We have received a number of comments on Pope John Paul II's March 20, 2004, statement on "Life-Sustaining Treatments and the Vegetative State: Scientific Advances and Ethical Dilemmas." They are arranged below in the order in which they were received.—Ed.

PVS versus the Dying Process

Initial reading of Pope John Paul II's address to the International Congress on "Life-Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas" (March 20, 2004) can be very disturbing. However, upon re-reading and reflection on the pope's statements, it is apparent that his address will be subject to misinterpretations and plagued with countless incorrect inferences. It must be borne in mind at all times that the pope's remarks refer exclusively to the use of AHN (artificial hydration and nutrition) in PVS (persistent vegetative state) patients. The misuse of these remarks will lead to confusion if intentionally extended to other medical conditions in which treatment with AHN may be utilized, e.g., terminal illness with death imminent.

It is critical to note that AHN does not refer to a single medical-treatment procedure. AHN can fall into one of four different classifications: 1) a supplemental or adjuvant treatment; 2) a temporary facet of acute life-support treatment; 3) an extraordinary medical treatment; or 4) a part of normal care. The word "artificial" does not apply to hydration and nutrition but applies to the means of delivery, i.e., the PEG tube (percutaneous endoscopic gastrostomy), through which liquids and solids are introduced into the gastrointestinal tract.

The pope's statements refer exclusively to normal care of PVS patients. A patient in PVS is not in the dying process. A patient with incurable metastatic cancer, unable to swallow liquids or solids, is in the dying process. AHN in this situation, i.e., terminal cancer, prolongs the dying process and thus would be classified as extraordinary medical treatment without medical benefit. Patients with incurable, terminal illnesses are not morally obligated to employ extraordinary medical means that do not provide any medical benefit. This is the important distinction between prolonging death in a terminal illness and preserving life in PVS.

Providing hydration and nutrition by spoon-feeding a patient is ordinary care. The surgical insertion and chronic use of a PEG tube to provide AHN should be considered as an alternative form of normal care for patients capable of being spoon-fed when death is not imminent. In PVS patients, it is not appropriate to classify AHN as a form of extraordinary medical treatment or even as ordinary medical treatment. The PEG tube takes the place of the spoon in providing hydration and nutrition, and thus the PEG becomes a substitute for the spoon as part of the normal care of a patient. Providing normal care to PVS patients in the form of AHN is in harmony with the true task of medicine, i.e., to cure if possible, but if unable to cure, to control the disease and always to care. The Christian aim is likewise always to care but never to kill. In PVS patients, failure to provide AHN, which is classified as a substitute form of normal care, would constitute euthanasia by omission as stated by the pope.

If a patient is in the dying process due to an incurable disease or irreversible trauma and not able to be spoon-fed due to the pathology of the disease or trauma, then the use of PEG for AHN becomes an extraordinary medical treatment. In these circumstances, it would be totally inappropriate to apply state-

ments made by the pope in his address on PVS to formulate moral inferences on the use of AHN in the palliative treatment of patients who are in the dying process due to terminal illness or trauma.

Ralph P. Miech, M.D., Ph.D.
Associate Professor Emeritus
Division of Biology and Medicine
Department of Molecular
Pharmacology, Physiology, and
Biotechnology
Brown Medical School
Brown University
Providence, Rhode Island

The Landscape of Dialogue

There are at least two reasons to believe that the recent papal allocution, "Life-Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas" (March 20, 2004), on the use of artificial hydration and nutrition (AHN) with patients in a persistent vegetative state (PVS) will generate more discussion on the topic rather than resolve a dispute.

First, at present its meaning appears unclear to such an extent that an outside observer who read the initial interpretations of the allocution that theologians have offered might wonder whether they are all discussing the same document.

On the one hand, there are those who note (some with dread, others with glee) that the allocution apparently reverses some basic Catholic norms or at least traditions of applying ethical principles. They ask questions like: Why was the principle of double effect not acknowledged? Are economic factors being removed from consideration of the burdens that may determine whether a treatment is extraordinary? Is the distinction between artificial and natural means—so important in the arena of sexual teachings—being dissolved or blurred? On the other hand, some have argued that the allocution changes very little. They observe that the statement pertains to patients in a PVS and that most patients receiving AHN have other diagnoses (e.g., severe stroke or end-stage Alzheimer's disease). They suggest that the statement might amount to little other than a reiteration of the traditional teachings that patients always maintain their dignity, euthanasia is wrong, and there should be a presumption in favor of providing AHN as long as it is beneficial and not overly burdensome.

Second, the context of this exercise in interpretation is contributing to the passion with which different parties disagree. It is occurring in the context of a Church that has developed across centuries a sophisticated framework and language for discussing end-of-life issues, yielding a sense that such issues should be settled on a case-by-case basis using well-established principles and norms.

Moreover, in the United States the discussion is occurring in the context of a very active health-care ministry dedicated to both healing and palliative care. This health-care setting presents not only deep concerns with the possibility that euthanasia could be practiced, but with the possibility that patients will have treatments they consider futile or overly burdensome (including financial burdens and the burden of not being allowed a natural death) forced upon them; or alternately, that Catholic hospitals will be required to transfer the care of patients to secular institutions in order to avoid battery.

Finally, these fears are exacerbated by the fact that in the United States, in contrast to many European nations, we are more likely to begin life-sustaining treatments on a time-limited basis rather than to decide to withhold treatments on the vague grounds that they are not indicated. This makes our end-of-life decisions—especially decisions to withdraw treatment—more public, drawn out, and emotionally charged.

Time will tell whether this landscape contributes to a dialogue more closely resembling Babel or Pentecost.

James M. DuBois, Ph.D., D.Sc.
Associate Professor of Health Care Ethics
Center for Health Care Ethics
Saint Louis University
St. Louis, Missouri

Gratitude and Caution

Rome has finally spoken, and it is with enthusiasm that I greet the Holy Father's allocution, "Life-Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas" (March 20, 2004), on the use of assisted hydration and nutrition (AHN) in patients with persistent vegetative state (PVS). It should come as a great relief for many, perhaps a challenge for some, that we now have the most definitive papal statement to date concerning assisted nutrition of these unfortunate persons. The core elements of the statement are unambiguous, and for the vast majority of PVS patients, this form of care is proportionate and a moral necessity. The pope's ethical and philosophical reasoning, rooted in the dignity of the human person, regardless of circumstances, is in my opinion beyond dispute.

However, a word of caution is in order. It is critical to distinguish PVS patients from other persons suffering from an array of other progressive and terminal diseases, including end-stage dementia and advanced malignancy; persons who, in fact, may not benefit in the least from tube feeding. This primarily medical question requires ongoing scientific study and good clinical judgment. It will take well-trained clinicians familiar with the current literature and their own reflective personal experience to advise patients and families well. When doubt of benefit exists the physician should still advocate for the utilization of AHN. I think that is the most prudent course of action. However, if the clinician is convinced such care would be ineffectual at prolonging survival or providing comfort, he is ethically obligated to share this medical judgment with compassion. Ignoring the fact that in some disease states AHN is not helpful, perhaps even painful, does a great disservice to those entrusted to the doctor's care.

So, we now have much for which to thank the Holy Father. Again he has lifted our hearts and minds to recognize the inherent dignity of all human life. With renewed fervor, physicians and researchers should seek knowledge as it relates to AHN in a variety of common medical disorders. Reliable data on patient survival and the relief of symptoms as desired endpoints in the use of AHN will be of great assistance to all. Undoubtedly, such information will guide clinicians as they care for the suffering in their midst, a truly noble calling.

Greg Burke, M.D., F.A.C.P.
Geisinger Medical Center
Danville, Pennsylvania

The Wisdom of Tradition

The recent papal statement on the care of patients in the persistent vegetative state and the use of artificial hydration and nutrition, "Life-Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas" (March 20, 2004), has potentially wide-ranging implications for clinical ethics and for patient care. Since it is much less formal than an encyclical or an apostolic letter, the rigor of the theological reasoning employed in the allocution is somewhat less exacting than one would find in other Vatican statements on matters of faith and morals. Therefore, while one can anticipate much debate, the demand for interpretation of this allocution will necessarily exceed the capacity of the medium employed to meet that demand. This will lead to frustration and may, unfortunately, raise more questions than can be answered.

In the meantime, three points are worth noting. First, the words of the Holy Father may serve as a call to clean up our language. The words we use, particularly our metaphors, help to shape our attitudes. As Psalm 115 says of those who create idols (even linguistic ones), "their makers shall be like them." To imply that any human being is a vegetable is horrific. It is this attitude that seems most to disturb Pope John Paul II (as it should every Christian). This suggests that we should begin to work to change the name of the diagnostic category. In Australia, such an undertaking has resulted in the perfectly apt term, "post-coma syndrome." Perhaps Catholic health-care professionals and ethi-

cists could help to start similar conversations in the United States and in other nations.

Second, it is absolutely vital for all moralists considering these questions to appreciate that Catholic moral thinking is based upon a living *tradition*. Those who genuinely subscribe to a tradition know that the outcome of a debate is far less important than fidelity to that tradition. For those who are faithful to a tradition, the tradition is more important than the issue at hand, more important than any political agenda, more important than any individual opinion.

Genuine questions have arisen about the moral necessity of using feeding tubes in persons suffering from the post-coma syndrome, and some of these touch at the very core of a centuries-old tradition of Catholic thinking about health care. A living tradition, of necessity, will often be *extended* as new cases arise and new challenges are met. But a true tradition ought never to be *subverted* for the sake of winning an argument. Given the way that the contentious issues about nutrition and hydration involve central tenets of the Catholic moral tradition in health care, there is a real danger that this tradition might, in fact, be devitalized in the course of the present debate. Nothing could be more antithetical to the Catholic approach to morality—and so we must proceed with the utmost caution. This will involve meticulous intellectual honesty and the eschewing of all attempts to disguise significant deviations from the tradition as mere extensions of the tradition. Our zealotry must be for the Church and its traditions, and for the Gospel of Jesus Christ, and never for any cause, however noble it may appear, except as that cause serves Christ's Gospel and Christ's People.

Finally, to aid our reflection, we should allow ourselves to be guided by the ancient wisdom of the Church. As Boethius once prayed in the sixth century, "with God's true help, I will temperately find the middle way of Christian Faith" (*Contra Eutychen et Nestorium*). The answers to these vexing questions will require such Catholic wisdom. And as we think about the role of medicine in our lives, St. Basil the Great, writing in the fourth century, reminds us:

> Whatever requires an undue amount of thought or trouble or involves a large expenditure of effort and causes our whole life to revolve, as it were, around solicitude for the flesh must be avoided by Christians.... Therefore, whether we follow the precepts of the medical art or decline to have recourse to them ... we should hold to our objective of pleasing God and see to it that the soul's benefit is assured, fulfilling thus the Apostle's precept: "Whether you eat or drink or whatsoever else you do, do all to the glory of God." (*The Long Rules,* ch. 55)

Daniel P. Sulmasy, O.F.M., M.D., Ph.D.
St. Vincent's Hospital–Manhattan
New York Medical College
New York, New York

A Clear Papal Teaching

In this allocution, "Life-Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas" (March 20, 2004), Pope John Paul II authoritatively teaches that ANH is to be provided to patients in a vegetative state, including those whose condition is considered permanent. He states that the supply of food and water, even when medically assisted, "always represents a natural means of preserving life, not a medical act," which is aimed at "providing nourishment to the patient and alleviation of his suffering" (n. 4). He considers the preservation of the lives of unconscious patients as a benefit to them, and counters arguments presented by those "who cast doubt on the persistence of the 'human quality' itself" in such patients (n. 3). In a similar vein, he rejects arguments that favor the discontinuance of ANH based on a patient's quality of life as "introducing into social relations a discriminatory and eugenic principle" (n. 5).

The pope reaffirms the traditional teaching of the Church that ordinary (proportionate) means to preserve life are morally obligatory while extraordinary (disproportionate) means are not obligatory. He employs the traditional criteria used to determine whether means are ordinary and extraordinary—availability and

ratio of benefit to burden, and presents an authoritative assessment of the benefits and burdens related to the medically assisted supply of nutrition and hydration to unconscious patients. He concludes that ANH is an ordinary (proportionate) means and, therefore, morally obligatory.

In reaching this conclusion, the Holy Father does not depart from or revise a five-hundred-year old teaching of the Church. Instead, he applies that teaching to the current question and reaches a very different conclusion from those who have been interpreting and applying the Church's teaching incorrectly. The pope goes on to point out that it is immoral to discontinue ANH when the described benefits are present. "Death by starvation and 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" (n. 4).

This conclusion does not preclude the discontinuance of ANH to every patient. If in a particular case ANH is unable to preserve life or alleviate suffering it would lack the beneficial effect for which food and water are supplied and would be futile. Various state Catholic conferences, individual bishops, and the USCCB Pro-Life Activities Committee "agree that hydration and nutrition are not morally obligatory either when they bring no comfort to a person who is imminently dying or when they cannot be assimilated by a person's body" (*Ethical and Religious Directives for Catholic Health Care Servives*, introduction to part V). These examples are compatible with the papal teaching outlined above.

The papal teaching stands as the most authoritative interpretation of the proper application of traditional Catholic moral principles to the question of supplying ANH to PVS patients. It is addressed to the Universal Church and is the norm by which any existing or future directives concerning this question must be interpreted. A case in point is directive 58 of the *Ethical and Religious Directives*, which states: "There should be a presumption in favor of providing nutrition and hydration to all patients, including patients who require medically assisted nutrition and hydration, as long as this is of sufficient benefit to outweigh the burdens involved to the patient."

Although the U.S. bishops may wish to revise directive 58 to make explicit reference to the Pope's recent allocution and incorporate some of its language, it is absurd to suggest that the papal teaching is not normative in the United States until the U.S. bishops offer their interpretation of the papal teaching and revise directive 58. The Pope's teaching is itself the authoritative interpretation of the relative benefits and burdens of ANH to PVS patients, and, therefore, of the meaning of directive 58. According to the papal teaching, the medically assisted supply of nutrition and hydration to vegetative-state patients may not be withheld or withdrawn in any Catholic facility when it preserves life or alleviates suffering.

This teaching should be reflected in all institutional policies so that all personnel and anyone being admitted to a Catholic health-care facility would understand that the institution will not comply with any request to discontinue ANH in the circumstances already identified. The Patient Self-Determination Act acknowledges the right to formulate institutional policies that protect individuals and institutions from complying with any living will or durable power of attorney which might make this or any other request contrary to Catholic moral teaching.

Msgr. Kevin T. McMahon, S.T.D.
The John Cardinal Krol
Chair of Moral Theology
Saint Charles Borromeo Seminary
Archdiocese of Philadelphia
Overbrook, Pennsylvania

An End to the Debate?

The Holy Father's address, "Life-Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas" (March 20, 2004), is most welcome. One hopes that it ends the debate that has gone on for over two decades among Catholic theologians, philosophers, and bishops regarding the obliga-

tion to provide persons in the "persistent vegetative state" with tubally administered food and hydration. The central passage in his address is the following:

> The sick person in a vegetative state, awaiting recovery or a natural end, still has the right to basic health care (nutrition, hydration, cleanliness, warmth, etc.) and to the prevention of complications related to his confinement in bed. He also has the right to appropriate rehabilitative care and to be monitored for clinical signs of eventual recovery.
>
> 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 and until it is seen to have attained its proper finality, which in the present case consists in providing nourishment to the patient and alleviation of his suffering. (n. 4)

I believe that the position taken by our Holy Father is basically the same as that set forth in1992 by the bishops of Pennsylvania and by the Committee for Pro-Life Activities of the National Conference of Catholic Bishops. These statements, filled with references to the medical literature, gave ample evidence that these bishops were familiar with the *medical facts*, and the same is true of the statement by John Paul II. All explicitly note that persons in the "persistent vegetative state" are *not* in danger of dying from some underlying pathology. This contrasts sharply with the 1990 statement of the Texas bishops on this issue, which affirmed that persons in this condition suffer from a "fatal pathology" and that therefore providing them with food and hydration by tubal means is not morally obligatory. Their document made no references to the medical literature.

In another passage (n. 4), the Holy Father declares: "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."

What John Paul II says here is true. Nonetheless, those bishops and Catholic moralists who, prior to the Holy Father's statement, claimed that it was not obligatory to provide food/hydration by tubal means to PVS patients, did not withhold such nourishment as a means of killing these people. They mistakenly thought that these were suffering from a fatal pathology and that feeding them in this way prolonged the dying process. Now they should know better.

Some theologians justifying withholding/withdrawing of tubally assisted nutrition/hydration based their view on an interpretation of a passage from Pius XII's 1957 address to a congress of anesthesiologists. In it he said: "normally one is held to use only ordinary means [to prolong life] … that is, means that do not impose any grave burden for oneself or another. A stricter obligation would be too burdensome … 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."[1] The claim was that this meant that any treatment which does not *enable* a person to pursue the spiritual goal of life is therefore extraordinary and not obligatory.

Obviously, John Paul II does not agree with this interpretation of the teaching of Pius XII, and rightly so. Were this view true, it would mean that one would not be obliged to prevent a trisomy 13 baby from dying from a cut artery by stopping the bleeding. Such a baby is not and never will be able to pursue the spiritual goal of life, nor will prolonging its life by stopping the bleeding from the artery *enable* it to pursue this goal, but surely this is ordinary and nonburdensome treatment.

Pope John Paul II's March 20 address was necessary and helpful.

William E. May, Ph.D.
Michael J. McGivney Professor
of Moral Theology
John Paul II Institute
for Studies on Marriage and Family
at The Catholic University of America
Washington, D.C.

[1] "The Prolongation of Life," November 24, 1957, *Pope Speaks* 4.4 (1958): 395–396.

The Benefits-and-Burdens Ratio

The Holy Father in his allocution "Life-Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas" (March 20, 2004), given to the participants at the Conference on Life-Sustaining Treatments and Vegetative State, affirmed the everlasting value and personal dignity of every living human being at all stages of their lives irrespective of their state of health or mental functioning. In this affirmation, the Holy Father happily upheld the Hippocratic philosophical tradition, which has guided all Christian physicians in their medical practice from apostolic times to the present. He clearly understood that the "vegetative state" was an acceptable term and a summarizing description when used by physicians.

This term succinctly encapsulates the description of a very complicated and poorly understood irreversible pathological change in the brain of an individual who has suffered loss of the oxygen supply to the brain for a period of over seven minutes. Such loss results in the irreversible death of the cells of the cerebral cortex but permits continued life of cells in the thalamus, the putamen, and the brain stem, i.e., the anatomically lower parts of the brain, which for convenience are collectively called "the vegetative" part of the brain. These parts of the brain control all the involuntary movements of the body such as heartbeat, respiration, digestion, urine formation, etc.

The pope weighs in on a medical problem regarding the cause of death for the individual in the persistent vegetative state from whom the artificial administration of nutrition and hydration is withdrawn. The death of the cerebral cortical cells sustained by the patient prevents any voluntary muscular movement, so that the individual can never move food to his mouth by hand and arm movements. The vegetative individual can never chew food because the muscles of mastication do not function. The vegetative individual cannot make any movements with the tongue to put a food bolus to the back of the oral cavity and into the esophagus where the vegetative function of peristalsis guides the thoroughly chewed food bolus down the esophagus and into the stomach. This is incurable and is a fatal pathological condition.

As the pope rightly indicates, the physiological outcome is dehydration and starvation, but it must be understood that this is caused by the individual's fatal pathological condition. Happily the pope affirmed what physicians have held for many years, that no one individual human being can ever judge "the quality of life" of another individual human being. The pope also says, supporting fully what physicians have long been saying, that society must provide resources for the care of patients in the persistent vegetative state as well as psychological support for their families and respite care for their immediate care givers.

In this allocution the pope quotes various Vatican documents. He does not refer to Pope Pius XII's Allocution to an International Congress of Anesthesiologists[1] or to the *Declaration on Euthanasia* issued by the Congregation for the Doctrine of the Faith (1980). In November 1957, Pius received the members of the International Association of Anesthesiology. Dr. Bruno Haid, its president, asked Pius whether it would be licit to withdraw use of a respirator in treating a patient with a fatal disease if death of the patient would follow immediately. Pius stated that it was perfectly licit to withdraw this artificial means of providing oxygen to the patient. He said that continued use of the respirator by a patient with a fatal disease while preserving a human good of great value, i.e., continuous physical life, did prevent the patient's obtaining his *telos*, i.e., the final and greatest good for the human being, namely everlasting life with God in glory. Pius's teaching on medical-moral matters was in conformity with continuous church teaching begun by Domingo Bañez, O.P. (1528–1604), in the sixteenth century, specifically, that a physician is obligated always to give ordinary treatment but is never obligated to give extraordinary treatment. Pius said: "Normally one is held to use only

[1]Pope Pius XII, Allocution, "Le Doctor Bruno Haid" (November 24, 1957), AAS 49 (1957), 1031–1032.

ordinary means according to circumstances of person, places, times, and culture—that is to say, means that do not involve any grave burden for oneself or another."

Since 1957 the definition of ordinary in medical treatment has changed. What was considered by physicians as extraordinary treatment in 1957, such as plasmaphoresis, organ transplantation, kidney dialysis, etc., is considered ordinary in 2004! The Congregation for the Doctrine of the Faith recognized this change. Its *Declaration on Euthanasia* suggested that patients and their physicians should evaluate the burdens and benefits of any treatment when considering continuance or withdrawal. The Congregation indicated that if burdens outweighed the benefits, one could licitly forgo or discontinue it. It also required consideration of any burdens from the standpoints of patient, the patient's family, and the patient's society.

In 1998, Pope John Paul said to the bishops of the southwestern U.S., during their *ad limina* visit, that "a great teaching effort is needed to clarify the substantive moral difference between discontinuing medical procedures that may be burdensome, dangerous, or disproportionate to the expected outcome and the taking away of the ordinary means of preserving life such as feeding, hydration, and normal medical care." In this statement he did not define the means of feeding and hydration, i.e., natural or artificial. The pope also has indicated that the burdens-benefit ratio must be considered in continuing or discontinuing medical treatments. In *Evangelium vitae*, issued in 1995, he wrote (n. 65):

> Certainly there is a moral obligation to care for oneself and to allow oneself to be cared for, but this duty must take account of concrete circumstances. It needs to be determined whether the means of treatment available are objectively proportionate to the prospects for improvement.

The Holy Father's silence on the teaching of Pope Pius XII and of the *Declaration on Euthanasia* of the Congregation for the Doctrine of the Faith indicates that this teaching is still valid. Thus, it is clear that patients or their surrogate decision makers mindful of the pope's allocution on the persistent vegetative state, still may judge initiating treatment, continuing treatment, or withdrawing treatment on the basis of its burdens/benefits ratio. This knowledge will go a long way in relieving many Catholics in the United States, who, hearing of the Holy Father's allocution on the persistent vegetative state, wondered whether their advance directives lawfully actualized would be still honored in a Catholic health facility. Not an inconsiderable number, especially those in the geriatric age group, have contacted their physicians to inquire about this. Fortunately the Catholic Health Association in the United States has already requested the ethicists and theological advisors of its Mission and Theology division to consider the impact the allocution will have on the practices of care at the end of life in Catholic health-care facilities.

Presently the advice that Rev. Michael Place, president of the Catholic Health Association U.S.A., has given is to continue to follow the *Ethical and Religious Directives for Catholic Health Care Services* last issued by the United States Conference of Catholic Bishops in 2001.[2] The current *Directives*, as judged by many Catholic health-care ethicists, support fully the Holy Father's directives in his allocution and also allow for discontinuation of treatment based upon an unfavorable burdens-benefits ratio.

The bishops' Pro-Life Committee said in 1992: "Such measures as nutrition and hydration must not be withdrawn in order to cause death, but they may be withdrawn if they offer no reasonable hope of sustaining life or pose excessive risks or burdens." In the 2001 edition of the ERDs, the introduction to part 5 is certainly consonant with the Holy Father's allocution. "These statements (those on artificial feeding) agree that hydration and nutrition are not morally obligatory either when they bring no comfort to a person who is imminently dying or when they cannot be assimilated by a person's body."

---

[2]Michael Place, Catholic Health Association of the United States of America, "Ethics Statement on the March 20, 2004, Papal Allocution" (March 27, 2004).

The Holy Father in his allocution says:

> The administration of water and food, even when provided by artificial means, always represents a *natural means* of personal life, not a *medical act*. Its use should be considered, in principle, *ordinary* and *proportionate* and as such morally obligatory, insofar as and until it is seen to have attained its proper finality, which in the present case consists in providing nourishment to the patient and alleviation of his suffering (n.4; original emphasis).

John Collins Harvey, M.D., Ph.D.
Center for Clinical Bioethics
Georgetown University Medical Center
Washington, D.C.

The Dignity of the Person

The recent allocution of Pope John Paul II on life-sustaining treatment and the vegetative state has, as anticipated, brought the question of artificial hydration and nutrition for persons in vegetative states to the immediate forefront of an important international debate. Worldwide developments which have systemically diminished human dignity, for example, legalized euthanasia, the physician-assisted suicide movement, and the withdrawal of care and treatment of the vulnerable ill, represent violent acts against the dignity of the human person, and, indeed, upon all humanity.

The Holy Father's position needs to be carefully, thoughtfully, and thoroughly examined in light of continuing scientific discoveries in medicine and nursing so that the interaction between faith, moral reasoning, and science remains inseparable in protecting and defending the dignity of the human person, especially when this person is made vulnerable by reason of illness or disability. It is this first principle of the Catholic moral tradition, that is, the protection of the dignity of the human person, that must never be violated or lost in the details of the clinical debates when determining care and treatment for the sick. The centuries-old doctrine of human dignity serves a unique dual role in health care: it provides the moral, ethical, and scientific framework which guides critical analyses of clinical issues while at the same time remaining as the *telos* of medicine and health care.

Threaded through the Holy Father's statement is the persistent and constant theme which has marked his pontificate, that is, the value and dignity intrinsic to every human person regardless of the circumstances of the person's life or the reason for illness. While the allocution is specifically directed toward the consideration of life-sustaining care and treatment of persons in persistent vegetative states, the document has a much wider and universal mission. It is explicitly calling all of us (ethicists, bishops and other clergy, physicians, nurses, ethics committees, families, and patients) entrusted with the serious moral responsibility (not simply a gentle reminder or admonition) to provide care and treatment for the sick with the understanding that no illness ever diminishes the intrinsic dignity and value of the human person. Regardless of the reason for his illness or his decisional capacity, a living person, as Pope John Paul II notes, is never less than fully human.

If the doctrine of human dignity is only casually applied in caring and treating persons who are seriously ill, how are we then to care for those who are victims of discrimination, stigmatized and marginalized because of lifestyle, color, ethnicity, age, and reason for their illness, who have the capacity to speak but whose voices remain unheard? Those who ask us for hope and healing number in the hundreds of millions. Their human dignity is at risk every day. They live a lifetime in a culture of vulnerability.

The allocation of health-care services built on the respect for the dignity of the human person in the current culture, which espouses the commodification of the human person, is a daunting challenge. The influence and power of the technological imperative in health care, profitability in health services, the creep of impersonal ethical paradigms which influence health-care decisions, escalating costs of health care, and increasing numbers of persons who are uninsured or

underinsured, remains an ever-present threat to human dignity. The appropriate development of a moral conscience, both in those who are sick and clinicians who have promised to help and to heal them, is also compromised in this culture. Such a culture selectively affirms persons who matter and discriminates against others because of their socio-economic status, age, color, ethnicity, gender, or diagnoses as useless, burdensome.

Pope John Paul II has challenged the health-care community, and indeed all humankind, to live out the moral act to protect and defend human life from the moment when this life is created until God brings this life back to Him. This life is God's creative act.

The application of the doctrine of human dignity requires clinicians and all others who participate in health-care decisions to continually reexamine the direction of their moral compass and focus on the question "who do we really care about?" This is one of the most fundamental questions emerging from the Holy Father's allocution. How this challenge is embraced and applied in light of caring for persons diminished in any way by reason of illness will speak loudly about how we are willing to care for one another and indeed ourselves.

Bro. Ignatius Perkins, O.P.,
D.N.Sc., M.A.Ed., R.N.
Professor and Chair, School of Nursing
Dean, College of Health
and Natural Sciences
Spalding University
Louisville, Kentucky

An Authoritative Teaching

John Paul II's March 20, 2004, address to the participants of the International Congress, "Life-Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas," comes as welcome news to many Catholic ethicists and theologians. Those of us who have argued for the position the Holy Father now articulates have been handicapped for years by the lack of consensus on the part of the U.S. bishops. Theologians such as Fr. Kevin O'Rourke, O.P., have drawn upon the 1990 statements of Bishop John Leibrecht of Missouri and (most of) the Texas bishops to argue that it is morally permissible to withdraw medically assisted hydration and nutrition from patients in the so-called PVS (persistent vegetative state).

The views of the sixteen Texas bishops, however, were vigorously challenged by a number of bishops and theologians. In an article published in his diocesan paper, Bishop René Gracida of Corpus Christi (one of the two Texas bishops who refused to sign the 1990 Texas statement) listed fourteen objections, including the lack of clear guidance on what type of burdens would render medically assisted hydration and nutrition optional.

Early in 1992, the Pennsylvania bishops released a detailed statement titled *Nutrition and Hydration: Moral Considerations* that stood in stark contrast to the position taken by the sixteen Texas bishops. In one memorable line, the Pennsylvania bishops noted that in some cases the removal of hydration and nutrition from PVS patients amounted to "euthanasia by omission." Some ethicists thought this was an extreme conclusion, but now we find the Holy Father in his address referring to the deliberate withdrawal of nutrition and hydration for PVS patients as "euthanasia by omission."

On April 2, 1992, the Pro-Life Committee of the U.S. bishops issued a statement titled *Nutrition and Hydration: Moral and Pastoral Considerations*, which spoke of the "the presumption" in favor of "providing medically assisted nutrition and hydration to all patients who need them." This statement leaned in the direction of the Pennsylvania bishops, but still left enough room for theologians such as Father O'Rourke to argue that his position had not been authoritatively rejected. Moreover, the guidance given in the *Catechism of the Catholic Church* (n. 2276–2279) limited itself mostly to general moral principles, and the question as to whether medically assisted hydration and nutrition was treatment or care was not resolved.

With such a state of affairs, the Holy Father could have decided to allow the issue further time for study and reflection, or to provide direction in virtue of his ministry as the supreme bishop who "confirms his brethren in their faith" (cf. Lk 22:32 and *Lumen Gentium*, n. 25). He chose the latter course, and he made it clear that "the administration of food and water, even when provided by artificial means, always represents a *natural means* of preserving life, not a *medical act*" (original emphasis). This was intended to remove nutrition and hydration from the category of medical treatment that could be considered "extraordinary." The next line of John Paul's allocution makes this even clearer when he teaches that the supply of such food and water "should be considered, in principle, *ordinary* and *proportionate*, and as such morally obligatory, insofar as it is seen to have attained its proper finality, which in the present case consists in providing nourishment to the patient and alleviation of his suffering" (original emphasis). What Father O'Rourke and others describe as morally optional, the Holy Father describes as morally obligatory. There can be no doubt that John Paul II wished to take a clear side on this theological debate.

What is the authority of the Pope's teaching? According to Catholic ecclesiology, it should be understood as an exercise of the ordinary papal magisterium as described in *Lumen gentium*, 25. There is nothing in the language used by John Paul II to suggest he was making a definitive, infallible, or *ex cathedra* pronouncement. *Lumen gentium*, 25, however, notes that even when the Roman pontiff is not speaking *ex cathedra*, the judgments expressed by him (*sententiis ab eo prolatis*) are to be received with a "religious submission of will and intellect" (*religiosum voluntatis et intellectus obsequium*). This means that such papal judgments are "to be sincerely adhered to according to his manifest mind and will, which are known especially by the character of the documents, by the frequent repetition of the same doctrine, or by his manner of speaking."

The pope's manner of speaking leaves little room for doubt that he wishes to affirm the type of analysis provided by the Pennsylvania bishops in 1992 and by other prelates such as Bishop Elio Sgreccia, vice-0resident of the Pontifical Academy for Life, and Cardinal Dionigi Tettamanzi, archbishop of Milan. While an address does not claim as wide a distribution as an encyclical or an apostolic letter, it nonetheless represents an authentic exercise of the ordinary papal magisterium. The Holy Father, moreover, was speaking directly to the issue of hydration and nutrition for patients in the PVS state. His comments, therefore, represent the official papal teaching on the subject. He has now confirmed the teaching he wishes the college of bishops to take on this issue.

In light of this authoritative papal judgment, I find the analysis of the March 20 papal address posted on the website of the Catholic Health Association (CHA) to be highly questionable. The CHA continues to understand the papal statement as something requiring "further study and discussion" rather than "religious submission of will and intellect." Rather than announcing that Catholic hospitals and nursing homes need to formulate their policies in light of what the Roman pontiff has taught, the CHA presents a chart opposing "Church Teaching Until Now" with the "Papal Allocution." But what the CHA presents as "Church Teaching Until Now" was the position of certain theologians and bishops, not the entire Catholic Church! The Roman Pontiff has now given a clear judgment on the issue, which, according to *Lumen gentium*, n. 25, is to be sincerely adhered to according to his manifest mind and will. Let us hope the CHA will conduct its "further study and discussion" with the pope's March 20, 2004, address as the authoritative point of reference on the subject.

Robert Fastiggi, Ph.D.
Associate Professor
Systematic Theology
Sacred Heart Major Seminary
Detroit, Michigan

The PVS Is Not Necessarily Fatal

John Paul II's recent statement, "Life-Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas" (March 20, 2004), will not be adequately appreciated if it is seen only as an attempt to resolve the specific question of the morality of providing medically assisted nutrition and hydration (MANH) to patients who have been diagnosed as being in a persistent vegetative state (PVS). Rather, to fully appreciate the statement's contribution, it must be seen as part of an ongoing effort to maintain a coherent and consistent understanding of what it means to allow patients a "natural death"; its message is, in fact, a repetition of the established tradition in Catholic biomedical ethics that the treatment of patients at the end of life must avoid two extremes, both a) passive euthanasia; and b) "therapeutic tyranny," the immoral prolongation of the dying process.[1]

If this statement is interpreted in this way, then it is hard to understand it as either breaking with or extending the tradition in any significant sense. It is rather a classic exercise in casuistry in Catholic biomedical ethics. Based on its understanding of the nature of the medical condition known as PVS (and thus open to revision should the medical understanding of PVS significantly change), it applies the classic principle of ordinary versus extraordinary treatment to the provision of MANH for such patients.

A weakness of the statement is its brevity. The appropriateness of the provision of MANH to patients is always "patient-dependent," that is, always dependent upon whether the provision of MANH will benefit a specific patient in his specific medical condition. One can legitimately fear that some readers will take this statement—which specifically focuses on PVS patients—to be an argument about the provision of MANH for patients who are dying, and this would be most unfortunate. It is important to recognize that the statement only pertains to one specific class of patients, albeit an important one.

I believe John Paul II has singled out the issue of withdrawing or withholding MANH from PVS patients (and not providing alternative methods of delivering food or fluids to them) because much of the theological literature on the subject is confused and convoluted. Much of the rationale for withdrawing MANH from PVS patients arises from the (often unargued and) erroneous claim that they are properly classified as dying patients. If this erroneous claim is accepted, then withdrawing MANH may seem to be merely a matter of not unduly extending the dying process. Once it is understood that MANH patients cannot be neatly classified as dying, this (otherwise legitimate) rationale for withdrawing MANH in some cases collapses.

In a recent article, I have summarized the kinds of arguments typically put forward to justify the withdrawal of MANH from PVS patients.[2] The strongest justification is the appeal to "excessive burden." This appeal clearly concerns John Paul II, as evidenced by the penultimate section in his statement.

But what most concerns John Paul II in this statement are those situations in which MANH is removed from PVS patients, not because the treatment is seen to have no

[1]"Contemporary medicine, in fact, has at its disposal methods which artificially delay death, without any real benefit to the patient. It is merely keeping one alive or prolonging life for a time, at the cost of further, severe suffering. This is the so-called 'therapeutic tyranny,' which consists in the use of methods which are particularly exhausting and painful for the patient, condemning him in fact to an artificially prolonged agony.

This is contrary to the dignity of the dying person and to the moral obligation of accepting death and allowing it at least to take its course. Death is an inevitable fact of human life: it cannot be uselessly delayed, fleeing from it by every means." Pontifical Council for Pastoral Assistance, *Charter for Health Care Workers* (Vatican City, 1995), n. 119.

[2]John Berkman, "Medically Assisted Nutrition and Hydration in Medicine and Moral Theology: A Contextualization of Its Past and Direction for Its Future," *Thomist* 68.1 (January 2004): 89–95.

benefit, but because it is assumed that such patients (and/or such patients' families and/or the wider society) would be better off if such patients were dead. Of course, in many specific cases it may be difficult to discern the intentions of the decision makers with regard to withdrawing MANH from patients. However, in the case of PVS patients, if they are in fact not dying, and if in removing the MANH there is no intention to try to provide them with food or nutritional fluids by other means, then I believe the burden of proof falls on those who make the decision to withdraw MANH from such patients to show that their intention is not indeed passive euthanasia.

John Berkman, Ph.D.
Assistant Professor in Moral Theology
School of Theology and Religious Studies
The Catholic University of America
Washington, D.C.

On a Careful Case-by-Case Basis

At a time of diminished regard for human life, especially vulnerable human life, the Holy Father's recent allocution on "Life-Sustaining Treatment and the Persistent Vegetative State" (March 20, 2004) underscores fundamental convictions that ought to guide the care of such patients. His address reminds all of us of the enduring humanness and the inherent and inviolable dignity of those who are irreversibly unconscious, the dangers of making quality-of-life judgments for others, and the prohibition of directly intending the death of a patient in a persistent vegetative state.

It is precisely these convictions that guide the care of persons in a persistent vegetative state in Catholic health-care facilities across the country. Health professionals and families strive in multiple ways to respect the dignity of these persons, providing them with care appropriate to their needs. They also often anguish over determining the goals of treatment and decisions about life-sustaining treatment.

In addition to reaffirming fundamental convictions, the Holy Father's allocution challenges us to rethink the terminology used to describe these individuals' clinical condition, to always take great care in the diagnosis of the condition, to provide all reasonable opportunities for recovery through rehabilitative efforts, and to offer needed assistance to their families. The Holy Father's observations both affirm the care being provided to these patients in Catholic health-care facilities and call health professionals in these facilities to reflect on the day-to-day care of these patients and their families with an eye toward identifying possibilities for improvement.

Read in the context of previous magisterial statements, it would seem that the papal allocution also calls for a presumption in favor of providing medically administered nutrition and hydration to persons in a persistent vegetative state. In fulfilling this presumption, careful consideration must be given to the benefits and burdens of these measures on a case-by-case basis in order to determine whether they truly fulfill their proper finality. Insofar as they do achieve their proper finality, namely, providing nourishment and relieving suffering, they should be employed.

Finally, a number of questions are raised by the Holy Father's address, questions that will need further study and discussion. Some of these questions are theological, while others are medical, clinical, and legal. This study and discussion will need to take into account scientific and medical data, clinical experience, the law, standards of care, and our long tradition of theological reflection on the duty to preserve life.

Rev. Michael D. Place, S.T.D.
President and Chief Executive Officer
The Catholic Health Association
St. Louis, Missouri