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Abstract

This paper discusses the methods used in Catholic Social Teaching (CST), a part of the Catholic Moral Tradition (CMT), as applied to bioethical problem solving and decision-making. In order to apply CST to a concrete bioethical problem and to analyze the methods used in CST, the nature and extent of the obligation to provide artificial nutrition and hydration (ANH) to patients in a persistent vegetative state (PVS) is addressed. In particular, this paper focuses upon the extent to which providing ANH to PVS patients is or should be considered morally obligatory. In this discussion, the current official view of the Roman Catholic Church (Church) is reviewed, as evidenced for the United States by the changes made in 2009 to Directive 58 of the *Ethical and Religious Directives for Catholic Health Care Services* (ERD), as well as contrary viewpoints. This paper argues that the methodology of CST, which includes the balancing of *benefits* and *burdens*, is a practical and ethical way to resolve difficult bioethical cases, including those where care decisions need to be made for patients in a PVS, defending against concerns that have been raised by some in or speaking for the Church about the withdrawal of ANH from PVS patients.

Keywords

Theology, religion, bioethics, Roman Catholicism, persistent vegetative state (PVS), artificial nutrition and hydration (ANH), Ethical and Religious Directives for Catholic Health Care Services (ERD).

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Method in Catholic Bioethics: ANH and PVS Patients

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Imagine a 300 bed Catholic hospital with all beds supporting PVS patients maintained for months, even years, by gastrostomy tubes...An observer of the scenario would eventually be led to ask: 'Is it true that those who operate this facility actually believe in life after death?'¹

Introduction:

In this paper, I discuss the methods used in Catholic Social Teaching (CST), a part of the Catholic Moral Tradition (CMT), as applied to bioethical problem solving and decision-making. In order to apply CST to a concrete bioethical problem and to analyze the methods used in CST, I address the nature and extent of the obligation to provide artificial nutrition and hydration (ANH) to patients in a persistent vegetative state (PVS). In particular, I focus upon the extent to which providing ANH to PVS patients is considered morally obligatory. In this effort, I discuss the current official view of the Roman Catholic Church (Church), as evidenced for the United States by the changes made in 2009 to Directive 58 of the *Ethical and Religious Directives for Catholic Health Care Services* (ERD),² as well as contrary viewpoints. ANH is referred to in the ERD as 'medically assisted nutrition and hydration' (sometimes abbreviated MANH in other literature published on this subject), but in both Church documents and other sources cited in this paper, the terms ANH and MANH are often used interchangeably. I have chosen to use the term ANH for convenience here.

The methodology of CST, which includes the balancing of *benefits-burdens*, is a practical and ethical way to resolve difficult bioethical cases, including those where care decisions need to be made for patients in a PVS. In making this case, I argue that the Church has departed from its traditional approach in bioethical decision-making,³ which included a *presumption* for providing ANH but emphasized the importance of the particular patient's circumstances. The current version of Directive 58 seemingly prescribes a new definitive obligation to provide ANH to all PVS patients with very limited exceptions.⁴ While the motives that prompted the changes made to Directive 58 are laudable and understandable, given the vulnerability of PVS patients, the rationale for the change to a less flexible approach is not persuasive, at least insofar as applied to the majority of PVS patients in the United States.

The Problem and Some Definitions:

For convenience, I will refer here to the Fourth Edition of the ERD issued in 2001 as ERD4 and the Fifth Edition issued in 2009 as ERD5. The version of Directive 58 in ERD4 reads as follows:

There should be a presumption in favor of providing nutrition and hydration to all patients, including patients who require medically assisted nutrition and hydration, as long as this is of sufficient benefit to outweigh the burdens involved to the patient.⁵

The version of Directive 58 in ERD5 reads as follows:

In principle, there is an obligation to provide patients with food and water, including medically assisted nutrition and hydration for those who cannot take food orally. This obligation extends to patients in chronic and presumably irreversible conditions (e.g., the ‘persistent vegetative state’) who can reasonably be expected to live indefinitely if given such care. Medically assisted nutrition and hydration become morally optional when they cannot reasonably be expected to prolong life or when they would be ‘excessively burdensome for the patient or [would] cause significant physical discomfort, for example resulting from complications in the use of the means employed.’ For instance, as a patient draws close to inevitable death from an underlying progressive and fatal condition, certain measures to provide nutrition and hydration may become excessively burdensome and therefore not obligatory in light of their very limited ability to prolong life or provide comfort.⁶

As is apparent from a comparison of these two versions of Directive 58, the 2009 version departs from the ‘presumption’ approach to providing ANH to patients found in the 2001 version by creating an obligation that applies ‘in principle’ to all patients, even those in PVS. The reasons for this change are discussed further below, but certainly the papal allocution in 2004 from Pope John Paul II cited below was a strong influence. The reasons for the difference are also reflected in the changes made in the text of the Introduction section to Part 5 of ERD 4 and the corresponding part of ERD 4.⁷

Both ANH and PVS have been discussed extensively in the bioethics literature by secular thinkers and by thinkers of Catholic⁸ and other faith traditions,⁹ so the constraints of time and space require both brevity and the use of certain definitions, limitations and assumptions. In this effort, I have adopted the distinction made by John C. Harvey regarding the two main causes of PVS: (a) cases caused by physical head trauma or poisoning; and (b) cases caused when “an individual develops cardiac standstill and anoxia (lack of oxygen) for a period longer than six or seven minutes before resuscitation is accomplished.”¹⁰ According to Harvey, persons in PVS who fall under (a) do not necessarily have a fatal condition, but those who fall under (b) always have such a condition.¹¹

I have also adopted the definition of PVS included in the comprehensive statement resulting from the work of the Multi-Society Task Force on the Persistent Vegetative State, as published in the *New England Journal of Medicine* in 1994 (*NEJM*), as follows:

The vegetative state is a clinical condition of complete unawareness of the self and the environment, accompanied by sleep-wake cycles, with either complete or partial preservation of hypothalamic and brain-stem autonomic functions. In addition, patients in a vegetative state show no evidence of sustained, reproducible, purposeful, or voluntary behavioral responses to visual, auditory, tactile, or noxious stimuli; show no evidence of language comprehension or expression; have bowel and bladder incontinence; and have variably preserved cranial-nerve and spinal reflexes. We define persistent vegetative state

as a vegetative state present one month after acute traumatic or nontraumatic brain injury or lasting for at least one month in patients with degenerative or metabolic disorders or developmental malformations.¹²

When referring to PVS patients, I have also assumed that the determination of PVS has been made by qualified and experienced physicians, consistent with the definition from *NEJM* above and based upon reasonable medical certainty. Although I am not a clinician, I have had the opportunity more than once in my law practice to observe PVS patients first hand and the *NEJM* description of ‘complete unawareness’ is quite consistent with my experience with such patients. In order to benefit from Harvey’s distinction noted above, the cause of PVS for each patient would have to be determined, so that a judgment can be made as to this particular patient whether the case at hand is one where recovery is possible, but unlikely, or one where recovery is not just unlikely, but impossible. The term ANH is used here to mean the use of a feeding tube. Two primary invasive methods of such feeding are common, using either a nasogastric (NG) tube or a percutaneous endoscopic gastrostomy (PEG) tube, with the selection of method being determined by clinical considerations.¹³

Overview of CST:

If to do good were as easy as to know what is good to do, chapels would be cathedrals and poor men’s cottages princes’ palaces.¹⁴

The United States Conference of Catholic Bishops (USCCB), the author of the ERD,¹⁵ describes CST as “a rich treasure of wisdom about building a just society and living lives of holiness amidst the challenges of modern society.”¹⁶ As in ERD4, ERD5 confirms the Church’s “full commitment to the health care ministry”¹⁷ and provides a theological basis for the guidance contained therein. There is a particular emphasis on the Church’s social responsibility in the ERD, grounded in human dignity, the preference for the poor and disadvantaged, the common good, responsible stewardship and avoiding moral wrong.¹⁸ The specific guidance provided in Directive 58 of ERD5, however, must be read in the context of Part Five of ERD5, especially Directives 56 and 57, along with the remainder of ERD5, in order to discern its true meaning and proper application, consistent with CST.

The USCCB describes seven themes of CST, including the following: (a) life and dignity of the human person; (b) call to family, community, and participation; (c) rights and responsibilities; (d) option for the poor and vulnerable; (e) the dignity of work and the rights of workers; (f) solidarity; and (g) care for God’s creation.¹⁹ Mark S. Latkovic has identified eight principles of CST, including the following: (a) respect for the dignity of the human person; (b) distributive equality of common goods; (c) respect for a division of labor or function of each human person; (d) authority as the “capacity to make decisions on behalf of a community...to benefit the common good of a community;” (e) the participation; (f) subsidiarity and functionalism; (g) the common good; and (h) Christian love.²⁰ According to Latkovic, these principles are the “core principles which undergird Church teaching in... [the] areas...of social, political and economic realities.”²¹ Latkovic’s ‘core principles’ appear to be in general harmony with USCCB’s ‘themes’ of CST.

The late Kevin P. O’Rourke,²² who died in 2012, constantly reinforced that a full consideration of the sources of ethical thought in CST would include the teachings of Jesus (love God and your neighbor), biblical counsels, commandments and parables taken from scripture, along with theology (human reason using principles of faith) and the authoritative teaching of the Church and natural law.²³ Over time CST has developed its own discrete literature, themes and principles as summarized above and discussed below,

each of which helps to ground the ERD firmly in the Church's emphasis on social justice in its teaching. For example, the obligation of responsible stewardship over the creatures and resources of the world is logically extended to the health care arena, along with the need to promote the common good.²⁴

As mentioned, CST is a prominent feature of ERD5 and the organization of each of the Parts thereof (including Part Five with which we are most concerned here) includes an introduction that is expository in nature, but also provides the "context in which concrete issues can be discussed from the perspective of the Catholic faith."²⁵ The second section of each Part includes specific guidance on particular matters, such as is contained in Directive 58. By its very structure, then, the intent is clear that we should be reading ERD5 as a whole to understand the full meaning of the Church's guidance. The entire text of Directive 58 is further qualified by the introductory phrase 'in principle' in dealing with the extent of the moral obligation to provide nutrition and hydration to patients, including those in PVS. This moral obligation to sustain life with food and water is not unlimited, as we were taught centuries ago by Francisco de Vitoria, discussed below.

M. Therese Lysaught confirms David Cloutier's²⁶ view of fulfillment when she argues that to "explore the Christian moral life, then, is to explore what it means to love God...[and that implies] worship...the liturgy...the Mass...the Lord...who loved us first and longs for our love...and invites us to become his friends."²⁷ Like learning to play the game of golf well, "Christian moral living is a skill that can be acquired only over time, through ongoing practice (and much grace)."²⁸ Part of that effort needs to include acquisition of the cardinal virtues [justice, prudence, temperance and fortitude] because they may "rightly be called the path to the good life."²⁹

Thomas Aquinas is often credited as the thinker who most fully developed natural law theory as applied to the Church's teaching. Stated simply, while we understand that all God's creatures are endowed by their creator with "proper ends and purposes," humans alone may "use reason to discern good and evil...to choose the path that God...has laid out for human fulfillment and well being..."³⁰ While many Catholic thinkers trace the roots of their thought back to natural law, controversy exists over how natural law should be viewed, including some feminist critiques that deserve attention.³¹ Some prefer a static approach (unchanging norms) or a dynamic one (evolutionary norms), while others, such as O'Rourke, advocate for a middle position, which "emphasizes the unchanging and essentially human, while acknowledging but according less significance to historical change."³² O'Rourke's middle ground seems to have been endorsed by Pope John Paul II (JPII), at least on some occasions, as when he declared that "'This triumph of the moral law...unfolds down the centuries: the norms expressing the truth remain valid in their substance, but must be specified and determined...in the light of historical circumstances."³³ Earlier, among the lessons of Vatican II, the Church taught that Catholics should "remain attuned to the progressive revelation of Christ through history."³⁴

Regardless of whether a Catholic thinker may be classified as having adopted an approach that is static, dynamic or occupies the middle ground, all share "an abiding commitment to the promotion and defense of human dignity from conception to death."³⁵ As creatures made in God's image, we may use the gift of reason "in combination with our natural inclination to recognize and seek the good... [and] to reflect upon and discover laws, in the form of general tendencies, that satisfy basic human needs and fulfill the divinely intended nature of human beings."³⁶ Among our natural inclinations that are divinely intended is the preservation of life, from which arise obligations of self-care and avoidance of risk and danger, such care and avoidance being "rationally extended to the dignity and lives of others."³⁷ Consistent with these observations, we find Directive 56 that requires us to use 'ordinary means' to preserve life and Directive

57 that permits us to forego 'extraordinary means' to do so, when such latter means do not "offer a reasonable hope of benefit or entail an excessive burden."³⁸ Directive 58 must be read with the guidance provided in Directives 56 and 57 in mind.

The Church counsels us to consider death as a part of life, the logical, unavoidable and ultimate end of our time here on earth. As mentioned in Part Five of ERD5, Catholics face "the reality of death with the confidence of faith."³⁹ We are given stewardship but not ownership of our bodies and remain "accountable to God for the life that has been given to us."⁴⁰ Life's true meaning is found in the resurrection of Jesus and hope for the life to come after earthly death.⁴¹ As CST has developed, and as found in Directives 56 and 57 of ERD5, Catholic thinkers have for centuries distinguished between *ordinary* and *extraordinary* measures for preserving life.⁴² This approach's challenge is chiefly to determine what may, in particular circumstances and for a particular patient, constitute ordinary (proportionate, useful, beneficial or easily borne) care and thus be obligatory and what may, under the same circumstances and for the same patient, constitute extraordinary (disproportionate, useless, harmful or burdensome) care and thus not be obligatory but only permissible.

To put the question more simply, as Gerald Kelly does, "How much does God demand that I do in order to preserve this life which belongs to God and of which I am only a steward?"⁴³ Where impossibility is encountered, one may be excused from making the effort to sustain one's life "especially where there is little hope of life, or none at all."⁴⁴ Our duty in the Catholic tradition is limited "to make do with the normal means medicine has to offer."⁴⁵ The Catholic view is that "Life is a gift of God, and, on the other hand death is unavoidable; it is necessary that we, without in anyway hastening the hour of death, should be able to accept it with full responsibility and dignity."⁴⁶ To preserve life at all costs would make idolatry out of or create a culture of worship for human life that would not find support in CST. God alone is worthy of worship and to elevate ourselves and our lives to that level would be inappropriate and unwarranted.

End of Life:

The hotly debated and much discussed issues of forgoing or withdrawing of medical technology in general and the issue of killing or letting die (particularly but not exclusively in the realm of euthanasia, physician-assisted suicide or PAS, or physician aid in dying or PAD) are beyond the scope of this paper, but basing any conclusions of moral permissibility solely on a characterization of a particular behavior as an action rather than an omission is a thin reed upon which to build an ethical foundation. The Catholic teaching forbids euthanasia, regardless of how accomplished, whether by action or omission. Therefore, it is no answer to say that one approach (euthanasia, PAS or PAD) represents an act resulting in death and letting die is only an omission, since the consequences are the same for Raanan Gillon "unless you also can say that makes the moral difference; whatever that something is, it must be different from the bare difference between acts and omissions."⁴⁷ According to Gillon, there are at least three moral claims that stand behind the Catholic rejection of any simple act-omission test in these circumstances: (1) the omission is morally culpable; (2) outcomes and prior moral obligations, along with the understanding and intent of the actor are all relevant; and (3) certain acts and omissions are always forbidden, such as intentionally ending the life of an innocent.⁴⁸

The above claims do not mean that, in an appropriate case, pain relief cannot be applied, even if use of the pain-killing drugs may shorten the life of the patient because the intent is to relieve pain, not cause death.⁴⁹ We operate in an area of moral ambiguity worthy of careful thought and review, however, in the case of letting die and in the area of moral prohibition in the case of killing.⁵⁰ Killing in this context includes

euthanasia, PAS and PAD. Letting die may take many forms, such as complying with a ‘do not resuscitate’ (DNR) order for a terminal patient where no measurable benefit can be gained from using a particular procedure, while a positive harm may result if action is taken in contravention of the DNR order (*e.g.*, puncturing the lungs of an elderly and infirm patient by resuscitation efforts). Therefore, while the ordinary-extraordinary distinction may seem strained, it remains a useful tool in analyzing bioethical dilemmas, perhaps particularly when considering whether to provide or withdraw ANH from a PVS patient. If ANH is withdrawn from a PVS patient and the patient dies, “Death comes not from the lack of tube feeding but from the underlying pathology that placed the person in that condition...the original pathology [is allowed] to take its natural course of events.”⁵¹

Presumption or Obligation?

When comparing Directive 58 in ERD4 and ERD5, it is clear that ERD4’s contemplation that this area may be one “requiring further reflection”⁵² has been replaced with the certainty of the language of obligation in ERD5. Directive 58 in ERD4’s formulation speaks in the language of presumption of providing ANH, “so long as this [providing ANH] is of sufficient benefit to outweigh the burdens involved to the patient.”⁵³ In ERD5’s formulation, however, the sufficient benefit standard is removed in favor of a standing obligation to provide ANH, except in very limited circumstances where ANH would be “excessively burdensome” or involve “significant physical discomfort”, especially where ANH has “very limited ability to prolong life or provide comfort.”⁵⁴ Although perhaps intended to end the prior debate among Catholic thinkers on this issue, that debate continues. Further dialogue on this issue is not only desirable, but also necessary for us to “remain attuned to the progressive revelation of Christ throughout history.”⁵⁵ For example, Richard McCormick observes that ANH “are not required for persons diagnosed as irreversibly in a PVS... [because it] is not a benefit to the patient and therefore is not in the patient’s best interests.”⁵⁶ Providing ANH for PVS patients in most instances is essentially futile care and not mandatory.⁵⁷ In this context, we should not conflate continuation of biological existence with conferring a ‘benefit’ on a patient who is no longer a sentient being in any real sense. O’Rourke⁵⁸ likewise focuses on the lack of actual benefit provided by ANH to the PVS patient. He also reminds us about the principle of double effect, benefit and double effect being two areas where proponents of the view espoused by a literal reading of Directive 58, such as William E. May,⁵⁹ either ignore or attempt to define away.⁶⁰ May finds a ‘benefit’ to be conferred by using ANH merely because biological existence continues for the PVS patient, conflating mere ‘existence’ with ‘life’ in the context of what is found in PVS from the NEJM article cited above, a “...clinical condition of complete unawareness of the self and the environment...”⁶¹ In Directive 58 (ERD4), the Catholic tradition allowed a *balancing* of interests, including whether the benefit of a particular intervention would be sufficient to outweigh its burdens. In Directive 58 (ERD5), unless the phrase ‘in principle’ may be read as qualifying the obligation to provide ANH to all PVS patients, the historic benefits-burdens analysis has seemingly been abandoned. At a minimum, at least when read on its own and without applying any limiting effect at all to the ‘in principle’ preamble, the new Directive 58 has conflated benefit with effect, because while routinely providing ANH on an indefinite basis to PVS patients may continue their biological existence, no practical benefit is thereby conferred on these patients.⁶² Considerable resources would be devoted to providing care that is useless, futile or perhaps even harmful. As O’Rourke has also observed, a formulation equivalent to new Directive 58 ignores issues of cost and the inherent burden imposed upon families and societies,⁶³ all such issues being important components of CST in its emphasis on the greater good and the prudent use of scarce resources, such as health care, in ways that will benefit the society at large.

Although defining the limits of morally obligatory health care interventions is certainly not easy,⁶⁴ perhaps

the question may be best framed something like this: “If God is calling you home, how much do you argue?” To move from a theological perspective to a practical one, it should be considered, consistent with Directives 56 and 57, how much can, should or must be done and at what cost in terms of financial and other personal and community resources, discomfort and distress for the family and patient? The question may be stated simply as done by Kelly, but it defies an easy answer, contributing to the “centuries of wrestling with these concerns.”⁶⁵ Francisco de Vitoria attempted to outline how far our duty extends, limiting it (in terms of nourishment) to “common and regular foods” and without imposing a duty to travel to a more healthful climate or location, particularly when “depression of the spirit is...low,” the effort great so as to be akin to “a certain impossibility.”⁶⁶ In such instances one may be excused from making the effort to sustain one’s life “especially where there is little hope of life, or none at all.”⁶⁷

Pope Pius XII’s pronouncements in 1957 on the requirement to “use ordinary means,”⁶⁸ which were confirmed by Cardinal Juan de Lugo⁶⁹ and Kelly⁷⁰ are again found in Directives 56 and 57 which apply what might be thought of as a ‘rule of reason’ when balancing benefits and burdens for a particular patient with her unique circumstances, disease state or injury, etc. More than twenty years after Pope Pius XII’s ‘ordinary means’ statement, perhaps reflecting rapid advances in medicine generally and medical technology in particular, the Sacred Congregation for the Doctrine of the Faith, in its *Declaration on Euthanasia* (1980), refers more to appropriate or proportionate means being obligatory rather than the classic *ordinary* test. Inappropriate or disproportionate (extraordinary) means are not obligatory, but are permitted, since the duty is limited “to make do with the normal means medicine has to offer.”⁷¹

Without situating Directive 58 in the context of the individual patient, JP II’s view on ANH in PVS (as now reflected in ERD5) seems to Peter Clark⁷² to be taking the Church in a different direction from the traditional analysis, which applied previously for both patients at the end of life and in PVS. Whether the obligation to provide ANH under all circumstances should be an unqualified rule appears to be debatable, despite Directive 58. Clark and others are inclined to limit the use of these statements to counter the undesirable effects of our Western *culture of death*, but perhaps these statements may undermine the battle with that culture by diminishing the value that the Church’s traditional approach has had. The traditional benefits-burdens method found in CST and CMT may seem a bit vague or even clumsy and imprecise, but perhaps that situation is unavoidable, due to the uniqueness of each life and each person’s life experience that should be considered where PVS is involved. Such a process of consideration is made all the more difficult for PVS patients, since they can no longer communicate their wishes and the health care team must rely on instructions from agents for these patients.

JP II’s allocation upon which Directive 58 is based also has some other problems to which Harvey alerts us. By limiting the effect of the allocation (and Directive 58’s mandate) to the first class of PVS patients described by Harvey, that would dramatically reduce the number of patients kept on life support indefinitely. As Harvey says:

The Holy Father spoke at length about...’reawakening centers’...It is clear from his words that he was speaking only about those individuals who were in PVS as a result of head trauma or poisoning by drugs or alcohol. It is this group of patients who do not necessarily have a fatal pathology and may recover consciousness months or even years after the traumatic insult.⁷³

In addition to the above problems that Harvey describes with JP II’s allocation, Clark observes that “it seems logically inconsistent to classify nutrition and hydration as basic care that is always obligatory, even

if artificially supplied, while not doing the same for oxygen supplied by mechanical ventilation or other basic elements of care necessary for life.”⁷⁴ Clark finds this inconsistency as to what is to always be regarded as ‘basic care’ to be “not only illogical but...irrational.”⁷⁵ In addition, I concur with Clark that JPII’s classification of the withdrawal of ANH as being the creation of a “second pathology, starvation/dehydration”⁷⁶ and thus such withdrawal constituting the “direct killing of the patient”⁷⁷ to be moral error based upon a misunderstanding of the clinical facts. This is so because withdrawing ANH for a PVS patient involves an “intention [which]...is not to end the life of the patient but to forgo a burdensome treatment and allow the patient to die from the original pathology.”⁷⁸

The traditional Catholic view is that life is a good but not the highest good, so there are limits on what must be done to preserve life. Determining what is obligatory and what may be foregone is a difficult task, since a simple assertion that we need not “do everything to maintain life at all costs,” consistent with Pope Pius XII’s guidance, does not provide a clear path for “most medical decisions” which, according to Kevin W. Wildes, “fall somewhere in between” the prohibition against taking innocent life and a *do everything* approach.⁷⁹ Within these boundaries lie the dilemmas, the places where the Catholic tradition sets the guideposts of ordinary and extraordinary means, which have the vice of being vague but the virtue of being flexible enough to adapt to the situation of the individual patient in question.⁸⁰

Wildes cites Archbishop Daniel A. Cronin, who emphasized in his 1958 doctoral dissertation that humans have only an imperfect dominion over their own lives, such lives being gifts from God, to be contrasted with the more perfect dominion humans have over animals and things in the physical world. Included within this notion of dominion is the concept of mastery, humans having mastery over certain operations conducted by them, but not mastery over their own lives.⁸¹ In this latter dominion is demonstrated the “considerable, though limited, freedom” given to human beings wherein we are obligated to conserve our lives, but in so doing to balance that obligation against “other obligations and the view that love of God orders all obligations.”⁸² The two main roadblocks presented that may prevent the use of a particular life-conserving means include physical and moral impossibility. When looking at potential means as possibilities for action, if neither of these impossibilities is present, then the means may be considered ordinary. Wildes’ focus, though, is on the effect of the treatment on the lives of *this* patient, such patient’s family and the others involved with the patient, rather than on the specific “means of treatment or care” involved.⁸³

For Wildes, the proper standard is a situated one, without absolutes and where the conscience of the individual, exercising “rational self-interest but according the promptings of the Holy Spirit” will be involved: clearly a patient-centered approach.⁸⁴ To be considered extraordinary, a means must be morally impossible, require excessive effort, involve great pain or discomfort, hardship-level expense or be repugnant to the patient.⁸⁵

Conclusion:

Whether to intervene at the outset with ANH for a PVS patient or to continue ANH once begun after a sufficient period of time has passed for good clinical judgment to be made is something to be decided with and for a particular patient and with due consideration for that patient’s values. If the process remains focused on a particular patient and such patient’s hopes, dreams, desires and goals, we may avoid the concerns over discrimination and eugenics about which JPII has warned us. Unless read more broadly in the context of the CST and the remainder of ERD5 (including Directives 56 and 57), Directive 58 of ERD5 can be considered as having effectively closed the door to considerations appropriate in CST to a balancing of interests in favor of an unqualified obligation to provide ANH in essentially all PVS cases. Rather than

adopting this literalist approach to Directive 58, I submit that the Church and respect for the dignity of the person of the PVS patient involved would be better served by a more inclusive benefits-burdens analysis, to be conducted in accordance with the historic ordinary-extraordinary distinction found in CMT and CST, at least insofar as any case under consideration falls in the second category of cases described by Harvey, if not all PVS cases. Even if the particular patient in question came to be in PVS due to a failed suicide attempt, the clinical reality and corresponding ethical analysis would be the same for that patient as for one who came to be in PVS due to a traumatic event not of the patient's own making. Regardless of the cause, if the patient falls in Harvey's second category of cases, providing ANH for such a patient should not be morally obligatory.

PVS patients are and remain persons and are thus entitled to the dignity, respect and protection afforded to persons. However, PVS patients are in a "...clinical condition of complete unawareness..."⁸⁶ and such a state of 'unawareness,' at least in Harvey's second category of cases, removes *permanently* the patient's ability to be a functioning and interactive member of the human community and to have relationships with others facilitated by perception and communication. To insist on continuing ANH for *all* PVS patients as Directive 58 can be read to do amounts to requiring futile care at considerable financial and human cost that is essentially 'arguing too much' with God, when He has, in effect, already 'called' this person to come home. As Todd A. Salzman and Michael G. Lawler have counseled with respect to reproductive matters,⁸⁷ further dialogue within the Church on ANH and PVS is not only desirable, but also necessary. This is so because providing ANH to PVS patients merely delays death by maintaining biological existence, rather than preserving life. Providing ANH may well be permissible here, but it should not be morally obligatory in *all* cases. Applying new Directive 58 literally and without a full contextual approach conflates protection of human dignity with preservation of biological existence. It also does not serve the common good or conserve scarce resources as would be consistent with the duty found in CST's injunction for us to be the good stewards of the 'goods' of this world. Finally, Directive 58's 'legalistic' approach does not aid in the needed reform Lysaught calls us to accomplish by making Christian health care ethics less about "isolated, rare, occasional treatment decisions" and more about Christian discipleship and the "shape of the entire Christian life as lived within and around the context of medicine."⁸⁸

¹ Richard McCormick, "Moral Considerations' Ill Considered," in *America*, volume 166, number 9 (March 14, 1992), pp. 210-214 at p. 214.

² United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Services*, Fourth Edition, Washington, D.C. (2001) [ERD4]; United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Services*, Fifth Edition, Washington, D.C. (2009) [ERD5].

³ Thomas A. Shannon and James J. Walter, "Assisted Nutrition and Hydration and the Catholic Tradition," in *Theological Studies*, volume 66, number 3 (September, 2005), pp. 651-662. Shannon and Walter point out "four unacknowledged shifts" in the Catholic tradition, ending with JPII's allocution in 2004, which they describe as "revisionist" and conclude strongly when they say that "...the Catholic tradition on end-of-life issues has never mandated doing useless or inane things to people in the name of morality. We should not start doing this now." *Ibid.* pp. 653, 662. Treating JPII's views as 'revisionist' has been challenged by, among others, John J. Paris, James S. Keenan and Kenneth R. Himes in "Did John Paul II's Allocution on Life Sustaining Treatments Revise Tradition?" in *Theological Studies*, volume 67, number 1 (March, 2006), pp. 163-168.

⁴ See, e.g., Justin F. Rigali and William E. Lori, "Human Dignity and the End of Life," in *America*, volume 199 number 3 (August 4, 2008), pp. 13-15, who would concur with the new version of Directive 58, since they argue that "food and water...constitute the 'basic care' that patients should receive." *Ibid.* p. 15.

⁵ USCCB, ERD4.

⁶ USCCB, ERD5.

⁷ The relevant part of the Introduction to Part Five (*Issues in Care for the Dying*) of ERD 4 includes the following: “Some state Catholic conferences, individual bishops and the USCCB Committee on Pro-Life Activities have addressed the moral issues concerning medically assisted hydration and nutrition. The bishops are guided by the church’s teaching forbidding euthanasia, which is “an action or an omission which of itself or by intention causes death, in order that all suffering may in this way be eliminated.” These statements agree that hydration and nutrition are not morally obligatory either when they bring no comfort to a person who is imminently dying or when they cannot be assimilated by a person’s body. The USCCB Committee on Pro-Life Activities’ report, in addition, points out the necessary distinctions between questions already resolved by the magisterium and those requiring further reflection, as for example the morality of withdrawing medically assisted hydration and nutrition from a person who is in the condition that is recognized by physicians as the “persistent vegetative state.” The relevant part of the Introduction to Part Five (*Issues in Care for the Seriously Ill and Dying*) of ERD5 is set out below in Endnote 15.

⁸ See, e.g., Christopher Tollefsen, ed., *Artificial Nutrition and Hydration: The New Catholic Debate*, Springer, Dordrecht, The Netherlands (2008) and Ronald P. Hamel and James J. Walter, eds., *Artificial Nutrition and Hydration and the Permanently Unconscious Patient: The Catholic Debate*, Georgetown University Press, Washington, D.C. (2007).

⁹ H. Tristram Engelhardt, Jr. and Ana Smith Iltis, “End of Life: The Traditional Christian View,” in *The Lancet*, volume 366, number 9490 (September 17, 2005), pp. 1045-1049.

¹⁰ John C. Harvey, “The Burdens-Benefits Ratio Consideration for Medical Administration of Nutrition and Hydration to Persons in the Persistent Vegetative State,” in *Christian Bioethics*, volume 12, number 1 (January 1, 2006) pp. 99-106 at pp. 102-103. See also Alan Sanders, “The Clinical Reality of Artificial Nutrition and Hydration at the End of Life,” in *The National Catholic Bioethics Quarterly*, volume 9, number 2 (Summer 2009), pp. 293-304, where Sanders argues that “...the clinical reality is that ANH may cause more physical harm than good for many patients...” p. 293.

¹¹ Harvey, “Burdens-Benefits,” pp. 102-103.

¹² The Multi-Society Task Force on the Persistent Vegetative State, “Medical Aspects of the Persistent Vegetative State – First of Two Parts,” in *New England Journal of Medicine*, volume 330, number 21 (May 26, 1994), pp. 1499-1508; The Multi-Society Task Force on the Persistent Vegetative State, “Medical Aspects of the Persistent Vegetative State – Second of Two Parts,” in *New England Journal of Medicine*, volume 330, number 22 (June 2, 1994), pp. 1572-1579 [the foregoing sources are hereafter cited collectively for convenience as “NEJM Task Force Articles on PVS.”]

¹³ Myles N. Sheehan, “Feeding Tubes: Sorting out the Issues,” in *Health Progress*, volume 82, number 6 (November-December 2001), pp. 22-27.

¹⁴ William Shakespeare, *Merchant of Venice*, Act 1, Scene 2, Lines 205-207.

¹⁵ The Introduction to Part Five (*Issues in Care for the Seriously Ill and Dying*) of ERD5 provides, in pertinent part, as follows: “The Church’s teaching authority has addressed the moral issues concerning medically assisted nutrition and hydration. We are guided on this issue by Catholic teaching against euthanasia, which is ‘an action or an omission which of itself or by intention causes death, in order that all suffering may in this way be eliminated.’ While medically assisted nutrition and hydration are not morally obligatory in certain cases, these forms of basic care should in principle be provided to all patients who need them, including patients diagnosed as being in a ‘persistent vegetative state’ (PVS), because even the most severely debilitated and helpless patient retains the full dignity of a human person and must receive ordinary and proportionate care.” The primary source cited in this Introduction is the *Declaration on*

Euthanasia issued by the Congregation for the Doctrine of the Faith in 1980. JP II's Allocution is cited later as support for Directive 58 itself.

¹⁶ United States Conference of Catholic Bishops, "Seven Themes of Catholic Social Teaching," Internet: <http://www.usccb.org/beliefs-and-teachings/what-we-believe/catholic-social-teaching/seven-themes-of-catholic-social-teaching.cfm> (Accessed October 17, 2015).

¹⁷ USCCB, *ERD5*, p. 3.

¹⁸ USCCB, *ERD5*, pp. 10-11.

¹⁹ USCCB, "Seven Themes."

²⁰ Mark S. Latkovic, "Catholic Social Teaching: Eight Principles of Social Justice," in *The Josephinum Journal of Theology*, volume 7, numbers 1-2 (Summer 2000), pp. 54-70.

²¹ *Ibid.*

²² Kevin P. O' Rourke, "Method in Health Care Ethics: The Catholic Perspective," Lecture to Health Care Ethics Faculty, Regis University (2006). The inspiration for and analysis of the CST sources discussed herein owe a great debt to the late Father O'Rourke.

²³ *Ibid.*

²⁴ USCCB, *ERD5*, p. 9.

²⁵ USCCB, *ERD5*, p. 4.

²⁶ David Cloutier, "Human Fulfillment," in David Matzko McCarthy and M. Therese Lysaught, eds., *Gathered for the Journey: Moral Theology in Catholic Perspective*, Wm. B. Eerdmans Publishing Co., Grand Rapids, MI (2007), pp. 142-143.

²⁷ M. Therese Lysaught, "Love and Liturgy," in *Gathered*, pp. 25-27.

²⁸ McCarthy and Lysaught, "Introduction," in *Gathered*, p. 2.

²⁹ William C. Mattison, III, "Moral Virtue, the Grace of God, and Discipleship," in *Gathered*, p.203. See also Edmund D. Pellegrino, *The Philosophy of Medicine Reborn*, H. Tristram Engelhardt, Jr. and Fabrice Jotterand, eds., University of Notre Dame Press, Notre Dame, IN (2008), where Pellegrino observes: "My principal aim is to examine the way in which the central virtue of the Christian life – the virtue of Charity – shapes the whole of medical morals." p. 349.

³⁰ Aaron L. Mackler, *Introduction to Jewish and Catholic Bioethics*, Georgetown University Press, Washington, D.C. (2003), p. 27.

³¹ Lisa Sowle Cahill, "Natural Law: A Feminist Reassessment," in Leroy S. Rouner, ed., *Is there a Human Nature*, University of Notre Dame Press, Notre Dame, IN (1997), pp. 78-91.

³² Mackler, *Introduction*. p. 28.

³³ *Ibid.* p. 39.

³⁴ Hazel J. Markwell and Barry F. Brown, "Bioethics for Clinicians: 27 Catholic Bioethics," in *Canadian Medical Association Journal*, volume 165, number 2 (July 24, 2001), p. 189.

³⁵ Deborah Bennett-Woods, "Catholic Moral Tradition" in *Ethics at a Glance*, Regis University, Denver, CO (2005), Internet: <http://rhchp.regis.edu/HCE/EthicsAtAGlance/index.html> (accessed April 19, 2015).

³⁶ *Ibid.*

³⁷ *Ibid.*

³⁸ USCCB, *ERD5*, p. 31.

³⁹ USCCB, *ERD5*, p. 29.

⁴⁰ Markwell and Brown, "Bioethics", p. 189.

⁴¹ *Ibid.*

⁴² See, e.g., Michael R. Panicola, "Catholic Teaching on Prolonging Life: Setting the Record Straight," in *Hastings Center Report*, volume 31, number 6 (November-December 2007), pp. 14-25.

⁴³ Mackler, *Introduction*, p. 86. See also Gerald Kelly, "The Duty of Using Artificial Means of Preserving Life," in *Theological Studies*, volume 12, number 4 (December 1951), pp. 203-220; and Kate Jackson, "Lessons from Gerald Kelly, S.J., the Father of American Catholic Medical Ethics," in *Health Care Ethics USA*, volume 23, number 2 (Spring 2015), pp. 7-18.

⁴⁴ *Ibid.* p. 87.

⁴⁵ *Ibid.* p. 89

⁴⁶ Sacred Congregation of the Faith, *Declaration on Euthanasia* (1980), Part III.

⁴⁷ Raanan Gillon, "Acts and Omissions, Killing and Letting Die," in *British Medical Journal*, volume 292, number 6513 (January 11, 1986), pp. 126-127.

⁴⁸ *Ibid.* p. 127.

⁴⁹ Sacred Congregation of the Faith, *Declaration on Euthanasia* (1980), Conclusion.

⁵⁰ James F. Keenan, "Assisted Suicide and the Distinction Between Killing and Letting Die," in *Catholic Medical Quarterly*, volume 42, number 1 (May, 1992). Internet: http://www.cmq.org.uk/CMQ/1992/suicide_lettingdie.html (Accessed October 18, 2015).

⁵¹ Peter Clark, "Tube Feedings and PVS Patients: Ordinary or Extraordinary Means?" in *Christian Bioethics*, volume 12, number 1 (January 1, 2006), p. 57.

⁵² USCCB, *ERD4*, p. 13.

⁵³ *Ibid.* p. 14.

⁵⁴ USCCB, *ERD5*, p. 30. Directive 58 finds support in John Paul II, Allocution "Life Sustaining Treatments and the Vegetative State," March 20, 2004; Congregation for the Doctrine of the Faith, "Responses to Certain Questions

Concerning Nutrition and Hydration," (2007) and "Commentary of Certain Questions Concerning Nutrition and Hydration," (2009).

⁵⁵ Markwell and Brown, "Bioethics", p. 189.

⁵⁶ Richard A. McCormick, "Physician Assisted Suicide – Flight from Compassion", in *The Christian Century*, volume 108, number 35 (December 4, 1991), pp. 1132-1134 at p. 1133; and McCormick, "Moral Considerations," p. 210.

⁵⁷ McCormick, "Moral Considerations," p. 214.

⁵⁸ Kevin O'Rourke, "On the Care of 'Vegetative' Patients," Parts One and Two, in *Ethics & Medics*, volume 24, numbers 4-5 (April-May, 1999), pp. 3-4,3. See also O'Rourke, "When to Withdraw Life Support?" in *The National Catholic Bioethics Quarterly*, volume 8, number 4 (Winter 2008), pp. 663-672; O'Rourke, "The Catholic Tradition on Forgoing Life Support," in *The National Catholic Bioethics Quarterly*, volume 5, number 3 (Autumn 2005), pp. 537-553; and Jason T. Eberl, "Extraordinary Care the Spiritual Gift of Life," in *The National Catholic Bioethics Quarterly*, volume 5, number 3 (Autumn 2005), pp. 491-501.

⁵⁹ William E. May, *Catholic Bioethics and the Gift of Human Life*, Second Edition, Our Sunday Visitor, Inc., Huntington, Indiana (2008). See pp. 285-302 on "Caring for the Permanently Unconscious and Persons in the 'Persistent Vegetative State.'" See also Mark S. Latkovic, "The Morality of Tube Feeding PVS Patients," in *The National Catholic Bioethics Quarterly*, volume 5, number 3 (Autumn 2005), pp. 508-513; Donald E. Henke, "A History of Ordinary and Extraordinary Means," *The National Catholic Bioethics Quarterly*, volume 5, number 3 (Autumn 2005), pp. 555-575; and The Catholic Medical Association, "Response to the Consortium of Jesuit Bioethics Programs Statement 'Undue Burden?,'" in *The Linacre Quarterly*, volume 76, number 3 (August 2009), pp. 296-303.

⁶⁰ Kevin O'Rourke, "Reflections on the Papal Allocution Concerning Care for PVS Patients," in *Christian Bioethics*, volume 12, number 1 (January 1, 2006), pp. 83-97.

⁶¹ NEJM Task Force Articles on PVS.

⁶² McCormick, "Moral Considerations."

⁶³ O'Rourke, "Reflections."

⁶⁴ See, e.g., Eileen P. Flynn, *Hard Decisions: Forgoing and Withdrawing Artificial Nutrition and Hydration*, Sheed & Ward, Kansas City, MO (1990) and Flynn, *Issues in Health Care Ethics*, Prentice Hall, Inc., Upper Saddle River, NJ (2000), pp. 112-126.

⁶⁵ Mackler, *Introduction*, p. 86. See also Lisa Sowell Cahill, *Theological Bioethics*, Georgetown University Press, Washington, D.C. (2005), especially Chapters 3 and 4 therein, where Cahill reminds us of the "...framework provided by the Roman Catholic tradition, which has for centuries provided guidance about practical decision making in times of illness and danger of death. This is the distinction between ordinary and extraordinary means of life support, which is implemented by the principle of double effect to evaluate end-of-life care." p. 73.

⁶⁶ Mackler, *Introduction*, p. 87. See also Julia Fleming, "When 'Meats are like Medicines': Vitoria and Lessius on the Role of Food in the Duty to Preserve Live," in *Theological Studies*, volume 69, number 1 (February 2008), pp. 99-115.

⁶⁷ Mackler, *Introduction*, p. 87.

⁶⁸ *Ibid.* p. 88.

⁶⁹ *Ibid*; Pope Pius XII, “The Prolonging of Life,” (1957) in *The National Catholic Bioethics Quarterly*, volume 9, number 2 (Summer 2009), pp. 327-332.

⁷⁰ Mackler, *Introduction*, p. 86.

⁷¹ *Ibid*. p. 89.

⁷² Clark, “Tube Feedings,” pp. 43-64. See also Daniel P. Sulmasy, “Preserving Life?” in *Commonweal*, volume 134, number 21 (December 7, 2007), pp. 16-18; and Consortium of Jesuit Bioethics Programs, “Undue Burden?” in *Commonweal*, volume 136, number 3 (February 13, 2009), pp. 13-15.

⁷³ Harvey, “Burdens-Benefits,” p. 104.

⁷⁴ Clark, “Tube Feedings,” p. 56.

⁷⁵ *Ibid*.

⁷⁶ Clark, “Tube Feedings,” p. 57.

⁷⁷ *Ibid*.

⁷⁸ *Ibid*.

⁷⁹ Kevin W. Wildes, “Ordinary and Extraordinary Means and the Quality of Life,” in *Theological Studies*, volume 57, number 3S (September 1996), pp. 501-512. Wildes uses the phrase ‘quality of life,’ but perhaps a better term would be ‘quality of function.’ See also Jos V.M. Welie, “When Medical Treatment is no Longer in Order,” *The National Catholic Bioethics Quarterly*, volume 5, number 3 (Autumn 2005), pp. 517-536.

⁸⁰ Wildes, “Ordinary,” p. 500.

⁸¹ *Ibid*.

⁸² *Ibid*. p. 501.

⁸³ *Ibid*.

⁸⁴ *Ibid*. p. 502.

⁸⁵ *Ibid*.

⁸⁶ NEJM Task Force Articles on PVS.

⁸⁷ Todd A. Salzman and Michael G. Lawler, *The Sexual Person: Toward a Renewed Catholic Anthropology*, Georgetown University Press, Washington, D.C. (2008).

⁸⁸ M. Therese Lysaught, “Love Your Enemies: Toward a Christoform Bioethic,” in *Gathered*, p. 309.

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