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CATHOLIC ETHICS
IN TODAY'S WORLD

REVISED EDITION

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as humane. Rather, euthanasia and PAS are inhumane, a misguided form of compassion, both final and definitive "solutions" to a medical condition that is usually treatable.

PATIENTS WHO ARE COMATOSE OR IN A PERSISTENT VEGETATIVE STATE

Although advancements in medical technology are generally good, they sometimes force patients, or patients' families, to make complicated and heart-wrenching decisions. For example, what should we do when a loved one is in a coma or, even worse, in a persistent vegetative state? These situations can pose vexing ethical questions for families, particularly when the incapacitated person has not expressed his or her wishes. In the final section of this chapter we begin by discussing an important philosophical question that has particular relevance for the topic at hand: are comatose individuals still human persons and, if so, what level of care is due to them? We then focus on how the Catholic Church has responded to two further, yet closely related, questions that arose during the Terri Schiavo controversy. First, do we have a moral obligation to provide artificial nutrition and hydration (ANH) to a patient in a persistent vegetative state (PVS)? Second, can we withdraw ANH when doctors determine with reasonable degree of medical certainty that the PVS patient will never regain consciousness?

Are comatose individuals still human persons? A patient may be technically alive in the sense that respiration and heartbeat are being maintained through artificial means, but if the patient is incapable, likely permanently, of interpersonal communication, can we really say that he or she is a person in the truest sense of the term?

Physicians have established medical criteria for determining when death has occurred. For example, the Harvard Medical School criteria for brain death includes (1) unreceptivity and unresponsivity to externally applied stimuli, including pain; (2) no spontaneous movement or breathing for a period of at least one hour; (3) no reflexes, indicating a failure of the central nervous system; and (4) two flat electroencephalogram (EEG) tests recorded at six-hour intervals.[14] These or similar criteria are used today to help determine brain death, and

many would argue that personhood ceases when these criteria have been met. But what about situations where the criteria have not been met, at least not completely? Is this individual still a person? Think about situations where an individual is unconscious and does not communicate or manifest any sign of interpersonal relationship, but brain-stem function remains so the person continues to breathe on his or her own and maintains at least minimal biological function, as in the case of persons in a persistent vegetative state. Or what about persons who are in a coma? Most people in a coma are not in a persistent vegetative state nor are they brain dead; they are, in fact, very much alive. The coma may be "light" in the sense that the patient can emerge from it with little or no ill effect, or it may be profound, lasting for years. From an ethical perspective, comatose individuals are persons. They retain the dignity and respect that is rightfully theirs until death has been determined by reasonably defined clinical criteria.

The second question is, what level of care must be afforded to comatose or PVS patients? Once again, Catholic Church teaching indicates that we have a moral obligation to provide nutrition and hydration when they constitute an ordinary means of care, but not when they constitute an extraordinary means of care. But how do we make this determination? One of the most contentious and controversial end-of-life issues today concerns the ordinary or extraordinary nature of ANH for PVS patients. Simply put, is artifical nutrition and hydration morally obligatory for PVS patients and, once begun, can it ever be removed?

The Terri Schiavo case amply illustrates the division of opinion in regard to this important ethical challenge. Terri Schiavo, a woman in her mid-twenties, collapsed at her Florida home in February 1990 and remained in a persistent vegetative state until her death in March 2005. She did breathe on her own during this period and she demonstrated some movement, although most medical experts did not believe these movements were controlled. She was not able to swallow, nor was she capable of interpersonal communication. Early on she was given a PEG (percutaneous endoscopic gastronomy) feeding tube for nutrition and hydration, which she retained, with some brief exceptions,[15] until 2005. In 1998, her husband Michael petitioned the Florida courts to allow for the removal of the tube,

but her parents, Robert and Mary Schindler, objected to this and even offered to become Terri's legal guardians so they could oversee her continued care. The courtroom battles between Michael Schiavo and the Schindlers went on for years. By 2003 the media had picked up the story. The governor and state legislature of Florida became involved in the dispute, as did the U.S. Congress and even the Supreme Court. In the end, the courts upheld Michael's request and on March 18, 2005, the feeding tube was removed for the final time. Terri Schiavo died thirteen days later on March 31.

Aside from the public spectacle it caused, the Schiavo case offers an excellent practical application of issues we have been discussing in the past two chapters. Many people think that if Terri had made it unequivocally known that she did not want to be kept alive artificially, then her wishes should have been respected. This is the principle of self-determination, and in fact it was invoked by her husband Michael, who repeatedly stated that before her incapacitation, his wife had told him that she never wanted to be kept alive by artificial means. Unfortunately, we have no independent confirmation that Terri had expressed this intention. Michael, acting as his wife's proxy, argued that the PEG tube constituted an extraordinary means of care because the burdens of continuing ANH outweighed any benefit it brought. Terri's parents disagreed. They maintained that Terri would have wanted to continue living no matter what. For them, artificial nutrition and hydration was an ordinary means of care that should have been continued until Terri died a "natural" death. Once again, we see that the ethical dilemma was not the use of artificial nutrition and hydration as such, but of whether in this particular case it constituted an ordinary or extraordinary means of care.

So is artificial nutrition and hydration an ordinary or extraordinary means of care for a patient in a persistent vegetative state? In Catholic health care circles this has been a much debated topic. A 1990 pastoral letter published by the Texas Conference of Catholic Bishops claimed that artificial methods of nutrition and hydration for PVS patients were burdensome, and, therefore, not morally obligatory.[16] In 1992, the Pennsylvania Conference of Catholic Bishops reached the opposite conclusion, stating that it was generally obligatory.[17] That same year the U.S. bishops' Pro-Life Committee reached a conclusion similar to that of the Pennsylvania bishops,

although they acknowledged that "legitimate Catholic moral debate continues."[18] Ethicists Benedict Ashley, OP, and Kevin O'Rourke, OP, stressing the Pro-Life Committee's recognition that legitimate debate continues, and interpreting the statement in the Vatican's *Declaration on Euthanasia* that "one cannot impose on the obligation to have recourse to a technique which is already in use but which carries a risk or is burdensome," argued for the moral legitimacy of withdrawing nutrition and hydration.[19] William May disagreed with Ashley and O'Rourke, arguing that since life is an intrinsic good and PVS patients are not suffering from a fatal pathology (they are not actively dying), withdrawing nutrition and hydration from them is never morally permissible.[20] The U.S. Catholic bishops as a whole offered tacit acceptance of removing artificial nutrition and hydration in Directive 58 of the fourth edition (2001) of their *Ethical and Religious Directives for Catholic Health Care Services*:

> There should be a presumption in favor of providing nutrition and hydration to all patients . . . as long as this is of sufficient benefit to outweigh the burdens involved to the patient.[21]

These competing and seemingly contradictory positions were the source of much confusion not only for Catholic health care professionals, but also for the families of patients who were in a persistent vegetative state. Was it permissible to remove ANH from a PVS patient or not? There did not seem to be a definitive answer. Then, in a March 2004 allocution, Pope John Paul II clarified the Church's teaching on the matter by stating that nutrition and hydration constituted an *ordinary* means of care, and thus they could never be interrupted or withdrawn from PVS patients. The pope's words deserve careful attention.

> 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. . . . The obligation to provide the "normal care due to the sick in such cases" includes, in fact, the use

> of nutrition and hydration. The evaluation of probabilities, founded on waning hopes for recovery when the vegetative state is prolonged beyond a year, cannot ethically justify the cessation or interruption of *minimal care* for the patient, including nutrition and hydration. Death by starvation or dehydration is, in fact, the only possible outcome as a result of their withdrawal. In this sense it ends up becoming, if done knowingly and willingly, true and proper euthanasia by omission.[22]

There are three important points to be taken from John Paul II's words. First, he never made any moral distinction with regard to the means of providing nutrition and hydration to a patient, whether PVS or not. This provision can be done either through actual eating and drinking, or through artificial means. The means employed make no difference in a moral sense because the ultimate end of each is to provide nourishment and hydration to the body, a "natural means of preserving life." Second, the pope held that providing nutrition and hydration (whether artificial or otherwise) is in principle an ordinary means of care and thus is morally obligatory. It does not matter that the patient is in a persistent vegetative state and is not expected to recover; the individual needs nutrition and hydration to continue biological life, so under no circumstance can they be stopped or withdrawn. Third, if ANH is ever withdrawn from a PVS patient, the act constitutes euthanasia by omission (failing to do something you should). The reason for this is that one is freely and directly choosing to *not* provide that which is necessary for the continued maintenance of life. Although the pope did not specifically state it, the implication of the allocution is that anyone who chooses, performs, encourages, or assents to the withdrawal of ANH is formally cooperating with an evil act.

In the months following the initial publication of John Paul II's address, the confusion only continued. Many were taken off-guard by the pope's teaching and commentators offered differing interpretations of how it could (and should!) be applied in real-life settings.[23] In July 2005, the U.S. bishops asked the Vatican for clarification of the pope's teaching (John Paul II had died in April of that year) and in September 2007 the Congregation for the Doctrine of the Faith (CDF)

responded by affirming that artificial nutrition and hydration are ordinary means of care and thus their provision is morally obligatory for all PVS patients. The only exceptions to this are when (1) it is physically impossible to provide ANH (for example, in remote places or in situations of extreme poverty), (2) the patient's body cannot assimilate food and water, or (3) the means used to deliver nutrition and hydration cause the patient significant physical discomfort. The CDF also affirmed that because of its ordinary nature, artificial nutrition and hydration may not be removed from a PVS patient even in situations where doctors judge that the patient will never again regain consciousness.[24]

In spite of John Paul II's teaching and the CDF's clarification, the issue is far from settled in the minds of many. Catholic health care professionals may find helpful the recent amendment of Directive 58 in the fifth edition (2009) of the *Ethical and Religious Directives*. The directive now reads:

> In principle, there is an obligation to provide patients with food and water, including medically assisted nutrition and hydration for those who cannot take food orally. This obligation extends to patients in chronic and presumably irreversible conditions (e.g., the "persistent vegetative state") who can reasonably be expected to live indefinitely if given such care.[25]

By amending Directive 58, the U.S. bishops brought the *Ethical and Religious Directives* in line with current magisterial teaching. Today, Catholic health care institutions in the United States have a moral obligation (1) to provide nutrition and hydration to all PVS patients as an ordinary means of care, and (2) not to remove artificial nutrition and hydration from a PVS patient (notwithstanding the exceptions identified by the CDF) even when it is medically certain that the patient will never regain consciousness. In short, the Church's recently clarified teaching upholds the position of Robert and Mary Schindler, Terri's Schiavo's parents. In the eyes of the Church, it is never morally permissible to remove a feeding tube from a PVS patient regardless of the patient's previously expressed wishes, or the substitute judgment of the patient's proxy.

We close our chapters on medical ethics by recalling Christianity's teaching on the mystery of the resurrection, which is foundational to much of this discussion. Christians are baptized into the life, death, and *resurrection* of Jesus. As such, they profess that death is not really the "end" because, just as Christ rose from the dead after his crucifixion, so also will all people be resurrected like him at the Last Judgment. The mystery of the resurrection serves as a reminder that human life is not the be-all and end-all of existence. Earthly life certainly holds great value, but it is not the ultimate value. Eternal life is. Christians are called to always keep in mind the truly relative nature of one's earthly existence, including the medical means used to preserve it, while at the same time maintaining faith and hope in the risen and living Lord.

REVIEW QUESTIONS

1. What is the difference between an ordinary and extraordinary means of care? Which, according to Catholic teaching, is morally obligatory?
2. What important clarifications did the U.S. Catholic bishops make concerning (1) who determines whether a treatment is ordinary or extraordinary, and (2) the ordinary or extraordinary nature of a particular treatment?
3. What is an artificial means of care? Under what conditions is an artificial means of care ordinary? Under what conditions is it extraordinary?
4. What is the difference between euthanasia and physician-assisted suicide (PAS)?
5. What arguments are offered in favor of euthanasia and PAS?
6. Why do the Catholic Church and others argue against euthanasia and PAS?
7. Why did Pope John Paul II teach that one must never withdraw artificial nutrition and hydration (ANH) from a patient in a persistent vegetative state (PVS)?
8. What clarifications did the Congregation for the Doctrine of the Faith make to the teaching that ANH must always be provided to PVS patients?

ENDNOTES

1. This section is adapted from Benedict Guevin, "Ordinary, Extraordinary and Artificial Care," *The National Catholic Bioethics Quarterly* 5, no. 3 (Autumn 2005): 471–79. Used with permission.
2. Gerald Kelley, SJ, "The Duty to Preserve Life," *Theological Studies* 12 (1951): 550–56.
3. Pius XII, "Allocution on Reanimation," *Acta Apostolicae Sedis* 49 (November 24, 1957): 1027–33 (emphasis added).
4. United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 5th ed. (2009), nos. 56 and 57 (emphasis added). In Directive 56, the bishops cite the Congregation for the Doctrine of the Faith, *Declaration on Euthanasia* (1980), Part IV; and John Paul II, *The Gospel of Life* (1995), no. 65.
5. Benedict Ashley, OP and Kevin O'Rourke, OP, *Health Care Ethics: A Theological Analysis*, 4th ed. (Washington, DC: Georgetown University Press, 1997), 428.
6. *Ethical and Religious Directives*, no. 59 (emphasis added). See also the Congregation for the Doctrine of the Faith's *Declaration on Euthanasia*, Part II.
7. William May, *Catholic Bioethics and the Gift of Human Life* (Huntington, IN: Our Sunday Visitor, 2000), 239. In defining the difference between euthanasia and PAS, May cites Timothy Quill, *Death with Dignity: Making Choices and Taking Charge* (New York: Norton, 1993).
8. For more information, see "FAQs about the Death with Dignity Act" available at *http://egov.oregon.gov/DHS/ph/pas/faqs.shtml#whocan*.
9. L. A. Roscoe et al., "Dr. Jack Kevorkian and Cases of Euthanasia in Oakland County, Michigan, 1990-1998," *The New England Journal of Medicine* 343, no. 23 (December 7, 2000): 1735–36.
10. Wesley Smith, "Depressed? Do Not Go See Dr. Kervorkian," Op. Ed., *New York Times*, September 16, 1995.
11. Raymond Devettere, *Practical Decision Making in Health Care Ethics*, 3rd ed. (Washington DC: Georgetown University Press, 2010), 344.
12. The Groningen protocol states, in part, that (1) the diagnosis and prognosis must be certain; (2) hopeless and unbearable suffering must be present; (3) the diagnosis, prognosis, and unbearable suffering must be confirmed by at least one independent doctor; (4) both parents must give informed consent; and (5) the procedure must be performed in accordance with the accepted medical standard. See Eduard

Verhagen and Pieter J. J. Sauer, "The Groningen Protocol—Euthanasia in Severely Ill Newborns," *The New England Journal of Medicine* 352, no. 10 (March 10, 2005): 959–62.

13. American Medical Association, "Code of Medical Ethics—Physician-Assisted Suicide," E-2.211 (emphasis added); available at *http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion2211.shtml.*
14. These criteria are taken from Richard J. Devine, *Good Care, Painful Choices*, 3rd ed. (Mahwah, NJ: Paulist Press, 2004), 202–3.
15. During Terri Schiavo's incapacitation there were short periods when the feeding tube was removed, but it was subsequently reinserted by order of various Florida courts.
16. Texas Conference of Catholic Bishops, "On Withholding Artificial Nutrition and Hydration" (May 7, 1990), *Origins* 20 (1990): 53–55.
17. Pennsylvania Conference of Catholic Bishops, "Nutrition and Hydration: Moral Considerations" (January 14, 1992), *Origins* 21 (1992): 542–53.
18. United States Catholic Bishops Pro-Life Committee, "Nutrition and Hydration: Moral and Pastoral Reflections" (April 2, 1992), *Origins* 21 (1992): 705–12, quote from 710.
19. Ashley and O'Rourke, *Health Care Ethics*, 427. In a more recent edition of the text, the authors describe John Paul II's characterization of the obligatory nature of providing artificial nutrition and hydration for PVS patients as "excessive." See Benedict Ashley, OP, Kevin O'Rourke, OP, and Jean DeBlois, CSJ, *Health Care Ethics: A Theological Analysis*, 5th ed. (Washington, DC: Georgetown University Press, 2006), 196.
20. William May, "Tube Feeding and the 'Vegetative State,'" *Ethics and Medics* 23, no. 12 (December 1998): 1–2; and 24, no. 1 (January 1999): 1–2. See Kevin O'Rourke's response, "On the Care of 'Vegetative' Patients," *Ethics and Medics* 24, no. 4 (1999): 3–4.
21. *Ethical and Religious Directives*, 4th ed. (2001), no. 58.
22. John Paul II, "Address to the Participants in the International Congress of 'Life-Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas,'" (March 20, 2004). For the full text of the pope's address, see *National Catholic Bioethics Quarterly* 4, no. 3 (Autumn 2004): 573–76. For commentary and discussion on the address, see articles by D. O'Brien, J. P. Slosar, A. Tersigni, P. Cataldo, and G. Kopaczynski in the same issue.

23. As one example of dissenting opinion, see the Consortium of Jesuit Bioethics Programs, "Undue Burden? The Vatican and Artificial Nutrition and Hydration," *Commonweal* 136, no. 3 (February 13, 2009).
24. Congregation for the Doctrine of the Faith, "Responses to Certain Questions of the United States Conference of Catholic Bishops Concerning Artificial Nutrition and Hydration" (September 14, 2007); reprinted in *National Catholic Bioethics Quarterly* 8, no. 1 (Spring 2008): 123–27.
25. USCCB, *Ethical and Religious Directives for Catholic Health Care Services*, 5th ed. (2009).