examine each of the essential elements of the ordinary and extraordinary means of conserving life, to clarify the terms as sharply as possible.

Within the domain of the ordinary means of conserving human life, Cronin delineated five categories that made a particular aspect of health care or medical treatment ordinary and therefore obligatory:

1. Hope of a beneficial result (*spes salutis*): The heart of this requirement was that any means to conserve life, whether natural or artificial, even common means like food and water, must offer a proportional benefit for those means to acquire obligatory status. This benefit, based on the observations of de Lugo (i.e., the analogy of the man condemned to fire) “must be worthwhile in quality and duration. Furthermore, it must be worthwhile in consideration of the effort expended in using the means.”

2. Common use of means (*media communia*): Nearly all moral theologians from Vitoria to the present referred in one way or another to the requirement that the means used to conserve life be common. This stipulation applied to all aspects

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35 Cronin, *The Moral Law*, 128. See also 102, where he explained the difficulty of establishing an absolute norm, particularly for the ordinary means. He remarked: “There are many factors in this notion of relativity. For example, the age of an individual … The person’s physical and psychological condition … His financial status …” See also O’Donnell, *Medicine and Christian Morality*, 62–64.

36 Kelly, “The Duty to Preserve Life,” 550–551. See also Kevin O’Rourke and Dennis Brodeur, *Medical Ethics: Common Ground for Understanding*, vol. 2 (St. Louis, MO: Catholic Health Association, 1989), 127–128. They comment that “the theologians developing the Catholic tradition in regard to prolonging life did not seek to remove decisions of conscience from ailing individuals. Thus they did not compile a list of ‘objective means’ that were too painful, expensive, difficult, or embarrassing for everyone. Neither did they seek to determine what would constitute ‘a significant length of time’ to prolong life. Rather, they determined some generic reasons that would justify the choice of a good that indirectly led to death and called upon people to make the required specific applications.”


38 Ibid., 100.
of care, ranging from food to medicine to living conditions, even to the level of attention one gave to the preservation of his or her life. The care one owed to the preservation of human life did not extend beyond normal conscientious observance. The relative nature of determining what precisely constituted “common” in this sense was based upon the subsequent pillar of the ordinary means.

3. According to social position (secundum proportionem status): The factor of social status was intended to indicate the available economic resources possessed by a particular patient, which could heavily affect the idea of what precisely “common” would comprise for such an individual. There were limits, however, to what even wealthy people would be required to do to preserve their lives.39

4. Means not too difficult to obtain or use (media non difficilia): The conclusion reached by moral theologians determined that the operative concept here was that the means could not be excessively difficult to obtain, if a person were to remain obligated to employ them. “They clearly state, however, that a moderate difficulty does not constitute an extraordinary means. Furthermore, from a study of their writings, one cannot say that the moralists teach that the terms “difficulty” and “ordinary means” are mutually exclusive.”40 This caveat applied to the acquisition of necessary foods and medicines, and also to enduring pain and the risk of the treatment, to name a few.

5. Means are easy to obtain or use (media facilia): Closely connected to, but less often used by moral theologians than media non difficilia, was the concept of media facilia. At its heart, the term signified that the means employed by an individual to conserve his or her life should be able to be obtained or used with a reasonable amount of convenience. Cronin pointed out that this did not imply that no difficulty whatsoever should be involved in using such means, but that the term “reasonable” was closer to the intended meaning of the phrase “easy to obtain or use.”41

The elements gleaned from the Catholic moral tradition regarding the extraordinary means of conserving life were likewise categorized by Cronin into five major areas:42

1. Certain impossibility (quaedam impossibilitas): The theological principle used by Cronin and other moral theologians was based upon the understanding that one was not always required to do a positive good; in this case, the human person was not always bound to conserve his life at all costs. Hence, the presence of a moral or physical impossibility, namely, a difficulty of sufficient


41 Ibid., at 99–112. See also Atkinson, “Theological History of Catholic Teaching,” 110–111.

magnitude to warrant a nonobligatory status relative to the condition of the patient, was enough to classify the difficulty as an extraordinary means of conserving life. In this instance, as with the other elements that made up the ordinary and extraordinary means of conserving life, the crucial decision must lie with the person experiencing the difficulty.43

2. Great effort or too difficult (summus labor and media nimis dura): This guideline affirmed that while a person was obligated to expend reasonable levels of effort in the preservation of his life, any effort that extended beyond the level of reasonable to the excessive would be classified as extraordinary.

3. Unbearable suffering and pain (quidam cruciatus and ingens dolor): The intense experience of pain and suffering, relative to the condition of the individual person, was nearly always cited as grounds to declare a particular treatment, operation, or type of care a moral impossibility. While the introduction of anesthetics has lessened the overwhelming presence of pain in the present age, the presence of pain and suffering remains a significant factor that must be assessed on a person-by-person basis.

4. Unreasonable expense (sumptus extraordinarius, media pretiosa, and media exquisita): According to an individual’s social status or financial well-being, the issue of excessive expense, relatively calculated, has been advanced by centuries of moralists as an extraordinary means.

5. Unreasoning fear or repugnance (vehemens horror): The final category that denoted a moral impossibility pertained to instances in which a particular medical action produced intense levels of fear or disgust in the mind and heart of a patient. Under the circumstances in which a particular individual was so completely overcome with fear or repugnance, a procedure of this nature could become extraordinary.44

Further Developments regarding the Ordinary and Extraordinary Means

The conclusion of the overview of the ordinary and extraordinary means of conserving life, specifically as it pertains to the PVS patient, is not complete without a momentary look at two major developments that have sprung from it. The first development within the tradition of the ordinary and extraordinary means came from the address by Pope Pius XII on the moral implications of prolonging life. In his remarks, mentioned above, the Pope directly addressed the obligations of a person to conserve his life. Because of its importance, his statement is worth repeating here:

[N]ormally one is held to use only ordinary means—according to circumstances of persons, places, times, and culture—that is to say, means that do not involve any grave burden for oneself or another. A more strict obligation would be too burdensome for most men and would render the attainment of the higher, more important good too difficult. Life, health, all temporal activi-


ties, are in fact subordinated to spiritual ends. On the other hand, one is not forbidden to take more than the strictly necessary steps to preserve life and health, as long as he does not fail in some more serious duty.\footnote{45}

This statement—in particular, the Pope’s mention of “the attainment of the higher, more important good” and the subordination of life to “spiritual ends”—became a focal point from which theologians argued the extraordinary, and therefore non-obligatory, character of providing AAHN to patients in conditions diagnosed as PVS.\footnote{46}

Kevin O’Rourke, O.P., held this position and stated:

Pope Pius XII, when speaking about life support systems, declared: “Life, health, all temporal activities are in fact subordinated to spiritual ends.” Thus, when the potential for spiritual function is no longer present, then it seems that all treatment or care efforts which would sustain physiological function are ineffective.\footnote{47}

The second important development within the Catholic moral tradition of the ordinary and extraordinary means of conserving life occurred due to confusion arising from the manner in which the health-care community used the terms, in contrast to the traditional theological meaning of the terms. Bryan Jennett’s understanding of the ordinary and extraordinary means of conserving life highlighted the difficulty between the medical and theological confusion. He commented:

Since the Pope’s 1957 declaration that physicians are normally obliged to use only ordinary means to preserve life, there have been debates about how to distinguish these from extraordinary treatments. Initially ordinary was taken to mean generally available and widely used, whilst extraordinary would include advanced technological methods that were scarce and expensive.\footnote{48}

\footnote{45} Pius XII, “The Prolongation of Life,” 395–396. See also Russell E. Smith, “Ordinary versus Extraordinary Means,” in Ethical Principle in Catholic Health Care, ed. Edward J. Furton (Boston, MA: The National Catholic Bioethics Center, 1999), 90. Smith states that “[i]n these four sentences, the Holy Father has summarized and ratified the theological tradition regarding the distinction between ordinary and extraordinary means. He does not embrace the ‘clinical’ definition of ordinary means as entirely normative for ethical evaluation. Rather, the Pope understands the distinction to be determined by the relevant circumstances of the case in its clinical and personal dimensions.”


\footnote{47} O’Rourke, “Should Nutrition and Hydration Be Provided,” 188. Other theologians disagreed with the interpretation given to Pius XII’s 1957 statement. Among those who disagreed is Orville Griese, “Pope Pius XII and ‘Medical Treatments,’” Linacre Quarterly 54.4 (November 1987): 43–49.

\footnote{48} Bryan Jennett, The Vegetative State: Medical Facts, Ethical and Legal Dilemmas (West Nyack, NY: Cambridge University Press, 2002), 105. Paul Ramsey proposed, particularly in the case of incompetents, a shift in terminology from “ordinary” and “ex-
In an attempt to clarify the distinction between what the medical community understood as the definitional characteristics of the terms *ordinary* and *extraordinary*, described by Jennett, and the theological understanding, which was significantly more nuanced than simple ease or difficulty in application, the Congregation for the Doctrine of the Faith (CDF) responded with its 1980 *Declaration on Euthanasia*. The declaration proposed that the terms used by moral theologians and medical personnel should shift away from the *ordinary-extraordinary* distinction, which had recently become a source of misunderstanding, to a different set of terms that would be more specific. The document indicated that

In the past moralists replied that one is never obliged to use “extraordinary” means. This reply, which as a principle still holds good, is perhaps less clear today by reason of the imprecision of the term and the rapid progress made in the treatment of sickness. Thus some people prefer to speak of “proportionate” and “disproportionate” means.

In any case, it will be possible to make a correct judgment as to the means by studying the type of treatment to be used, its degree of complexity or risk, its cost and the possibilities of using it, and comparing these elements with the result that can be expected, taking into account the state of the sick person and his or her physical and moral resources.\(^{49}\)

In this way, the CDF offered the terms *proportionate* and *disproportionate* as a substitute, to avoid the confusion that had crept into the application of the terms *ordinary* and *extraordinary*. Instead of centering attention on the treatment alone as common and inexpensive or technologically advanced and expensive, as had been the practice within the medical community, the Catholic moral tradition pointed to more comprehensive guidelines. As O’Donnell indicated, the terms *proportionate* and *disproportionate* were not intended to classify means according to “a consideration of the therapeutic measures considered in themselves, but rather considered ‘relatively’ to the condition and circumstances of the individual patient.”\(^{50}\)

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\(^{49}\) Congregation for the Doctrine of the Faith, *Declaration on Euthanasia* (May 5, 1980), *Origins* 10.10 (August 14, 1980): 156. See also Smith, “Ordinary versus Extraordinary Means,” 89–90. As far back as Augustinus Lehmkuhl, S.J., the distinction between the theological understanding of the ordinary and extraordinary means and the medical interpretation of the same has been a part of the Catholic tradition. Fr. Lehmkuhl maintained that a person need not undergo a treatment involving pain, horror, or revulsion, even if that treatment was medically considered an ordinary means of conserving life. See Cronin, *The Moral Law*, 81; and Augustinus Lehmkuhl, *Theologica Moralis*, 10th ed. (Freiburg-im-Breisgau: Herder, 1902), 345.

The Obligatory or Optional Classification of AAHN

Generally, every group concerned with health-care issues has agreed that the provision of basic nursing care was an aspect of medical care owed to all patients, including the PVS patient. The universally accepted elements that constituted basic nursing care included simple actions or articles required to maintain personal hygiene and dignity; for example, proper clothing, temperature control, cleanliness, and even food and water for those who could consume them orally. Basic nursing care was considered, by all accounts, an aspect of medical care that should always be provided to patients regardless of the severity of their condition. Nevertheless, the specific characteristics of AAHN made it difficult to determine whether it should be classified as an aspect of normal care or as a medical treatment. Because the purpose of AAHN was to deliver food and fluids, many ethicists, lawyers, and medical personnel concluded that it was simply an aspect of the normal care owed to any patient; however, others determined that the requirement of skilled medical professionals to administer AAHN necessarily made it a medical treatment. In the end, although some in the Catholic tradition maintained that the provision of AAHN was obligatory because it was an example of basic care, several documents issued under the umbrella of the Church hierarchy in America ultimately determined that the nature of AAHN was not the critical factor that made AAHN provision obligatory or optional.

51 Both the Pontifical Academy of Sciences and the Pontifical Council for Pastoral Assistance considered the provision of AAHN an example of normal care. See Pontifical Academy of Sciences, “The Artificial Prolongation of Life,” Origins 15.25 (December 5, 1985): 415. The original document can be found in Enchiridion Vaticanum, IX (Bologna, Italy: Edizioni Dehoniane Bologna, 1987), 1727, n. 1768. See also Pontifical Council for Pastoral Assistance, Charter for Health Care Workers (Boston, MA: Daughters of St. Paul, 1995), n. 120.

The Determination of Catholic Moral Theology regarding AAHN

At the most basic level, the heart of the Catholic moral tradition regarding the proper care of the PVS patient has sought to determine whether AAHN was an ordinary (proportionate) means of preserving life, or whether it should be considered an extraordinary (disproportionate) means of preserving life. Thus, leaving aside the question of whether AAHN was believed to be an aspect of basic nursing care or a medical treatment, the fundamental reason why its provision was determined to be obligatory centered on the assessment that AAHN was an ordinary means of conserving life. For some Catholic organizations and theologians, the provision of food and water, whether delivered orally or through a feeding tube, was an aspect of basic nursing care on a par with hygienic measures, clothing, and proper temperature control. 52 Within this concept was the understanding that as long as food and water...
accomplished its intended purpose, namely, maintaining the life of the patient, it was an ordinary means of conserving life. Only under the specific circumstances in which a patient was imminently dying or the body could no longer assimilate nourishment would it become optional. Thus, to remove AAHN from a PVS patient whose life could be easily maintained by the provision of food and fluids was to withdraw an ordinary means of sustaining life and, as a consequence, to directly intend the death of the patient by dehydration.53

Later attempts of bishops’ committees to address the issue of AAHN provision to PVS patients used a slightly different approach. Instead of resting their argument on the contention that AAHN was an example of basic care that must nearly always be provided to patients, these documents contended that the distinction between “treatments,” which may be discontinued, and “care,” which must be continued, did not offer a complete resolution to the problem, because both terms remained subject to the norms of ordinary and extraordinary means. Hence, as one document stated, “Whether it is viewed as treatment or care, it would be morally wrong to discontinue nutrition and hydration when they are within the realm of ordinary means.”54 From this later perspective, the key to determining whether the provision of AAHN to a PVS patient was morally obligatory or morally optional was to assess the benefits and burdens associated with its provision. The Pennsylvania bishops concluded that the provision of AAHN to PVS patients was clearly beneficial because it fulfilled the purpose for which it was given, namely, to sustain life. At the same time, the bishops determined that the provision of AAHN in these circumstances was not seriously burdensome, because it could be administered easily and with negligible amounts of pain or suffering.55 Serious consideration was given to the charge that the excessive economic burdens of providing AAHN to a PVS patient made it an extraordinary means of preserving life; however, although these later documents acknowledged the


serious financial burdens of caring for PVS patients, the U.S. Bishops’ Pro-Life Committee believed that other options were available to make the cost of caring for PVS patients more manageable.\textsuperscript{56} Both the Pennsylvania bishops and the U.S. Bishops’ Pro-Life Committee advanced the belief that adequate assistance was available to make the provision of AAHN to PVS patients a financially affordable decision, especially in a society as affluent as the United States. The Pennsylvania bishops stated: “However, in the society in which we live this does not present a fully convincing argument. Resources are available from other sources, and these can often be tapped before a family reaches dire financial straits. Such assistance has been and continues to be available.”\textsuperscript{57}

\textsuperscript{56} U.S. Bishops’ Pro-Life Committee, “Nutrition and Hydration,” 708. They stated: “The difficulties families may face in this regard, and their need for improved financial and other assistance from the rest of society, should not be underestimated. While caring for a helpless loved one can provide many intangible benefits to family members and bring them closer together, the responsibilities of care can also strain even close and loving family relationships; complex medical decisions must be made under emotionally difficult circumstances not easily appreciated by those who have never faced such situations: “Even here, however, we must try to think through carefully what we intend by withdrawing medically assisted nutrition and hydration. Are we deliberately trying to make sure that the patient dies in order to relieve caregivers of the financial and emotional burdens that will fall upon them if the patient survives? … Does my decision aim at relieving the patient of a particularly grave burden imposed by medically assisted nutrition and hydration? Or does it aim to avoid the total burden of caring for the patient? If so, does it achieve this aim by deliberately bringing about his or her death?” See also William E. May et al., “Feeding and Hydrating the Permanently Unconscious and Other Vulnerable Persons,” \textit{Issues in Law and Medicine} 3.3 (Winter 1987), 210. The authors commented: “The question remains whether providing food and water in this way to these patients is excessively burdensome because of its cost. At the outset we make two critical points. First, the cost of providing food and fluids by enteral tubes is not, in itself, excessive. Such feeding is generally no more costly than other forms of ordinary nursing care (such as cleaning or spoon-feeding a patient) or ordinary maintenance care (such as the maintenance of room temperature through heating or air conditioning). Second, one must also take into account the benefits that such care may provide both to the patient and to the caregivers.” See also William E. May, \textit{Catholic Bioethics and the Gift of Human Life} (Huntington, IN: Our Sunday Visitor Press, 2000), 268–269. He stated: “We granted that the total cost of caring for PVS patients (providing them with a heated room, nursing care, etc.) could be quite great, but that in our affluent society, which provides similar care for other persons in severely compromised positions (e.g., those who must be institutionalized because of chronic but non-fatal illnesses, etc.), it would be unfair and unjust to deprive the permanently unconscious of their fair share.”

It can be observed, therefore, that the Catholic moral stance regarding the
decision to provide or withhold AAHN from PVS patients was based upon the crite-
ria that are used to make the distinction between ordinary and extraordinary means
of conserving life. The specific factors involved in the provision of AAHN to PVS
patients led the majority of the American Catholic hierarchy to conclude that, based
upon the current level of medical science, providing food and fluids to the PVS
patient served a life-sustaining purpose that outweighed the minimal burdens that
accompanied it, thus making it an ordinary means of conserving life that must be
continued. While the distinction between the ordinary and extraordinary means of
conserving life necessarily contained some subjective elements (the experience of
excessive pain and suffering or financial concerns), not all of which were considered
applicable to an irreversibly unconscious patient, the primary focus of the Catholic
moral tradition was centered upon the benefit or burdensomeness of the particular
treatment, in relation to the condition of the patient. In this manner, the Catholic
moral tradition advocated an assessment process that took into consideration the
specific circumstances of each patient, while at the same time holding to an objective
decision-making framework. Thus, if a proposed treatment was deemed ordinary,
there was a moral requirement to employ it; if a proposed treatment was deemed
extraordinary, an option existed whether to apply it or not.

Although the publicly stated goal of both the Catholic Church and the American
medical community regarding the care of patients is to provide effective medical care
to treat a patient’s injury or disease, it would seem that, in the case of the PVS
patient, the decision of the Catholic Church to promote the provision of AAHN to
sustain the patient’s life is more in line with respect for the person than is a position
that advocates the removal of AAHN so that the patient will die. In the end, because
the evidence regarding the PVS patient’s level of inner awareness is inconclusive, the
decision to withhold or withdraw AAHN from a permanently unconscious patient
comes too close to the abandonment of a person who cannot be cured. The position
taken by the Catholic Church in relation to seriously ill patients has held that “the
health-care worker who cannot affect a cure must never cease to treat.”58 Within the
context of the PVS patient, the decision to treat through the delivery of AAHN is not
an example of a vitalistic approach to health care that intends to maintain life at all
costs. Rather, it is based on an assessment that the non-dying patient can benefit
from the provision of food and fluids that will sustain his life. At the same time, the
AAHN given to the PVS patient is not determined to be excessively burdensome to
receive, either in terms of pain, cost, or complexity. In the event that AAHN delivery
was believed to be excessively burdensome for the PVS patient, or if he could no
longer assimilate the nutrients provided to him, it would probably no longer be an
obligatory treatment.

The decision to provide AAHN to the PVS patient is ultimately grounded in an
acceptance of the limitations placed upon the human person’s autonomy by God,
and compassion for a seriously debilitated patient who requires care. In the first

58 Pontifical Council for Pastoral Assistance, Charter for Health Care Workers,
n. 64.
place, it acknowledges that God is the master of life, and that even though existence in a PVS is perceived to be undesirable, the decision to remove AAHN to bring about the death of the patient lies outside the parameters for human action. Second, the decision to sustain the life of a PVS patient by providing AAHN involves a decision to recognize the value of a vulnerable patient’s life and to remain in solidarity with him.\footnote{Congregation for the Doctrine of the Faith, \textit{Declaration on Euthanasia}, 156. The Congregation stated that “According to Christian teaching, however, suffering, especially suffering during the last moments of life, has a special place in God’s saving plan; it is in fact a sharing in Christ’s passion and a union with the redeeming sacrifice which he offered in obedience to the Father’s will.”} The true meaning of compassion, based upon love, involves maintaining contact with a suffering or seriously debilitated patient in the midst of his condition; compassion does not attempt to end the life of a patient because his continued existence is distressing. The decision to withhold or withdraw AAHN from PVS patients advances the belief that some lives are not worth preserving. In contrast, the decision to provide AAHN to PVS patients recognizes the incalculable worth of the human person and the intrinsic good of his life, regardless of his condition. In the end, the Catholic moral tradition considers no human life valueless.