

Kevin O'Rourke, O.P. on the Morality of Tube Feeding PVS Patients: A Critique

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ABSTRACT: This paper criticizes an influential argument advanced by Kevin O'Rourke, O.P. to justify the withholding and/or withdrawal of nutrition and hydration—regardless of how it is supplied—from patients in a permanent vegetative state (PVS). First, I examine the author's "spiritual end of human life" argument in the context of his views on end-of-life care. Second, I criticize this argument along with his "fatal pathology" argument. I take objection to O'Rourke's interpretation of Pope Pius XII's 1957 address on the criteria for determining when treatment is ordinary or extraordinary, his understanding of the human person, his position on the hierarchy of goods, as well as his views on John Paul II's March 2004 address on the care of PVS patients.

My paper¹ will examine and critique the influential position of the eminent Dominican Kevin O'Rourke, O.P. on the morality of tube feeding patients in a so-called "permanent vegetative state" (PVS).² Fr.

¹ A slightly different version of this paper will appear in *The National Catholic Bioethics Quarterly* (Autumn 2005) as part of an issue devoted to "Ordinary and Extraordinary Treatments." A longer version of it will appear in *Nutrition and Hydration: The New Catholic Debate*, ed. Chris Tollefsen (Springer), forthcoming.

² PVS patients "show signs of arousal and may grimace or make other reflex movements, but show no signs of awareness or response to communication." Benedict M. Ashley, O.P. and Kevin D. O'Rourke, O.P., *Health Care Ethics: A Theological Analysis*, 4th edition (Washington, D.C.: Georgetown Univ. Press, 1997), p. 423. The medical and moral literature on PVS is enormous and controversial.

O'Rourke has consistently maintained that caregivers are not morally obliged to feed PVS patients, whether orally or tubally. In addition to examining O'Rourke's published writings, I will use material from an April 2005 debate in Detroit that I moderated between O'Rourke and moral theologian William E. May,³ as well as news reports of O'Rourke's negative reaction to both Pope John Paul II's March 2004 address on the question of tube feeding PVS patients⁴ and the case for tube feeding the severely brain-damaged Florida woman Terri Schiavo (whose alleged PVS condition was intensely debated). In light of these two events, it is both important and timely to scrutinize O'Rourke's view more closely.

I. O'ROURKE ON WHY FEEDING AND HYDRATING PVS PATIENTS IS NON-OBLIGATORY

³ This debate took place for priests of the Archdiocese of Detroit (April 26, 2005). See also, William E. May, "Tube Feeding and the 'Vegetative' State," *Ethics & Medics* 23.12/24.1 (Dec. 1998/Jan. 1999): 1-2/1-2 and Kevin O'Rourke, O.P. "On the Care of 'Vegetative' Patients," *Ethics & Medics* 24.4/24.5 (April 1999/May 1999): 3-4/3-4.

⁴ The address is titled, "Life-Sustaining Treatments and the Vegetative State," available at: http://www.vatican.va/holy_father/john_paul_ii/speeches/2004/march/documents/hf_jp-ii_spe_20040320_congress-fiamc_en.html. For O'Rourke's reaction, see Judith Graham, "Schiavo Case Put Priest on Hot Seat," available at: <http://www.chicagotribune.com/news/local/chi-0504240028apr24,1,3428290.story?coll=chi-news-hed&ctrack=2&cset=true>.

A. The “Spiritual Purpose of Human Life” Argument

The starting point for understanding O’Rourke’s position is his long-standing interpretation—developed with Benedict Ashley, O.P. and long the subject of intense debate—of Pope Pius’ XII’s 1957 address on the criteria for withholding or withdrawing life support. Pius XII declared: “Normally one is held to use only ordinary means [to sustain life]—according to the circumstances of persons, places, times, and cultures—that is to say, means that do not involve any grave burdens for oneself or for another. A more strict obligation would be too burdensome for most people and would render the attainment of higher, more important goods too difficult. *Life, health, all temporal activities are in fact subordinated to spiritual ends.*”⁵ Ashley and O’Rourke interpret this to mean that prolonging life is a benefit “only when it gives the person opportunity to continue to strive to achieve the spiritual purpose of life.”⁶ To strive for the spiritual end of life, they add, one needs “some degree of cognitive-affective function.” Thus, they conclude, to determine whether a treatment is of benefit to someone, “mere physical survival” at some minimal level must be assessed in terms of the “possibility of spiritual advance it offers.”⁷ If it remains possible in some fashion to perform acts of knowing and loving God and neighbor, that is, the “spiritual purpose of life,” then the artificial prolongation of life by

⁵ Pope Pius XII, “Prolongation of Life,” quoted in Ashley and O’Rourke, *Health Care Ethics*, p. 425, their emphasis. An excerpt of this papal address can be found in *Medical Ethics: Sources of Catholic Teachings*, 3rd Edition, ed. Kevin D. O’Rourke and Philip Boyle (Washington, D.C.: Georgetown Univ. Press, 1999), pp. 280-81.

⁶ Ashley and O’Rourke, *Health Care Ethics*, p. 426. They cite Kevin O’Rourke and Jean DeBlois, “Removing Life Support: Motivations, Obligations,” *Health Progress* (July/August 1992): 20-28. In Ashley and O’Rourke’s *Ethics of Health Care: An Introductory Textbook*, 3rd Edition (Washington, D.C.: Georgetown Univ. Press, 2002), p. 195, appeal is made to St. Thomas Aquinas, *Summa theologiae*, I-II, q. 1, a. 1 to support the idea that it is by means of human acts that persons are able to pursue the spiritual purpose of life.

⁷ Ibid.

medical means is justified; when this becomes impossible “because consciousness and freedom have been irrevocably lost by deterioration of the brain,” then such means cease “to be of any real benefit to the subject.” This position, they argue, is in keeping with their teleological understanding of the Christian moral life: “that all of our free decisions must be measured by our ultimate goal, eternal life with God.”⁸

⁸ Ibid.

According to Ashley and O'Rourke, although human life is a "great good," making possible our pursuit of other goods, it is neither absolute nor ultimate. Thus, they tend to see human life as "basic" but also "instrumental." "Moral theology," they write, "has always held that that 'benefit' for the human being cannot be measured in merely physical terms, but rather in terms of the goal of the total person, soul and body. *Physical life* is a great human value, but it is *subordinated to the eternal destiny of the whole person.*" Its existence, therefore, cannot outweigh "all burdens required to preserve it."⁹ With regard to medically assisted nutrition and hydration to PVS patients, the authors argue: "if cognitive-affective function cannot be restored, the artificial nutrition and hydration may be withheld or withdrawn because there is no moral obligation to continue using ineffective medical means."¹⁰ While sensitive to Church documents that speak of a "presumption in favor of providing hydration and nutrition to all patients,"¹¹ because of the abuses that can happen in end-of-life care, nonetheless they say "presumptions yield to facts, and consequently the real issue remains the estimation of benefits and burdens involved."¹² So, when a PVS or other grave condition has been diagnosed with a high level of certainty as

⁹ Ibid. p. 425.

¹⁰ Ibid., p. 426. Note the reference to O'Rourke, "The A.M.A. Statement on Tube Feeding: An Ethical Analysis," *America* (Nov. 22, 1986), pp. 321-23, 331.

¹¹ Ibid., p. 427. Ashley and O'Rourke cite the *Ethical and Religious Directives for Catholic Health Services* (1994), no. 58.

¹² Ibid.

ruling out a patient's ability to perform human acts, "further life support can only be judged 'aggressive' and 'extraordinary,' and thus ceases to be obligatory." "Such care by its very nature," they continue, "is highly burdensome to the caregivers and is an indignity to the patient. 'Normal' or 'comfort care' that avoids any pain or indignity to the dying patient always remains obligatory," but it "need not include the continuation of nutrition and hydration by intubation."¹³

B. Some Further Clarifying Points

¹³ Ibid. See also their *Ethics of Health Care*, pp. 189-94, 195-96.

In order to understand O'Rourke's position on the care of PVS patients, it will be helpful to note a number of other clarifying points that apply to the seriously ill and dying, and not just to PVS patients. First, Ashley and O'Rourke insist that to evaluate whether medical means to prolong life are "ordinary" or "extraordinary," "one must consider the condition of the patient as well as all the social and familial circumstances."¹⁴ O'Rourke has been quite clear in saying that Pius XII's statement presents "the spiritual goal of life as the norm for judging whether a grave burden is present." Thus, he understands "ordinary" measures as those "which are obligatory because they enable a person to strive for the spiritual purpose of life," while extraordinary measures of life support are those "which are optional because they are ineffective or a grave burden in helping a person strive for the spiritual purpose of life."¹⁵

Second, against those who would apply the benefit and burden assessment only to medical treatment and not to "comfort care," Ashley and O'Rourke argue that medical treatment "can also be a form of 'normal care,'" while tube feeding "is obviously a form of medical intervention." For them, the real question "is whether a particular form of 'care' is of real benefit, no matter whether it be 'medical' or not."¹⁶

Third, they affirm that the decision to withhold or remove life support "should not be made *unless a fatal pathology is present*; that is,

¹⁴ Ibid., p. 420. Ashley and O'Rourke prefer the terms *ordinary* and *extraordinary* rather than the terms *proportionate* and *disproportionate*, but "define them as does the *Declaration on Euthanasia* by the proportion of benefit to burden, while at the same time maintaining, contrary to proportionalism, the principle that *direct* killing is intrinsically and always unethical, although 'letting die' when the therapy will not benefit the patient (indirect killing in accord with the principle of double effect) is ethically justifiable" (ibid., pp. 420-21).

¹⁵ Kevin O'Rourke, "Evolution of Church Teaching on Prolonging Life," *Health Progress* 69.1 (1988): 28-35, at 32.

¹⁶ Ashley and O'Rourke, *Health Care Ethics*, p. 421. "[C]lassical moral theology held that taking food and drink even in a normal manner ceases to be obligatory for a patient if its benefit no longer exceeds its burden" (ibid.).

an illness or disease from which the person will die if therapy is not utilized. Hence, life support should not be withheld from the retarded or severely debilitated simply because they are disabled."¹⁷

¹⁷ Ashley and O'Rourke, *Ethics of Health Care*, p. 190.

The reference to a “fatal pathology” seems to indicate that Ashley and O’Rourke would be willing, at least *in principle*, to feed and hydrate PVS patients tubally. However, that is not the case. In addition to the “spiritual purpose of life” argument, O’Rourke is well known for his “fatal pathology” argument.¹⁸ Although this is sometimes identified as a separate argument for withholding or withdrawing food and water that is artificially provided,¹⁹ the way Ashley and O’Rourke employ it, the argument forms, along with the spiritual end of human life argument, one single rationale for the non-obligatory nature of tube feeding. That is, PVS patients are unable to pursue human life’s purpose precisely because they have a fatal pathology, that is, the inability to chew and swallow. Thus, says O’Rourke, one is morally justified in allowing the “existing fatal pathology...to take its natural course”²⁰ by withdrawing or withholding artificially administered food and water. If a minimum degree of cognitive-affective function “in an adult cannot be restored or if an infant will never develop this function, and if a fatal disease is present, the adult or infant may be allowed to die.”²¹ This “allowing to die,” would then be morally justified based on the principle of double

¹⁸ See O’Rourke, “The A.M.A. Statement on Tube Feeding,” 321-23, 331.

¹⁹ See John Berkman, “Medically Assisted Nutrition and Hydration in Medicine and Moral Theology: A Contextualization of Its Past and a Direction for Its Future,” *The Thomist* 68 (2004): 69-104, at 89-90.

²⁰ O’Rourke, “The A.M.A. Statement on Tube Feeding,” 322.

²¹ O’Rourke, “Evolution of Church Teaching on Prolonging Life,” p. 33.

effect.²²

II. REASONS WHY O'ROURKE'S POSITION IS WRONG AND THE ADDRESS OF JOHN PAUL II

A. Responding to O'Rourke's Arguments

²² See Ashley and O'Rourke, *Health Care Ethics*, p. 425.

John Berkman notes, however, that “fatal pathology” can be understood in two senses. First, it could mean “fatal if no treatment is given” or it could mean “fatal regardless of the treatment given.”²³ If it means the latter, “then this would seem to mean that the patient is imminently dying, or at least terminally ill.” The terms “immanently dying” and “terminally ill,” for Berkman, “more unambiguously constitute a prognosis of a particular patient’s condition than does ‘fatal pathology,’ and thus function better as criteria for evaluating the choice to withhold or withdraw” medically assisted nutrition and hydration.²⁴

²³ Berkman, “MANH in Medicine and Moral Theology,” p. 90.

²⁴ *Ibid.*

Berkman argues that this distinction illumines the differences between the Catholic theological discussion in the 1950's of medically assisted nutrition and hydration for patients in a "terminal coma"—where this condition was at the time considered "imminently dying"—and the debate as it proceeded in the 1980's, where "whether for good or ill, PVS patients could not for the most part be accurately defined as being imminently dying or even terminally ill."²⁵ That PVS patients are neither dying nor terminal is a point that William E. May has stressed in articles criticizing O'Rourke's position.²⁶ Judgment about whether a fatal pathology is present, let it be noted, should be made *before*, not after, life support has been utilized.²⁷ Moreover, as Eugene Diamond observes, contra O'Rourke, "patients in the so-called [PVS] are able to swallow their own secretions in most cases. The nerves and muscles required for mastication and deglutition are characteristically intact."²⁸ He also notes that a study of forty-three PVS patients in London published in the *British Medical Journal* (July 1996), "indicated that some had cognitive impairment but were still able to communicate with therapists and even do simple computations. Over half [of them] regained consciousness eventually." Thus, he concludes, "there is evidence for cognitive and affective function in PVS."²⁹

Even if one were to claim that PVS patients were suffering from a fatal pathology (understood as, e.g., terminal cancer), I would argue that there are good reasons for regarding medically assisted nutrition and hydration as *ordinary* and *basic care* that, unless the patient is *imminently* dying from the fatal disease other than the PVS itself, should be

²⁵ Ibid.

²⁶ See William E. May et al., "Feeding and Hydrating the Permanently Unconscious and Other Vulnerable Persons," *Issues in Law in Medicine* 3 (1987): 203-17.

²⁷ See O'Rourke's response to May, where he claims it is "irrelevant to state that PVS is not a fatal pathology *after* life support has been utilized" (part two, p. 4).

²⁸ Eugene F. Diamond, M.D., "Medical Issues when Discontinuing ANH," *Ethics & Medics* 24.9 (September 1999): 1-2, at 2.

²⁹ Ibid., p. 2.

given when the patient's digestive tract can assimilate it and when it is not overly burdensome to him or her. As John Keown argues (with reference to the famous early 1990's Tony Bland case in England, one similar to the Schiavo case), inserting "a gastrostomy tube into the stomach requires a minor operation that is clearly a medical procedure. But it is not at all clear that the insertion of a nasogastric tube is a medical intervention. It is, after all, something that even relatives can be shown how to do...The question in such a case [as Bland] is surely why *the pouring of food and water down the tube* constitutes medical treatment. What is the pouring of food and water supposed to be treating?"³⁰

³⁰ John Keown, *Euthanasia and Public Policy: An Argument against Legalization* (Cambridge: Cambridge Univ. Press, 2002), p. 219. See also pp. 232-35, 239-59.

But what of Ashley's and O'Rourke's claim that if a respirator can be withdrawn as a form of extraordinary *medical treatment* (morally acceptable in certain cases according to Catholic moral teaching), so too can tube feeding?³¹ Keown observes, however, that "ventilation replaces the patient's capacity to breathe whereas a tube does not replace the capacity to digest and merely delivers food to the stomach...A feeding-tube by which liquid is delivered to the patient's stomach is, it could be reasonably argued, no more medical treatment than a catheter by which it is drained from the patient's bladder."³² The larger question, however, that Keown raises is this: Even if one regards tube feeding as medical treatment, why is it useless? Is it because it will not restore PVS patients to some decent level of health, consistent with the purposes of *medicine*? Or is it because the *lives* of these patients are considered useless?³³

If one applies the theological anthropology of Ashley and O'Rourke as they themselves apply it to the PVS patient, then it seems the answer to Keown's question is as follows: the treatment is useless because his or her life is futile, that is, of no benefit, not worth living. This judgment rests, I believe, on a dualistic understanding of the person and can border on a "quality of life" ethic. Berkman summarizes well the powerful criticisms of the "spiritual purpose of life" argument. Critics of the latter, he notes, claim "that it assumes a dualistic anthropology, requiring persons to disassociate 'themselves' and their spiritual purpose from their character as bodily creatures. Critics further note that humans are not 'in' their bodies, but that their bodies are in some sense constitutive of who they are."³⁴ Moreover, Berkman continues, the "spiritual purpose of life" argument "typically assumes functional criteria for 'personhood'

³¹ See Ashley and O'Rourke, *Health Care Ethics*, p. 422.

³² Keown, *Euthanasia and Public Policy*, p. 220.

³³ Ibid.

³⁴ Berkman, "MANH in Medicine and Moral Theology," p. 91. For an argument against dualism, see Germain Grisez, "Dualism and the New Morality," in *Atti del congresso internazionale Tomasso d'Aquino nel suo settimo centenarrio*, Vol. 5, *L'agire morale* (Naples: Edizioni Domenicane Italiane, 1977), pp. 323-30.

and thus leads to the exclusion of certain classes of human beings from care typically extended to all persons." Hence not only PVS patients could be denied medically assisted feeding, but also, according to the logic of the argument, "various classes of patients who through genetic disease or other debility are unable to perform human acts." Since tube feeding or other medical treatments will not benefit them (i.e., by enabling them to pursue the "spiritual end of life"), "there is no purpose to treating them should they develop any kind of life-threatening (but manageable) illness."³⁵

³⁵ Berkman, "MANH in Medicine and Moral Theology," pp. 91-92.

Hence, William E. May argues that O'Rourke's reasoning would wrongly justify the decision not to stop arterial bleeding in an infant suffering from trisomy 13, who has no cognitive abilities. For simply stopping the infant's bleeding would be *ineffective* in enabling him to pursue the spiritual goal of life and therefore it would be *extraordinary* in O'Rourke's (and Ashley's) analysis, if they are both consistent. According to May, however, only treatments "which would *prevent* a person from pursuing the spiritual goal of life, *disabling* him or her, would be truly 'extraordinary' because of the terrible burden it would impose upon them."³⁶ In their recent Detroit debate, May pressed O'Rourke on this point and he responded by saying that infants with trisomy 13 are still capable of "affection." This of course is true. But it is a far cry from the role that the ability to perform human acts plays in Ashley's and O'Rourke's anthropology. For recall that Ashley and O'Rourke claim that in order to pursue the spiritual goal of life one must be able to engage in acts *requiring not merely "cognitive/affective" abilities (which little babies have) but reasoning and free choice*. I am not saying that O'Rourke would refuse to bandage the wound of the trisomy 13 infant (I am sure that he would, as he said in the debate). But his interpretation of Pius XII's address would not give him a principled *reason* for doing so.

³⁶ William E. May, *Catholic Bioethics and the Gift of Human Life* (Our Sunday Visitor Press, 2000), p. 256.

Fr. Peter Ryan argues that although O'Rourke recognizes human life as a "basic good," he "fails to recognize that bodily life is intrinsically valuable; he regards it only as instrumentally valuable and considers it worthwhile only insofar as it enables a person to participate in other goods,"³⁷ for example, to pursue life's spiritual goal. This leads O'Rourke to fall, however reluctantly and even inconsistently with his own anthropology,³⁸ into "quality of life" judgments which focus not so

³⁷ Peter Ryan, S.J., "The Value of Life and Its Bearing on Three Issues of Medical Ethics," available at: <http://www.wf-f.org/Sum2K-Ryan.html> (This article was originally given as a talk at the June 1999 UFL conference and subsequently published in *Life and Learning*). Without committing the error of treating a person's life instrumentally, one can admit that PVS patients are no longer participating in the basic good of life to its fullest. Nonetheless, no bad condition such as a PVS can lessen a person's dignity. Moreover, PVS patients can be harmed or benefited even when they do not actually experience the harm or benefit.

³⁸ See Ashley and O'Rourke, *Health Care Ethics*, pp. 31-34, where they express their disagreement with dualistic anthropologies. They hold that their anthropology is non-dualistic—emphasizing the unity of the person, body and soul—and inspired by the Aristotelian-Thomistic tradition. See also pp. 3-21.

much on the objective usefulness of the *treatment*, but on the value of the *life* that is to be preserved or not preserved; not on whether the treatment is burdensome, but on whether the person's life is burdensome.³⁹ Morally sound "quality of life" judgments, however, are those "which bear on the usefulness or burdensomeness of specific kinds of *treatments* for persons in *specific kinds of conditions*." These "are not the same as 'quality of life' judgments asserting that those persons' *lives* are no longer of any value."⁴⁰

³⁹ During the Detroit debate, O'Rourke said he likes to speak of "quality of function," rather than "quality of life."

⁴⁰ May, *Catholic Bioethics and the Gift of Human Life*, p. 258, note omitted.

Ryan also shows that O'Rourke's "conception of knowing and loving God [i.e., the "spiritual purpose of life"] is very narrowly drawn." Catholic pastoral practice, he points out, "treats those who apparently do not have that capacity or potential as apt recipients of the sacraments. Just as the severely retarded are regularly baptized, so also PVS patients, like patients in a coma and on the verge of death, are apt recipients of Baptism, Confirmation, and the Sacrament of the Sick. This pastoral practice presupposes that the relationship these recipients have with God can be affected by receiving these sacraments. Moreover, to agree that the purpose of life is to know and love God does not entail holding either that fundamental human goods, including the good of bodily life itself, lack intrinsic value or that the purpose of life does not include participating in those goods."⁴¹ O'Rourke would probably respond to this last point by saying that to consider human life as an intrinsic good does not imply that it must be kept alive "as long as is physically possible." He thinks those who make this claim (e.g., William E. May) are influenced by Germain Grisez's moral theory of incommensurable goods which he says are non-hierarchically ordered and "independent" of each other, and that this departs from the thought of St. Thomas Aquinas, who held that "the goods toward which we have a natural inclination may at times be subordinate to other human goods." Proximate goods, for Aquinas, says O'Rourke, "are subordinate to our final goal or good..." and they "are to be evaluated morally in so far as they are proportionate to striving for the objective ultimate good: knowing and loving God."⁴² I would argue with Grisez and John Finnis⁴³ that St. Thomas does *not* arrange the goods to which we have a

⁴¹ Ryan, "The Value of Life and Its Bearing on Three Issues of Medical Ethics."

⁴² O'Rourke, "On the Care of 'Vegetative' Patients," part two, p. 3. O'Rourke quotes Ashley: "[t]he human body is human precisely because it is a body made for and used by intelligence. Why should it be dualism to unify the human body by subordinating the goods of the body to the good of the immaterial free and contemplative intelligence?" (ibid.) But even if one grants this point, it does not, as we will see, determine whether the "subordinating" is morally good or morally evil. That still needs to be rationally determined.

⁴³ See Germain Grisez and John Finnis, "The Basic Principles of Natural Law:

natural inclination to in a hierarchy and that it can be dangerous to do so. For example, it can be dangerous when a so-called lesser good of human persons, such as human life, is no longer deemed worthy of protection because it itself no longer serves as the instrument for realizing the so-called higher goods.⁴⁴

A Reply to Ralph McInerney," *American Journal of Jurisprudence* 26 (1981): 21-31, especially 28-31. Moreover, a "first-order good" (e.g., life) may not, according to Aquinas, be intentionally harmed in order to save a "third-order good" (e.g., friendship with God). See John Finnis, *Natural Law and Natural Rights* (Oxford: Oxford Univ. Press, 1980), pp. 94-95 (Finnis cites *Summa theologiae*, II-II, q. 64, a. 5 and 6).

⁴⁴ On this, see William E. May, "Contemporary Perspectives on Thomistic Natural Law" in *St. Thomas Aquinas and the Natural Law Tradition: Contemporary Perspectives*, ed. John Goyette, Mark S. Latkovic, and Richard

S. Myers (Washington, D.C.: The Catholic Univ. of America Press, 2004), pp. 113-156, at 128-129.

Without pursuing this point any further, there is one other problem I would like to note with regard to O'Rourke's analysis and that is his use of the equivocal term "subordinate" (sometimes he and Ashley speak of "sacrificing" a good). According to Ashley's and O'Rourke's ethics of "prudential personalism," one is never morally permitted to directly take the life of an innocent human person (and both grant that the PVS patient is a human person) or to "directly contradict" any basic human good. Human acts that do so are "intrinsically evil."⁴⁵ The word "subordinate," then, can never mean justifying the direct killing of the innocent. By speaking in terms of "subordinating" goods, however, O'Rourke begs the question of *when* it is morally allowable to withhold or withdraw tube feeding from a PVS patient. That is, to say that one good, of a so-called lower order (e.g., bodily life) is subordinate to another good, of a so-called higher order (e.g., the ultimate end which is the "spiritual end of human life") says nothing about the *criteria* by which one can judge whether one's subordination of a good is morally upright (i.e., as in letting the patient die a natural death) or morally wrong (i.e., as in intentionally killing the patient) in a particular situation.⁴⁶ Those who defend feeding PVS patients do not "absolutize"

⁴⁵ See Benedict Ashley, O.P. "What Is the End of the Human Person?: The Vision of God and Integral Human Fulfillment" in *Moral Truth and Moral Tradition: Essays in Honor of Peter Geach and Elizabeth Anscombe*, ed. Luke Gormally (Dublin: Four Courts Press, 1994), pp. 68-96, at 92.

⁴⁶ Ashley argues that bodily life, as "the least in the hierarchy of basic goods ...can be sacrificed to the higher goods, but only on condition that the sacrificial act (1) does not involve an injustice; (2) is not intrinsically evil" (Ashley, "What Is the End of the Human Person?" p. 92). But one needs some objective moral standard in order to show precisely *why* the sacrifice is not unjust or intrinsically evil. What Ashley says simply begs the question. I argue that denying food to PVS patients *is* unjust. See also Peter J. Cataldo, "Pope John Paul II on Nutrition and Hydration: A Change of Catholic Teaching?" *National Catholic Bioethics Quarterly* 4.3 (Autumn 2004): 513-36 on "[h]ow subordination [of the obligation to preserve life] to the last end [of man] does not eliminate the subordinate duty to preserve life for Aquinas..." (p. 524n37); see pp. 530-36. Cataldo shows how Pius XII's address is directed to the patient "who is conscious and functionally able to pursue the spiritual ends of life...If the type of

the good of *bodily life*, but rather they absolutize the *moral norm* that states one is never to directly kill innocent human persons.⁴⁷

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patient to whom Pius XII refers was a permanent-coma patient, then the problem he discusses of attaining this higher good would not be relevant" (p. 535).

⁴⁷ I recognize that there are many situations where one is under no moral obligation to preserve human life at all costs, e.g., when doing so would involve extraordinary means. Thus, I would grant that even the factor of *cost* in relation to what care givers are actually capable of doing and affording, could justify withdrawing or withholding a feeding tube from someone in a PVS without the intention to kill. Also, Christians can speak of "sacrificing" certain earthly goods (e.g., one's life) to "higher goods" (e.g., Christian faith) as in martyrdom. But the martyr does not intend his death, but freely accepts its loss as a side effect of being faithful to God.

In the Detroit debate, O'Rourke seemed willing to concede the point, in light of John Paul II's address—yet contrary to his previous argument that such “medical therapy” as tube feeding “does not offer ‘hope of benefit’ to the [PVS] patient”⁴⁸—that there *is* “hope of benefit.”⁴⁹ He then went on to emphasize, however, that the “heavy human, psychological and financial burden” of caring for patients in a PVS leads to the conclusion that one need not feed them. News reports on the Schiavo case quoted O'Rourke as saying that one could specify in an advance medical directive one's refusal of a feeding tube should one

⁴⁸ O'Rourke, “On the Care of ‘Vegetative’ Patients,” part one, p. 4. Although I disagree with this position, I do not have the space to respond to it.

⁴⁹ This concession seemed strained in the sense that O'Rourke was highly critical of the address in his debate with May. Although he said that he accepted it as non-definitive “Church teaching.” I do question, however, whether O'Rourke would counsel persons to follow the Pope's moral teaching in the address.

fall into a PVS in order to spare the family the burdens of care.⁵⁰

⁵⁰ See Agostino Bono, "Schiavo Case Raises Issue of Advance Medical Directives," available at: <http://www.the-tidings.com/2005/0401/schiavo.htm>.

William E. May has responded to the “excessive burden” argument by noting that the total cost of caring for PVS patients could be quite high, but that “in our affluent society, which provides such care for other persons in severely debilitated conditions [e.g., quadriplegics, multiple amputees, and the severely mentally and physically handicapped], it would be unfair to deprive the permanently unconscious of their fair share of such care.” “[I]f one were to seek to avoid the expense involved in caring for such persons by denying them food,” May continues, “the means chosen to avoid this expense would not be the withholding of food as such but rather the subsequent death of these persons.”⁵¹ Because tube feeding PVS patients is generally neither useless nor overly burdensome, it ought to be given unless, for example, the patient’s body were unable to assimilate the food, he or she were imminently dying, or the tube was causing a serious infection.⁵²

Finnis also treats the question of what constitutes “excessive expenditure,” showing how families do not have to bankrupt themselves in caring for family members in a PVS. Finnis recognizes that although human life “even in irreversible unconsciousness is of intrinsic value, and may not be intentionally destroyed by act or omission, that value wholly lacks the further goods which normally accompany it (knowledge, friendship, play and skill, communication in prayer, etc).” Thus, he asks, might not someone contemplating being in so radically deprived a state reasonably decide that any use of hospital and specifically medical

⁵¹ May, “Tube Feeding and the ‘Vegetative’ State,” part one, p. 4. May is summarizing the conclusions of May, et al., “Feeding and Hydrating the Permanently Unconscious and Other Vulnerable Persons.” The authors had acknowledged that “*if it is really useless or excessively burdensome* to provide someone with nutrition and hydration, then these means may rightly be withheld or withdrawn, *provided* that this omission does not carry out a proposal to end the person’s life but rather is chosen to avoid the useless effort or the excessive burden of continuing to provide the food and fluids” (ibid., p. 209). But because they are *generally* a useful means in preserving the great good of human bodily life and can be provided without excessive burden, “both morality and law should recognize a strong presumption in favor of their use” (ibid., p. 211).

⁵² On why PVS patients should be fed in most cases, unless it is truly futile or excessively burdensome, see Ryan, “The Value of Life.”

resources would be excessive? "If so," Finnis argues, the patient "could judge that the duty to give and accept ordinary care requires no more than this: the giving of such food, water and nursing care as can be provided from the resources available in one's home."⁵³

⁵³ John Finnis, "Living Will' Legislation" in *Euthanasia, Clinical Practice and the Law*, pp. 167-76, at p. 176.

Against theological positions such as O'Rourke's,⁵⁴ John Paul II teaches in his March 2004 address: "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" (no. 4).

John Paul II has now spoken authoritatively for Catholics on an issue that had been vigorously debated for over twenty years in the Catholic Church, and in doing so has given Catholics (and others) invaluable moral guidance for properly forming their consciences. He is not teaching that artificially assisted nutrition and hydration must be provided in *every* case (note the use of the words "in principle" in the papal address), nor is he insensitive to the difficulties faced by families who care for PVS patients (note how he speaks of "support" for families and his suggestions for how to do this in §6). In this address, the Pope has given the faithful a document that is not only consistent with the tradition, but one that is both informed by the current medical facts and sure to be pastorally helpful in real life health care situations. May Fr. O'Rourke, who has done much good for the Catholic Church in bioethics, reread this papal document and then seriously reconsider his own view. This, I believe, would be of great benefit to any present and future patients who might find themselves in a PVS.⁵⁵

⁵⁴ Ashley and O'Rourke fear that feeding PVS patients will appear to the public as "vitalism" and thus create a climate favorable to the legalization of euthanasia (see Ashley and O'Rourke, *Health Care Ethics*, p. 428). However, we already have a climate that is favorable to euthanasia. Thus, one could argue that the unwillingness to feed PVS patients is a *symptom* of the "culture of death." By not feeding them, we only contribute to the false notion that such patients' lives are worthless.

⁵⁵ For a defense of O'Rourke's view, see Jason Eberl, *National Catholic Bioethics Quarterly* (Autumn 2005). I did not have access to this article at the time of my writing.