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"UNBIND HIM AND LET HIM GO" (JN 11:44): ETHICAL ISSUES IN THE DETERMINATION OF PROPORTIONATE AND DISPROPORTIONATE TREATMENT

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The article (1) reviews a variety of magisterial documents and essays concerning the terms "morally ordinary" and "extraordinary" treatment in relation to the provision of assisted nutrition and hydration, particularly for patients in a "permanent vegetative state"; (2) considers how the terms "ordinary" and "extraordinary" are used in both the moral and medical contexts, the process by which they are defined, and how economic issues relate to moral analysis; and (3) argues that the content of the terms is changing as well as the method to determine whether a treatment is ordinary or extraordinary.

THE PUBLICATION OF "On Basic Care for Patients in the 'Vegetative' State" in the May–June 2008 issue of *Health Progress* and "Human Dignity and the End of Life" in the August 4–11, 2008, issue of *America* by Cardinal Justin Rigali, Chairman of the U.S. Conference of Catholic Bishops' (USCCB) Committee for Pro-Life Activities, and Bishop William Lori, Chairman of the USCCB's Committee on Doctrine, continues the discussion of questions surrounding the ethical issues related to end-of-life care and particularly the use of assisted nutrition and hydration (ANH). I wish to discuss this topic, first, by framing it within some issues in U.S. culture and Catholicism; second, by examining the moral evaluation of medical interventions within the Roman Catholic tradition, showing how

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these perspectives have been changing over the last several years; finally, I will comment on the articles by Cardinal Rigali and Bishop Lori.

U.S. CULTURE AND CATHOLICISM

One of the first major problems confronted in the newly developing area of bioethics was the technological imperative: if we can do it, we should. Capacity generated obligation. The imperative was a driving force in the development and implementation of various technological advances. Joined with this was the medical imperative that says, if a physician prescribes a treatment, then there is an obligation to use it. This is also known as the "medical indications policy": specific and obligatory interventions necessarily follow from the diagnosis. Authority and capacity join together to generate an obligation for the patient, but an obligation not necessarily of the patient's choosing.

In both of these imperatives, personal moral analysis and accountability are diminished because the obligation comes from either the technological capacity or the expertise or both together. No further moral analysis is needed if both or either are present. This was conspicuously the case in the funding of the Human Genome Project (HGP). While in fact the funding for the project included a massive amount of money to be spent on examining ethical issues raised by the HGP, this funding was available only after the decision to fund and undertake the project itself.

This lack of moral analysis is particularly critical in the medical context, for the patient is either marginalized or left out of the decision-making process altogether. What is determinative of moral obligation to treat is either the capacity to intervene or a medical judgment that this is the proper course. Absent is a consideration of either the patient's wishes or the effect of the intervention on the patient. Thus, instead of a personal standard of morality for evaluating what to do or not do, we have an impersonal standard rooted in technical capacity and/or medical expertise.

A second issue, a first cousin of the technological and medical imperatives, is fear of entrapment: the fear that once an intervention or technology is started, it may not be stopped. To stop would violate the technological imperative and would be a sign of defeat in the face of the traditional enemy of medicine: death. The intervention and/or technology may have been started appropriately—for example, the patient needed emergency stabilization, or the patient or family in consultation with the physician determined the intervention was appropriate. However, after initiating the intervention, it was found to be either ineffective or too burdensome or both. Yet for many the assumption is that once a technology or therapy has been started, you are on it until you die.

Because of the fear of technological entrapment some people may in fact refuse to initiate an intervention that may actually be beneficial, because they fear that if it is not, they will not be able to stop the intervention. This is a major harm, but one that is likely to occur as long as these imperatives hold sway.

A third critical context is authority and its structuring. One hallmark of our age is an increased focus on authority and, in particular, centralized authority. We see this politically in a variety of dictatorships and in our own country with the reality of an increasing expansion of executive authority. We also see this tendency in the Catholic Church, particularly in the modern papacy, that is, since the French Revolution. Allowing for varying types of leadership style and bureaucratic emphasis, pontiffs from Pius IX through the current pope have established or maintained a more centralized authority in the Church. Now clearly the Catholic Church is hierarchical in its structure, but that does not necessarily translate to centralization of authority around the pope. Though national hierarchies seem to follow suit in centralizing authority around the local bishop, even they think they need to clear procedures and decisions with Rome before implementing them. The growing use of catechisms also serves to centralize authority around a central set of texts that provide the measure of orthodoxy. Providing a single solution to problems seems to be the way centralized authority seeks to maintain control over complex issues. This is at a far remove from *Octagesima adveniens* in which Paul VI said:

> In the face of such widely varying situations it is difficult for us to utter a unified message and to put forward a solution which has universal validity. Such is not our ambition, nor is it our mission. It is up to the Christian communities to analyze with objectivity the situation which is proper to their own country, to shed on it the light of the Gospel's unalterable words and to draw principles of reflection, norms of judgment and directives for action from the social teachings of the Church.[1]

This statement by Paul VI does not repudiate papal or hierarchical authority. Rather, it recognizes that countries and communities have circumstances unique to them, that their situation needs to be taken into account in arriving at appropriate moral resolutions of problems, and that individuals within those communities need to participate actively in determining such resolutions. In short, the text from *Octagesima adveniens* affirms the well-established principle of subsidiarity.

A fourth issue is the conjoined twin of centralized authority, moral micromanagement in which solutions to moral problems are determined by the central authority and then handed down. For example, in *Humanae vitae* the morality of specific individual actions within heterosexual married intercourse was defined and then promulgated. The recent tendency to intervene in medical issues with a single resolution of the problem, par-

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[1] Paul VI, *Octagesima adveniens* no. 4. This text can be found in David J. O'Brien and Thomas A. Shannon, *Catholic Social Thought: A Documentary History* (Maryknoll, N.Y.: Orbis, 1992) 266; hereafter cited as O'Brien and Shannon.

ticularly assisted nutrition and hydration follows this trend. For example, in "Nutrition and Hydration: Moral and Pastoral Reflections," the USCCB's Committee for Pro-Life Activities declares: "It is not easy to arrive at a single answer to some of the real and personal dilemmas involved in this issue."[2] Given their acknowledment of the complexity of the question, the many medical and ethical dilemmas involved in it, as well as the variety of social circumstances surrounding each case, why should one think there would or even should be a single answer? Why not, rather, follow the lead of the pastoral position in the *Challenge of Peace: God's Promise and Our Response*: "This passage [referring to *Gaudium et spes* no. 13] acknowledges that, on some complex social questions, the Church expects a certain diversity of views even though all hold the same universal moral principles."[3] In the quest for unity of teachings, one can easily fall into a demand for uniformity.

Finally is the issue of the value of life, particularly biological life. Human life is seen as sacred and valuable, yet it is created and finite. This has ethical significance in evaluating medical therapies and technologies. For, while life is valuable, it is neither the ultimate value nor the only value relevant for the moral resolution of a particular case. Nor does life's being a basic value necessarily give it a privileged position among other values or provide a normative resolution of a particular moral problem. Thus, for example, some argue that the demands of justice can require the taking of human life as in war, self-defense, or even capital punishment. Were human life of ultimate value, moral positions asserting the priority of other values would not be viable within Roman Catholicism, and pacifism, for example, would be normative. Values and practices must be seen in relation to our journey to God, not as ends in themselves. To say or suggest that anything else has the ultimate value or meaning that God has is to approach making biological life a false god.

Designating biological survival as the normative or ultimate value in decision-making comes close to making an idol of biological life and reinforces the technological and medical imperatives because physical life is given an importance beyond its created status. Physical life is made an ultimate good rather than remaining a finite good.

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[2] National Conference of Catholic Bishops' Committee for Pro-Life Activities, "Nutrition and Hydration: Moral and Pastoral Reflections" no. 6 (April 1992), http://www.priestsforlife.org/magisterium/bishops/92–04nutritionandhydrationnccbprolifecommittee.htm (accessed September 15, 2008). This document can be found in Ronald P. Hamel and James J. Walter, eds., *Artificial Nutrition and Hydration and the Permanently Unconscious Patient: The Catholic Debate* (Washington: Georgetown University, 2008) 128; hereafter cited as Hamel and Walter.

[3] NCCB, The Challenge of Peace: God's Promise and Our Response no. 12. See O'Brien and Shannon 494.

In spite of continued affirmations—even by the hierarchy—that biological or physical life is not of absolute value, the emphasis and priority given to physical life or the maintenance of biological functions by many within and without the hierarchy belies that position. It seems relatively clear that the goal of preserving biological life for as long as possible for the sake of itself is now close to a normative position within Roman Catholicism. Clearly the value of life needs defending in our American culture—that should go without saying. But it is very difficult to present arguments defending life while simultaneously having to fend off arguments that essentially raise biological life to an absolute value.

To be fair, the hierarchical magisterium has not claimed that biological life is an absolute value. But the continuous calls for the nearly absolute protection that biological or physical life receives make it seem as though this position is assumed. When the assumption that biological life is of nearly absolute value is coupled with the position that abortion and euthanasia are the most critical life issues in the forthcoming elections, it is even more difficult to argue that physical life is not being given absolute priority. While it is the case that the hierarchy opposes other practices opposed to life, such as torture and racism, it is not the case that support for these issues should lead voters to reject candidates supporting such practices, whereas support for abortion or euthanasia should lead Catholic voters to reject such candidates.[4]

What seems to be the case is that in the determination of what interventions may be morally mandatory, there is confusion between the value of life and the normative judgments that seek to protect it, a confusion of the axiological (the determination of value) and normative (the determination of obligations) levels in technical terms. As my colleague James Walter and I noted earlier, this confusion has consequences:

> Failure to make this important and traditional ethical distinction between axiology and normativity leads one to affirm wrongly that the affirmation of the value or sanctity of life of the patient in and of itself imposes normative obligations with

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[4] See, for example, the 2008 USCCB statement "Forming Consciences for Faithful Citizenship": "28. . . . The direct and intentional destruction of innocent human life from the moment of conception until natural death is always wrong and is not just one issue among many. It is always to be opposed. 29. . . . Racism and other unjust discrimination, the use of the death penalty, resorting to unjust wars, the use of torture, war crimes, the failure to respond to those who are suffering from hunger or a lack of health care, or an unjust immigration policy are all serious moral issues that challenge our consciences and require us to act. . . . Although choices about how best to respond to these and other compelling threats to human life and dignity are matters for principled debate, this does not make these optional concerns or permit Catholics to dismiss or ignore Church teachings in these important issues" (http://www.usccb.org/faithfulcitizenship/FCStatement.pdf [accessed September 15, 2008]).

> respect to medical interventions. In addition to being the fallacy of deriving an "ought" from an "is," the failure also implicitly may signify a form of vitalism that affirms that biological life is the only or most important value. Finally, the failure to make the distinction leads to a form of a "medical indications policy" as the moral criterion that mandates that particular interventions necessarily must follow from the diagnosis.[5]

Human life must be protected and protected in a variety of contexts. But when physical or biological life is made an end in itself, as happens when ANH is mandated for the sake of only maintaining physical life, then we are close to idolatry. And that position will not necessarily help us to defend life.

DECISION-MAKING IN THE CONTEXT OF SPECIFIC ILLNESSES AND AT THE END OF LIFE

One of the main Roman Catholic contributions to the general bioethics discussion has been its wisdom on deciding the morality of interventions in various illnesses and particularly end-of-life issues.[6] Beginning in the late 15th century, Catholic moral theologians have thoughtfully reflected on the circumstances under which the obligation to preserve life is binding and which interventions, therefore, are obligatory. That reflection has continued up into our own time with continual refinements of the tradition in light of developments within contemporary medicine. Recent developments in hierarchical teaching, however, have challenged both of these dimensions of the decision-making process. As Walter and I have argued earlier:

> The first of these [changes] is a shift in the very method itself: from proportionate reasoning as in the *Declaration on Euthanasia* from the Congregation for the Doctrine of the Faith in 1980 to a deontological reasoning as in the March 2004 papal allocution "Care for Patients in a 'Permanent' Vegetative State." Second, there is a shift in applying the ordinary-extraordinary distinction from the general context of obligations to oneself while ill to restricting the application to the context of imminent dying. Third, there has been a shift from making a determination of whether or not to use an intervention such as chemotherapy or assisted nutrition and hydration to a presumption in favor of using such interventions. Finally, following John Paul II's Allocution, there is a shift from a presumption to use to an

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[5] Thomas A. Shannon and James J. Walter, "Assisted Nutrition and Hydration and the Catholic Tradition," *Theological Studies* 66 (2005) 652–62, at 661. See also Hamel and Walter 232–33.

[6] See in particular Daniel A. Cronin's 1927 classical study, "Moral Law in Regard to the Ordinary and Extraordinary Means of Conserving Life," in *Conserving Human Life*, ed. Russell E. Smith (Braintree, Mass.: Pope John Center, 1988). See also Hamel and Walter 29–51; Michael Panicola, "Catholic Teaching on Prolonging Life: Setting the Record Straight," *Hastings Center Report* 31.6 (2001) 14–25; and Julia Flemming, "When 'Meats Are Like Medicines': Vitoria and Lessius on the Role of Food in the Duty to Preserve Life," *Theological Studies* 69 (2008) 99–115.

obligation to use. Thus, in a series of statements from various ecclesial commissions and magisterial authorities, the tradition has been moved recently from a patient-centered focus and obligations determined through the use of proportionate reason to a technology and intervention-centered focus with obligations being determined by deontological principles.[7]

Here I wish to focus on two key thematic elements of the tradition—the patient as moral subject and the method of decision-making—and how they are being substantively altered by these revisions in the tradition.

First, the tradition recognized clearly that the person is to be the decision-maker for all moral acts, not just ones in medicine. All persons are held accountable for forming their conscience and for acting in accordance with it. As *Gaudium et spes* no. 16 notes: "In fidelity to conscience, Christians are joined with the rest of men in the search for truth, and for the genuine solution to the numerous problems which arise in the life of individuals and from social relations."[8] This search is necessary particularly with respect to medical decisions, where the decisions significantly impact the person making the decisions. The patient is a moral subject who is to make an informed and ethically sound decision about whether a proposed intervention is morally obligatory or optional or whether it is proportionate or disproportionate. Additionally the tradition recognized that the patient may not be able to make a decision because of some type of incapacity and affirmed that in this situation the patient's family, or other appropriate person may be the decision-maker.

As the 1980 Declaration on Euthanasia by the Congregation for the Doctrine of Faith (CDF) notes, "in the final analysis, it pertains to the conscience either of the sick person, or of those qualified to speak in the sick person's name, or the doctors, to decide, in the light of moral obligations and of the various aspects of the case."[9]

What has happened in recent years as a result of the centralization of authority and the micromanagement of moral decision-making, is that such responsibility for conscience formation and proper decision-making responsibility has been replaced with a priori and/or abstract decisions and rules about what one must do in particular medical contexts. Thus, instead of having the patient as a moral subject determine in his or her specific circumstances whether an intervention is proportionate or disproportionate, the patient is now told that some interventions are in fact always in principle ordinary and, therefore, obligatory. And this is done by fiat rather

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[7] Shannon and Walter, "Assisted Nutrition and Hydration," cited in Hamel and Walter 224–25.

[8] *Gaudium et spes* no. 16. See O'Brien and Shannon 175.

[9] CDF, Declaration on Euthanasia, *Origins* 10 (1980) 154–56; see Hamel and Walter 104.

than by a process of moral analysis. The patient is no longer a moral subject, but one who is simply to follow orders.

Second is the question of how the patient as moral subject is to determine whether an intervention is proportionate or disproportionate, to use the language of the 1980 CDF Declaration on Euthanasia. The traditional answer from the 15th century until recently is that one makes this determination by examining the impact of the intervention on the patient. Put differently, what does the intervention do to the patient and for the patient? The tradition asks the patient to engage in a traditional teleological (not consequentialist) evaluation of the various outcomes of the intervention to determine whether or not they are proportionate to the end to be achieved. If they are, the intervention is obligatory; if not, the treatment is morally optional.

A good example of this methodology is Pius XII's 1958 Address "Prolongation of Life." Although as an address to a medical meeting of anesthesiologists it ranks low in the hierarchy of authoritative teachings, the address is important because it is among the earliest efforts of a modern pope to address questions arising from a new medical intervention—the ventilator—and new moral questions associated with this intervention: must one always use it, may one withdraw it once one has begun to use it, and how does its use affect the understanding and definition of death and the administration of the last rites? In addressing these questions, Pius XII first discusses aspects of the new technology and its consequences. But when he comes to resolving the moral dimensions of its use, he turns to the tradition: "But normally 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."[10]

Pius XII does not categorize the intervention and he makes no a priori judgment about when it is to be used or not used. Rather he argues that the patient, or his or her family, should make the decision according to the traditional method: evaluate the impact of intervention on the patient. Additionally he notes that the consideration of burden extends to the impact of the treatment on the family. Pius XII does not mandate a norm; rather, he comes to a conclusion based on the traditional methodology.

> Consequently if it appears that the attempt at resuscitation constitutes in reality such a burden for the family that one cannot in all conscience impose it upon them, they can lawfully insist that the doctor should discontinue these attempts, and the doctor can lawfully comply. There is not involved here a case of direct disposal of the life of the patient, nor of euthanasia in any way; this would never be licit. Even when it causes the arrest of circulation, the interruption of attempts at resuscitation

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[10] Pius XII, "Prolongation of Life," *The Pope Speaks* (Spring 1958) 393–98; see Hamel and Walter 94.

> is never more than an indirect cause of the cessation of life, and one must apply in this case the principle of double effect and of "voluntarium in causa."[11]

The 1980 CDF Declaration on Euthanasia affirms the same methodology:

> 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 costs 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.[12]

This is as clear and clean a statement of the moral methodology of decision-making within the area of medical ethics of the last 500 or so years as one could wish for. It assumes the patient as the proper moral subject and as the one to make the determination as to whether the intervention is proportionate or disproportionate according to traditional guidelines. [13]

The *Catechism of the Catholic Church* echoes the tradition with respect to the patient as the appropriate moral subject and the methodology when it says:

> Discontinuing medical procedures that are burdensome, dangerous, extraordinary, or disproportionate to the expected outcome can be legitimate; it is the refusal of "over-zealous" treatment. Here one does not will to cause death; one's inability to impede it is merely accepted. The decisions should be made by the patient if he is competent and able or, if not, by those legally entitled to act for the patient, whose reasonable will and legitimate interests must always be respected.[14]

Also important to note is that such decisions about the treatment are not limited to the time of imminent dying, but are to be made within the context of a particular illness. The tradition has not limited such judgments about proportionate or disproportionate interventions to the time of death.

This position affirming the patient as a moral subject is presented as well in the 2001 USCCB Ethical and Religious Directives for Catholic Health Care Services (ERDs). The ERDs do this in four places. In no. 25, the directives note that a person "may identify in advance a representative to make health care decisions as his or her surrogate" in the event of incapacity and as long as these decisions are "faithful to Catholic moral principles and to the person's intentions or values . . . or the person's best interests." The ERDs then state in nos. 32 and 33 that:

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[11] Ibid.; see Hamel and Walter 96.

[12] CDF, Declaration on Euthanasia; see Hamel and Walter 104.

[13] See also Texas Bishops and the Texas Conference of Catholic Health Facilities, "On Withdrawing Artificial Nutrition and Hydration," *Origins* 20 (1990) 53–55; see Hamel and Walter 110.

[14] *Catechism of the Catholic Church* (Washington: United States Catholic Conference, 1994) no. 2278.

> While every person is obliged to use ordinary means to preserve his or her health, no person should be obliged to submit to a health care procedure that the person has judged, with a free and informed conscience, not to provide a reasonable hope of benefit without imposing excessive risks and burdens on the patient or excessive expense to family or community.
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> The well-being of the whole person must be taken into account in deciding about any therapeutic intervention or use of technology. Therapeutic procedures that are likely to cause harm or undesirable side-effects can be justified only by a proportionate benefit to the patient.[15]

No. 56 continues this theme, maintaining that "a person has a moral obligation to use ordinary or proportionate means of preserving his or her life."

The affirmation of the patient as the responsible moral subject for decision-making—the patient's intentions model, as the ERDs suggest[16]—as well as the traditional method for determining whether an intervention is proportionate or disproportionate are the key elements in the tradition of proper moral decision-making in the context of illness, whether the illness is episodic, chronic, or terminal. This is the tradition that is being challenged by current hierarchical teaching.

CHANGE IN METHOD

Under question is the status of the patient or of his or her family or another duly designated decision-maker as the proper decision-maker when ANH is under consideration. In 1981, the Pontifical Council on Health Affairs issued the report "Cor Unum: Questions of Ethics Regarding the Fatally Ill and the Dying." First the Council gave a traditional explanation of the ordinary–extraordinary distinction.

> The criteria whereby we can distinguish *extraordinary* measures from *ordinary* measures are very many. They are to be applied according to each concrete case. Some of them are *objective*: such as the nature of the measures proposed, how expensive they are, whether it is just to use them, and what the options of Justice are in the matter of using them. Other criteria are *subjective*: such as not giving certain patients psychological shocks, anxiety, uneasiness, and so on. It will always be a question, when deciding upon measures to be taken, of establishing to what extent the means to be used and the end being sought are proportionate.[17]

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[15] USCCB, Ethical and Religious Directives for Catholic Health Care Services, 4th ed., http://www.usccb.org/bishops/directives.shtml (accessed September 15, 2008).

[16] See James F. Keenan, S.J., "What's New in the Ethical and Religious Directives," *Linacre Quarterly* 65 (1998) 33–40.

[17] Pontifical Council on Health Affairs "Cor Unum," "Questions of Ethics Regarding the Fatally Ill and the Dying" (June 27, 1981) no. 2.4.2, italics original, http://www.academiavita.org/template.jsp?sez=DocumentiMagistero&pag=pontifici_consigli/mal_mor/mal_mor&lang=english (accessed September 15, 2008).

In the next paragraph, the Council quotes approvingly from a 1970 address by Cardinal Jean-Marie Villot to the International Federation of Catholic Medical Associations:

> This does not, however, mean that a physician is under obligation to use all and every one of the life-maintaining techniques offered him by the indefatigable creativity of science. Would it not be a useless torture, in many cases, to impose vegetative reanimation during the last phase of an incurable disease?[18]

This certainly coheres with the mainstream of the tradition and reflects its patient-centered orientation. Yet in the very next paragraph the Council says:

> There remains the strict obligation to apply under all circumstances those therapeutic measures which are called "minimal": that is, those which are normally and customarily used for the maintenance of life (alimentation, blood transfusions, injections, etc.). To interrupt these minimal measures would, in practice, be equivalent to wishing to put an end to the patient's life.[19]

I see four problems with this last cited paragraph. First, it in no way coheres with the previous two and, in fact, contradicts them. Second, does the new nomenclature of "minimal" refer to what the tradition called ordinary or proportionate means? The term is not defined, nor is any rationale given for this shift of terminology. Third, proportionate and disproportionate forms of treatment are traditionally not determined by classifying an intervention according to whether or not it is routinely used by physicians. Whether a medical intervention is *morally* proportionate has historically been determined by its effects on the patient and on those who have the responsibility to care for the patient. To argue that what is *medically* ordinary or routine as determined by its routine usage by physicians is also *morally* ordinary equivocates on the term "ordinary" and substantively misrepresents the core of the medical ethical tradition of the Catholic Church. Fourth, the document simply stipulates by fiat that such "minimal" interventions are obligatory. What is the argument for such claims, as well as for the claim that not doing this is intending the death of the patient? Though this is the statement of a Pontifical Council, not official church teaching, it was incorporated into Pope John Paul II's allocution in 2004 as if it were. Finally, the title of the document suggests that the traditional moral methodology is applicable only when a person is fatally ill or actively dying. The tradition had not limited this methodology only to the time of dying but applies it throughout the course of an illness.

In 1985, the Pontifical Academy of Sciences, in its document "The Artificial Prolongation of Life," stated as a medical guideline: "If a patient is in a permanent, irreversible coma, as far as can be foreseen, treatment is

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[18] Ibid. no. 2.4.3.

[19] Ibid. no. 2.4.4.

not required, but all care should be lavished on him, including feeding."[20] Again, this is a statement of a pontifical academy and, therefore, not part of official church teaching, though it too will be quoted as if it were. Second, no reasons are proposed to support the position that ANH is part of care and, more importantly, that such feeding is assumed to be proportionate and obligatory. Additionally, the patient as a moral subject is not mentioned.

The previously cited 1992 USCCB statement "Nutrition and Hydration: Moral and Pastoral Reflections" presents a more nuanced analysis:

> We reject any omission of nutrition and hydration intended to cause a patient's death. We hold for a presumption in favor of providing medically assisted nutrition and hydration to patients who need it, which presumption would yield in cases where such procedures have no medically reasonable hope of sustaining life or pose excessive risks or burdens.[21]

The shift here is that there is now in place a presumption in favor of a particular intervention—assisted nutrition and hydration—rather than the tradition's presumption in favor of the use of proportionate means. The document does recognize that the patient, or family when appropriate, is the correct decision maker and that ANH could be withdrawn; nonetheless the shift to a presumption in favor of a specific intervention is a critical shift in the tradition.

This shift is also reflected in the 2001 ERDs: "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 sufficient benefit to outweigh the burdens involved to the patient."[22] While this statement recognizes the role of weighing burdens and benefits, nonetheless, the assertion of a presumption is made in the absence of such a weighing. If the role of weighing benefits and burdens is important, one would think that the statement would suggest a presumption for proportionate means and then use the benefit-burden test as a way to specify the moral obligation of the proposed intervention. As stated, no. 58 reversed the traditional method.

In 2004, Pope John Paul II gave an allocution entitled "Care for Patients in a 'Permanent' Vegetative State" to the International Congress on Life-Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas sponsored by the World Federation of Catholic Medical

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[20] Pontifical Academy of Sciences, "The Artificial Prolongation of Life," *Origins* 15 (1985) 415; cited in Hamel and Walter 108.

[21] USCCB, "Nutrition and Hydration" no. 4; cited in Hamel and Walter 130.

[22] USCCB, "Ethical and Religious Directives" no. 58, 4th ed. (June 15, 2001), http://www.usccb.org/bishops/directives.shtml (accessed September 15, 2008); cited in Hamel and Walter 139.

Associations and the Pontifical Academy for Life.[23] In this allocution, the pope argued that ANH is "a natural means of preserving life, not a medical act."[24] Yet, he later claimed that the use of ANH "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 the alleviation of his suffering."[25]

This use of the traditional terminology seems to imply that ANH is indeed a type of treatment, albeit an ordinary and morally required one. Additionally, people in a persistent vegetative state will always remain human, maintain their dignity, and have "the right to basic health care (nutrition, hydration, hygiene, warmth, etc)."[26] Furthermore, in the pope's view, the "moral principle according to which even the slightest doubt of being in the presence of a person who is alive requires full respect and prohibits any action that would anticipate his or her death."[27] Finally, the pope notes that "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."[28]

I would note several problems in this allocution—which, it is important to remember, is low in the hierarchy of official teachings. First is the shift in methodology, from teleological reasoning to a deontological basis for deciding what are proportionate or disproportionate means of treatment. That is, the pope stipulated that ANH is morally mandatory without alluding to relevant circumstances. Second, the reason for this deontological shift is that the pope defines ANH as an ordinary means of intervention. No argument is given for this position; it is simply stated. Third, the pope later incorporates statements from pontifical councils as if they were church teaching and binding on the faithful. While such councils and other advisory groups are helpful, to reference them simply as if they are church teaching is problematic and confusing. Fourth, the allocution continues to equivocate the terms "medically ordinary" and "morally ordinary," which leads to moral confusion.

But then on November 12, 2004, John Paul II addressed the participants

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[23] John Paul II, "Care for Patients in a 'Permanent' Vegetative State," *Origins* 33 (2004) 737, 739–40; cited in Hamel and Walter 203–7.

[24] Ibid. 205.

[25] Ibid.

[26] Ibid.

[27] Ibid. In this context it is helpful to recall the discussion of taking human life and the moral theory of probabilism. See Carol A. Tauer, "The Tradition of Probabilism and the Moral Status of the Early Embryo," *Theological Studies* 45 (1984) 3–35.

[28] Ibid.

in the 19th International Conference of the Pontifical Council for Health Pastoral Care, saying, among other things:

> True compassion, on the contrary, encourages every reasonable effort for the patient's recovery. At the same time, it helps draw the line when it is clear that no further treatment will serve this purpose.
>
> The refusal of *aggressive treatment* is neither a rejection of the patient nor of his or her life. Indeed, the object of the decision on whether to begin or to continue a treatment has nothing to do with the value of the patient's life, but rather with whether such medical intervention is beneficial for the patient.
>
> The possible decision either not to start or to halt a treatment will be deemed ethically correct if the treatment is ineffective or obviously disproportionate to the aims of sustaining life or recovering health. Consequently, the decision to forego aggressive treatment is an expression of the respect that is due to the patient at every moment.
>
> It is precisely this sense of loving respect that will help support patients to the very end. Every possible act and attention should be brought into play to lessen their suffering in the last part of their earthly existence and to encourage a life as peaceful as possible, which will dispose them to prepare their souls for the encounter with the heavenly Father.[29]

First, it is unclear whether this statement is intended to be a correction, a development, or an addendum to the statement of March 20, 2004. This statement certainly differs in tone and clearly recognizes that sometimes further treatment may not be necessary. Second, we have another change in terminology: "aggressive treatment." Is this to be understood as a synonym for "extraordinary treatment" or "disproportionate treatment"? If so, it would be helpful to state this. Third, the address uses the traditional method of determining whether the intervention is of benefit to the patient, or disproportionate to the aims of sustaining life or recovering health. Indeed, "the decision to forego aggressive treatment is an expression of the respect that is due to the patient at every moment." Though not without its areas of imprecision, this address is clearly more in harmony with the tradition's respecting the patient as a moral subject and with the methodology of determining what to do than is the March 20, 2004, statement. How they are to be understood in relation to each other is as yet unclear.

On August 1, 2007, the CDF stated in response to a query from the American hierarchy that "the administration of food and water even by artificial means is, in principle, an ordinary and proportionate means of

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[29] John Paul II, Address to the Participants in the 19th International Conference of the Pontifical Council for Health Pastoral Care (November 12, 2004) no. 4, http://www.vatican.va/holy_father/john_paul_ii/speeches/2004/november/documents/hf_jp-ii_spe_20041112_pc-hlthwork_en.html (accessed September 15, 2008).

preserving life."[30] Interestingly, on the CDF's Web site, the response is found under the section for doctrinal statements, not disciplinary ones. The CDF concludes that as long as the feeding contributes to its proper finality—nutrition and hydration of the patient—it is obligatory. Because the patient in a permanent vegetative state (PVS) is a person, he or she possesses a fundamental human dignity and must therefore receive ordinary and proportionate care. The CDF's subsequent commentary notes three exceptions: physical impossibility such as the unavailability of feeding tubes, when the patient's body cannot assimilate the nutrition or hydration, or medical complications from ANH.[31]

The USCCB Committee on Doctrine and the Committee on Pro-Life Activities also provided a set of questions to augment the CDF's response and commentary.[32] Question 3 states that "in modern societies with advanced medical services the administration of nutrition and hydration by artificial means to patients in a 'vegetative state' who need such assistance is generally neither extraordinary nor disproportionate." Question 4 restricts the discussion of ANH to the stage of imminent death. And Question 6 asserts that "in technologically advance societies the costs directly attributable to the administration of nutrition and hydration are generally not excessive." The question does recognize that total costs may become significant but resolves this by saying that "to act to end life because life itself is seen as a burden, or imposes an obligation of care on others, would be euthanasia."

This response continues to assume that one determines whether an intervention is proportionate or disproportionate either by classifying it according to what the technology does and its use in medical practice or by setting up categories of intervention defined as proportionate or disproportionate, abstracted from their impact on patients. This move repeats the equivocation between "medically" and "morally ordinary." The moral analysis in the common moral tradition is centered on the effects of the intervention on the patient and others, including the general society, not by whether this intervention is usually offered or used. The tradition is patient-centered; the commentary is intervention-centered.

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[30] CDF, Responses to Certain Questions of the United States Conference of Catholic Bishops concerning Artificial Nutrition and Hydration, http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20070801_risposte-usa_en.html (accessed September 15, 2008).

[31] Ibid. For a more thorough response, see Thomas A. Shannon, "At the End of Life," *America* 198.5 (February 18, 2008) 9–12.

[32] USCCB Committee on Doctrine and Committee for Pro-Life Activities, Q&A regarding the Holy See's Responses on Nutrition and Hydration for Patients in a "Vegetative State," www.usccb.org/comm/hydrationq&a.doc (accessed September 15, 2008).

Second, the commentary side-steps the traditional moral analysis to determine whether an intervention is proportionate or disproportionate by simply defining ANH as proportionate—but again without argument. Rather than use the traditional method proposed, for example, by the CDF's 1980 statement—"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"—the commentary asserts a position that all are to follow.

The 2007 CDF statement was responded to by, among others, John Hardt and Kevin O'Rourke, both at the Neiswanger Institute for Bioethics and Health Policy at Stritch Medical School.[33] Their response based on a canonical interpretation is twofold. First, following canon 18, they note that laws establishing a penalty or a restriction of a right are to be interpreted strictly. Canon 52 states: "A singular decree has force only in respect to the matters which is decides and for the person for whom it was given." Basing themselves on these canons, Hardt and O'Rourke argue that the CDF's response applies only to patients diagnosed with PVS and that the response applies only to the Church in the United States. Second, the authors comment on several other points in the response and commentary, showing that ANH can in fact incur excessive expense and would typically require hospitalization and could then be removed. They note further that the advance directives or living wills that many make reflect what in traditional moral theology is called psychic aversion, reflecting a fear that the proposed intervention will be a burden rather than a benefit. Such an example was noted above in the statement of Cor Unum's discussion of subjective judgments of extraordinary means: ". . . not giving certain patients psychological shocks, anxiety, uneasiness, and so on." They also note that any life support intervention—including ANH—that does not offer hope or that imposes a burden may be removed and that this act does not intend death. If such refusals of ANH or other forms of life support are argued to be euthanasia, then no forms of life support intervention—for example, a ventilator or kidney dialysis—could ever be removed. The authors conclude that there could be cases in which the removal of ANH could be morally permissible in a variety of situations, including PVS.

Cardinal Justin Rigali of Philadelphia and Bishop William Lori of Bridgeport, who chairs the USCCB Committee on Doctrine, responded to

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[33] John J. Hardt and Kevin D. O'Rourke, O.P., "Nutrition and Hydration: The CDF Response, In Perspective," *Health Progress* 88.6 (2007), http://www.chausa.org/Pub/MainNav/News/HP/Archive/2007/11Nov-Dec/Articles/Features/hp0711g.htm (accessed September 15, 2008).

Hardt and O'Rourke in the May–June 2008 issue of *Health Progress*.[34] Additionally the article continues the discussion of the issues raised by the previously mentioned 2007 CDF response. The article is organized around six points.

Point one rejects Hardt and O'Rourke's assertion that the 2007 CDF statement is a public policy statement and that it is subject to traditional rules of interpreting canonical decrees. Here I simply note my confidence in O'Rourke's abilities as a canon lawyer to know the rules of interpretation of documents, when and how to apply them, and how to draw reasonable conclusions. Even authoritative statements of the ordinary magisterium are subject to traditional methods of understanding and interpretation before they can be applied.

Point two notes that "not everything in the CDF 'Responses' applies solely to patients in a 'vegetative state.'" Rigali and Lori reference the CDF statement by noting that the "administration of food and water even by artificial means is, in principle, an ordinary and proportionate means of preserving life." They clarify that the phrase "in principle" means "as a general rule." This is helpful because it suggests room for interpretation and evaluation. However, this point continues to repeat the new method of determining proportionate and disproportionate means by either classifying the treatment based on medical usage or by stipulation in advance of the traditional consideration of the circumstances of the patient. This is an innovation and needs to be identified as such. Whether or not it is a helpful innovation can certainly be disputed, especially the observation that the "CDF's statement about the general or presumptive obligation to provide food and fluids as a form of ordinary care clearly has broad application." Again the tradition derived the obligation of what to do for a patient on a case-by-case basis, not on the basis of categorization of treatment or a priori stipulation of an intervention.

Point three argues that withdrawing ANH because decision-makers judge "the patient's continued life to be useless or burdensome" is euthanasia. I think all Catholic moral theologians would agree that the intent directly to kill a patient by removing the interventions keeping that person alive would be morally unjustified and would be a case of direct euthanasia. The motive for withdrawing an intervention in the case of euthanasia is secondary; the intent to kill directly is primary. But the point gets confused by conflating several issues. First, as just noted, motive can become conflated with intent and confuse the moral analysis. Second, euthanasia is not

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[34] Justin F. Rigali and William E. Lori, "On Basic Care for Patients in the 'Vegetative' State: A Response to Dr. Hardt and Fr. O'Rourke," *Health Progress* 89.2 (2008), http://www.chausa.org/Pub/MainNav/News/HP/Archive/2008/05May-June/Articles/Features/hp0805o.htm (accessed September 15, 2008).

the point of the discussion; the determination of proportionate and disproportionate means is. Third, the inability of the patient orally to eat or drink is morally relevant because this particular physical condition is one of the manifestations of the particular illness. It is a consequence of the illness or the neurological trauma and should not be examined in isolation from the totality of the patient's condition. The issue for most is neither euthanasia nor a negative judgment about the patient's dignity or quality of life. Rather, contrary to Rigali and Lori, it is a debate precisely about the means themselves and whether they are proportionate or disproportionate seen in relation to the totality of the patient's well-being. That is, while ANH certainly fulfills its purpose of providing nutrition and hydration, the larger moral issue is what impact does ANH have on the overall welfare of the patient? The focus needs to be the patient, not a particular biological system or organ.

Point four engages the financial issues associated with ANH and affirms that "providing food and fluids generally accounts for a very small fraction of this cost." The authors note that, if the intent is to remove ANH because this will lead to an early death and thus decrease costs, "then it seems clear that the patient's death is being intended precisely as a means to saving these other costs." Such an action would clearly be an act of euthanasia. But here again we have confusion between moral evaluation and the alleged intent of euthanasia to save money. First, one cannot disaggregate the costs as easily as the authors suggest. More likely than not, the patient is in a facility of some sort precisely because of the severity of his or her condition and because the patient cannot be appropriately cared for at home. The costs of such total care continue to increase and the extreme difficulty of caring for people at home will not lessen in either the near future or the long term. Millions of people either have no health insurance or are critically underinsured. A majority of bankruptcy cases already results from an inability to pay medical bills.[35] Married couples and many others often need to work two jobs just to meet basic expenses. For most

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[35] See, for example, David U. Himmelstein et al, "MarketWatch: Illness and Injury as Contributors to Bankruptcy," *Health Affairs*, February 2, 2005, http://content.healthaffairs.org/cgi/content/full/hlthaff.w5.63/DC1 (accessed September 15, 2008). The authors write: "In 2001, 1.458 million American families filed for bankruptcy. To investigate medical contributors to bankruptcy, we surveyed 1,771 personal bankruptcy filers in five federal courts and subsequently completed in-depth interviews with 931 of them. About half cited medical causes, which indicates that 1.9–2.2 million Americans (filers plus dependents) experienced medical bankruptcy. Among those whose illnesses led to bankruptcy, out-of-pocket costs averaged $11,854 since the start of illness; 75.7 percent had insurance at the onset of illness. Medical debtors were 42 percent more likely than other debtors to experience lapses in coverage. Even middle-class insured families often fall prey to financial catastrophe when sick."

people, staying at home to care for a relative, no matter how much they want to do this, is simply not an option. And fewer and fewer federal and/or state funds are available to assist in such arrangements. Finally, though Catholic health-care facilities may desperately want to provide all manner of services and intervention to their patients, they can engage in deficit spending for only so long. The critical choices in the near future may in fact be between which services can be provided and bankruptcy—and quality of care may take a seat in the very last row for this debate. The financial questions are much more critical and pressing than recent magisterial statements by Rigali and Lori, among others, suggest. And these financial realities are morally relevant to the question of what kind of treatment to provide in general, not just to the specific issue of ANH. As difficult as it is to acknowledge, cost of treatment can constitute a genuine burden and become disproportionate to the outcome desired and, therefore, cause an intervention to become extraordinary. Conflating an alleged intent to commit euthanasia with a morally responsible economic analysis of the patient's situation does not help anyone resolve a difficult question.

Point five rejects the concept of a "psychic burden" as the basis for withdrawing ANH. However, this point begs the question of whether this traditional category is in fact euthanasia. Such considerations of psychic burden or even a burden to others are a part of the older tradition and now seem to be excluded by decree rather than on the basis of moral argumentation.

Point six discusses advance directives and cites ERD 24: "The institution, however, will not honor an advance directive that is contrary to Catholic teaching." Assumably this means that, if a Catholic patient has an advance directive that states a refusal to accept ANH, then that advance directive will not be honored.[36] If this is the case, it will set up a significant administrative nightmare of implementation, will ensure many difficult and prob-

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[36] The Kansas Catholic Conference has issued a sample "Catholic Declaration on Life and Natural Death" that states: "6. *Nutrition and Hydration.* I believe that food (nutrition) and fluids (hydration) are not medical treatment, nor medical procedures, but ordinary means of preserving life. Therefore, I direct my health care provider(s) to provide me with food and fluids orally, intravenously, by tube, or by other means to the full extent necessary both to preserve my life and to assure me the optimal health possible. Furthermore, if at such time I am unable to eat and drink on my own (i.e. in a natural manner) *food and fluids must be provided to me* in an assisted manner (i.e. by tubes or a similar manner) *unless*: (a) my death is imminent (i.e. likely to happen without delay); or (b) I am unable to assimilate food or fluids; or (c) food or fluids endanger my condition" (Kansas Catholic Conference, January 2006, http://www.cdowk.org/catholic_advance/docs/Declaration.pdf), italics original (accessed July 28, 2008). For more on how the terms "ordinary" and "extraordinary" means of treatment are being defined, see Ron Hamel, "Advance Directives and ANH," *Health Care Ethics USA* 16.3 (2008) 16–17.

lematic lawsuits, and create numerous conflicts among patient, physicians, nurses, and administrators. One would hate to see a screening of advance directives as a condition of admission to a Catholic hospital, but that seems to be the implication of the directive and the comments of the authors.

The article concludes with the statement that the next iteration of the ERDs will include the doctrinal clarification that "this presumption applies [as much] to the patient in a 'vegetative state' as to other patients." I conclude that ANH is now to be considered an ordinary means of treatment, with few exceptions—such as terminal stomach cancer, unavailability of the intervention, or ANH cannot be assimilated without extreme discomfort.[37] Such a position continues the new tradition of diminishing the patient as the appropriate moral subject and further revises the tradition by determining ordinary and extraordinary forms of treatment either by stipulation or by categorization of the treatment according to its medical usage.

Whether a tradition should be changed or not is clearly a debatable question, but such changes should be debated and not passed off as if these changes had not been made. Question 3 of the USCCB's questions and answers for the CDF's responses perhaps demonstrates this problem most clearly.

> Does this represent a change in Church teaching? No. These Responses reaffirm what was taught by Pope John Paul II in his 2004 Address, which itself is in continuity with the Holy See's Declaration on Euthanasia of 1980 and other documents regarding the right of patients to receive normal or basic care.[38]

Without a doubt, John Paul II and his writings are part of the tradition. However, the tradition of the Church on this matter goes back a little farther than he, and his positions need to be understood in relation to it.[39] Also, recent statements and documents in fact give problematic readings of the 1980 CDF document, particularly with respect to the determination of what is a proportionate or disproportionate form of intervention and its application being limited to the state of imminent death.

Finally, Cardinal Rigali and Bishop Lori recently responded directly to my position.[40] However, I think their article raises further issues about

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[37] At the June 2008 meeting of the USCCB, the bishops "directed their Committee on Doctrine to begin revising guidelines for Catholic health care institutions on medically assisted nutrition and hydration" ("Roundup: Bishops' Spring Meeting," http://www.usccb.org/index071108.shtml [accessed September 15, 2008]).

[38] USCCB, Q&A regarding the Holy See's Responses.

[39] On this point, see Robert J. Egan, S.J., "Continuing the Conversation: Two Versions of History," *Commonweal* 127.15 (September 8, 2000) 7–8.

[40] Justin F. Rigali and William E. Lori, "Human Dignity and the End of Life: Caring for Patients in a Persistant Vegetative State," *America* 199.3 (August 4, 2008) 13–15.

ANH. First is the issue of terminology. They introduce the term "ordinary care owed to sick persons because of their human dignity." Such care is owed the patient even when "certain medical interventions have been withdrawn as useless or overly burdensome." The provision of food and water either orally or through ANH is the example they give of "ordinary care." Later, however, they note that such an obligation to provide "ordinary care" can be "exhausted when such assistance can no longer fulfill its basic purpose of finality." While the term "ordinary care" seems intended to specify the traditional distinction between ordinary and extraordinary forms of treatment, the criteria for evaluating the provision of "ordinary care" seem to be the same as determining whether a treatment is ordinary or extraordinary in a moral sense. What is gained by this introduction of new terminology? More importantly, their proposal introduces the problem of withdrawing *care*! The tradition spoke of withdrawing treatment or interventions that were useless or burdensome; the new terminology creates the impression that we no longer need to provide care for the patient. We are always obligated to provide care; we are not always obligated to offer medical treatments. Terminology is important, and I do not think that introducing the term "ordinary care" helps clarify the moral dilemma here.

The article also shifts the analysis to euthanasia by omission, particularly by omitting ANH. Yet we need to be careful in setting up the moral analysis. First, we cannot beg the question of euthanasia by omission by assuming that the withdrawal of ANH is ipso facto euthanasia by omission. This needs to be demonstrated by showing convincingly that a particular withdrawal of ANH is done with the direct intention of causing the death of the patient rather than the patient's death being an unintended, though foreseen, consequence. Second, we need to evaluate the burdens associated with or imposed by an intervention in relation to the totality of their impact on the patient. Modern medicine has given us the capacity to maintain a particular organ or biological system while not providing any overall therapeutic benefit to the patient. The person does not exist for the sake of maintaining a particular biological system; the biological system exists for the sake of the person. To maintain an organ or biological system because we can seems to hold the person hostage to technological capacity and favor an organ or system rather than the person. The intent is not to deny the value of a person or to make a social-worth judgment. The intent is to recognize that medicine and the interventions it can offer have limits and that further interventions will be burdensome and extraordinary.

Finally, the authors note that "some ethicists want to assess all the costs and burdens of caring for a helpless patient in a P.V.S., and then count these among the 'burdens' of assisted feeding." The argument is that the withdrawal of ANH is to remove the *associated* costs of a nursing home, nursing care, etc. However, one does not add up the costs associated with a nursing home, medical care, and nursing care and *then* add up the costs of ANH, as if they were additional costs. My point is that the totality of all costs can be the source of the burden to the patient or family. First, the tradition includes economic factors as legitimate parts of the moral determination of ordinary or extraordinary forms of treatment. Second, the economic burden to the family is a legitimate part of the moral evaluation. As the 1980 CDF statement noted, interventions can be rejected out of a "desire not to impose excessive expense on the family or the community."[41] I take this statement, as well as the tradition out of which it comes, as validating the moral judgment that the totality of the expenses can be too burdensome for a family and that they may terminate all interventions. No one expense is singled out as the burden; the totality creates the burden. To be fair, the tradition does not specify how such a calculation is to be done, but suggestions are made: there is no obligation to move to a more healthful climate or to buy the most expensive foods or medicines. Nonetheless such lack of specificity does not invalidate the moral relevance of economic issues.

CONCLUSION

I would draw five conclusions. First, continuous discussions of medical developments and interventions are important because the issues are complex, technically and ethically. We should not think that the nuances of cases involving ANH are easily grasped or even more easily resolved. Familiarity with the medical and social realities of the interventions is critical. Second, we need to recognize the power of technology and how technology and the technological and medical imperatives in particular in many ways drive the practice of modern medicine. High-tech rescue medicine is practically normative in the United States and if not utilized, many feel—often mistakenly—that they are not being treated properly. Historically the Catholic medical ethics tradition provided a bulwark against such technological and medical imperatives, but that wall is now in danger of being breeched. Third, the equivocation between "medically" and "morally ordinary" continues to be made. Fourth, we need to attend to terminology. The documents discussed here introduce terms such as "minimal therapeutic measures," "aggressive treatment," and "basic care." These terms are not carefully defined and seem to be ways of inserting a new obligation to treat based on a categorization of a particular treatment. I submit that the traditional terms of "morally ordinary" and "morally extraordinary" are more than adequate for the proper moral task of evaluating what a treatment or intervention does to and for a patient. Finally, the affirmation that

[41] CDF, Declaration on Euthanasia; see Hamel and Walter 105.

life is not an absolute value needs more critical examination and evaluation of its application to a variety of cases.

Many current documents and teachings seem not to take into account these five critical issues. Additionally, moral argumentation is missing in these same documents and teachings. What is ordinary and extraordinary treatment is now determined abstractly on the basis of the categorization of treatment and by authoritative pronouncements. The role of the patient in the decision-making process is consequently diminished. We now have a combination of rules determined in the abstract, moral micromanagement, a diminishment of the role of the patient, and authoritative declarations, not moral reasoning. This is a clear reversal of the moral methodology of the last 500 years of moral reasoning in the Catholic medical ethics tradition.

A problem with issuing a variety of mandates without apparent consultation, broad study, and attention to the moral methodology of medical ethics of the past 500 years is that the faithful may not hear what the bishops have to contribute to the discussion. If what is being taught does not have any resonance with the lived moral experience of the Catholic faithful and if in effect they are being told that they are not able to come to a morally appropriate judgment on their own, then the faithful may simply not attend to the teaching.

The problems are also institutional. What will a pastor or chaplain say at the bedside of a patient? What will a Catholic hospital do? What will Catholic health care providers do? What will patients who are not Catholic but are in a Catholic hospital do? These are not issues that affect only the conscience of the patient. Rather they have major institutional implications, particularly in areas in where a Catholic hospital may be the only one available. Clearly the decision about ANH is a significant moral decision and needs to be made with all the care and moral wisdom we can bring to it. The tradition has put such decision-making capacity in the hands of the patient and/or his or her family. The tradition trusted the moral agency of these individuals and trusted the framework of moral analysis to give correct guidance.

Many years ago when I began doing ethics rounds at the medical school where I taught, I was asked to speak with two elderly, unmarried Roman Catholic Irish sisters who wanted to withdraw treatment for their third sister. We discussed the situation and it was clear that death was approaching and further therapies useless. Indeed, this was the classic case for terminating therapy. Toward the end of our conversation, I asked if they wanted to discuss this question with their parish priest, for I was surprised that they asked to speak with the ethicist rather than him. “No,” they said, “he will tell us we can’t stop the treatments, but we know it’s the right thing to do and we’re going to do it.” I was taken aback, both because the two sisters were so firm in their assessment of what their pastor would say and because I would not have thought that this would be the priest's response. But I did not know him and they did. What a tragedy to feel that the Church has abandoned you at the time of deepest need!

Yet this tragedy is now in danger of being replicated in many families as they seek to do what they judge is best for a loved one and also seek the ministry of the Church in their time of need. The patient and/or the family may come to the difficult, but loving and conscientious decision that medical interventions have reached their limits and that any further interventions would be futile and burdensome. They then ask to cease all interventions and remove all life support, including the feeding tube. The patient and family are then told that, since the feeding tube is achieving its proper finality of providing nutrition and hydration, it is authoritative Catholic moral teaching that the feeding tube is considered an ordinary form of treatment and may not be withdrawn. What is the family now to do and to whom will they turn? This is a tragedy that can be avoided if patients and facilities are treated as responsible moral agents and trusted to use appropriately the traditional method of judging the benefits and burdens of treatment. But this tragedy will become common if the emphasis continues to be on the intervention rather than on the patient.