Kevin O'Rourke, O.P., "On the Care of 'Vegetative' Patients," Parts One and Two, Ethics & Medics 24.4-5 (April-May, 1999), pp. 3-4, 3.

On the Care of "Vegetative" Patients

A Response to William E. May's "Tube Feeding and the 'Vegetative' State"

First of Two Parts

My friend and esteemed colleague William E. May has authored a two-part article in recent editions of *Ethics and Medics* (23.12 and 24.1) concerning the matter of care of people in persistent vegetative state (PVS). The editors of *Ethics and Medics* have offered me an opportunity to respond to his article.

Points of Agreement

There are several facts or principles upon which May and I agree. First of all, I see no reason to repeat the description of the PVS condition which May offered in his recent articles. The significant medical information is that PVS patients will not recover cognitive-affective function after they have been diagnosed accurately as having this pathology. Perhaps recovery from this condition when accurately diagnosed could not be defined as impossible, but given the state of medical expertise and technology, recovery is at least unprecedented.

Secondly, neither is there any need to discuss whether or not a person with this pathology is still a human being. Given the Catholic theological interpretation of the relationship between the body and its animating principle (soul), a person with a debilitating or severely impairing pathology remains a human being, even if the person is no longer able to utilize his or her higher functions.

Thirdly, May and I agree that intending (*finis operantis*) the death of any debilitated person is highly unethical. Fourthly, we both affirm that at times, circumstances do occur which allow withholding or withdrawing life support in the face of a fatal or lethal pathology. What are these circumstances?

Ordinary versus Extraordinary

This question was first proposed explicitly by Spanish theologians at the University of Salmanca in the early XVI Century. Using fundamental insights from faith and reason found in the writings of Saint Thomas Aquinas, they considered this question and their answer was accepted by the Catholic theologians who came after them, and ultimately, by the Magisterium of the Church. Basically, their answer is contained in the distinction between ordinary and extraordinary (sometimes called proportionate and disproportionate) means to prolong life. Using this distinction, May and his colleagues (many of whom are mentioned in his article) will agree that the moral mandate to prolong one's own life, or the life of another for whom one is responsible, exists if the means to prolong life offer benefit to the person, and do not impose an excessive burden upon the person, the family, or the community.

On the other hand, the mandate to prolong life is not operative if the means to prolong life does not offer a benefit to the person, or imposes an excessive burden upon the patient, the family of the person, or the community at large. This distinction is stated authoritatively in the recently revised *Ethical and Religious Directives for Catholic Health Care Services*, nos. 56 and 57. If there is agreement on these significant principles and distinctions, what is the source of disagreement? Fundamentally, the disagreement is summed up in the following argumentation.

The Purpose of Life

Even though most ethicists and medical personnel would describe AHN [assisted hydration and nutrition] as a medical therapy, May and his colleagues call it usual or normal care. Normal or usual care, they maintain, is due to each and all patients who cannot care for themselves. This type of care (for example, keeping the person clean and changing bedding frequently) is required because of the dignity of the human person. When discussing this type of care, proponents of this distinction often refer to it as "ordinary care."

If they are using the term in its strict theological sense, then they are presuming what they should prove. Thus, it seems wiser to avoid calling AHN for PVS patients "ordinary care" until it has been evaluated by the theological criteria of hope of benefit and excessive burden. May and his colleagues also refer to the use of AHN for PVS patients as "comfort care." But in fact, this type of care does not provide comfort in the sense that it alleviates pain (Cox, *Ethics and Medics*, 12.9). AHN does prolong life, and so the question becomes, is this necessary? Hence, the assertion that AHN is usual or ordinary care is unfounded unless there is an investigation of the ethical reasons for prolonging life.

The question which must be addressed is: what gives rise to the moral mandate to prolong life of debilitated patients? To be more specific, what is the ethical basis for foregoing or utilizing AHN when caring for PVS patients?

In order to answer this question, we must consider the fundamental reason for prolonging our own lives or the life of another person in our care. In brief, the answer is that we have a moral or ethical mandate to prolong life if it helps us strive for the purpose of life. This concept is at the heart of the disagreement between May and me. May and his colleagues do not delve into this question but they indicate indirectly that they do not accept the following reasoning. The moral or ethical obligation to

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prolong human life arises from the need and desire to strive for the purpose of life. The purpose of life, as described in the *Catechism of the Catholic Church* (1.1), is to know and love God. Saint Thomas Aquinas often calls friendship with God (charity) the purpose of human life. Either description bespeaks the intimate and essential relationship between the purpose of life and a person's capacity to function at the cognitive-affective level.

In order to know and love God, or to maintain and develop friendship with God, either a person must possess this capacity for cognitive-affective function or have the potential to develop this capacity. Acts of cognitive-affective function are called human acts (*actus humanus*; ST I-II, 1.1). Other acts which may involve bodily activity but not the intellect and will are called involuntary acts (*actus hominis*, ibid.).

Dysfunctional Cerebral Cortex

By definition, the ability and the potency to perform human acts are not present in people with PVS because of dysfunction of the cerebral cortex. A person in this condition may perform involuntary acts, such as breathing or digesting food, but human acts properly so called, those acts which emanate from the intellect and will, are not within the present or future capacity of people with this pathology. The ability to strive for the purpose of life becomes the touchstone for using or forgoing life support for persons with serious or fatal pathologies. Hence, when people are in PVS, there is no moral mandate to utilize AHN on their behalf.

When discussing care of PVS patients with physicians and other medical personnel the term "striving for the purpose of life" often is a stumbling block. It helps however to distinguish between the proximate purposes or goals in life, such as rearing children, earning a living, and building a good marriage, and the ultimate purpose of life, to which these proximate goals are ordered. Discussions of this nature help medical personnel to realize that they fulfill neither the goals of medicine nor the goal of human life by prolonging mere physiological function of patients in PVS. There is no moral permission to directly kill persons in this condition, but at the same time, there is no moral mandate to prolong their lives because this form of medical therapy or normal care, call it what you will, does not offer "hope of benefit" to the patient. The purview of this essay does not include the pastoral and emotional issues which surround withholding or withdrawing care from PVS patients, for both families and medical personnel, but rest assured that this is also a matter for our concern.

Withdrawing is Not Causing

Clearly, if AHN is withheld or withdrawn from people in PVS, death will follow. But the act of withholding or withdrawing is not a direct (intended) cause of death in these circumstances. Rather, as Pope Pius XII indicated when discussing the removal of a respirator from comatose patients, if death occurs it is never more than an "indirect voluntary" (*The Pope Speaks* 4 [1958] 398). Even if death is foreseen, it is not necessarily intended as the object (*finis operis*) of the action, nor need it be the remote intention (*finis operantis*) of the action. In an ethical action of removing life support, what is directly willed (*finis operis*) is the cessation of a medically or ethically futile procedure, that is, one that does not offer "hope of benefit."

If life support is withheld or removed because it imposes "an excessive burden" then the object of the act (*finis operis*) is to alleviate the suffering of the person. The remote intention (*finis operantis*) of an ethical act of removing life support may include many goals, for example, fulfilling one's moral or professional responsibilities toward a severely debilitated person or limiting the expense of health care.

As this discussion indicates, this analysis of forgoing life support and the subsequent effects of this action involve the principle of double effect. May and his colleagues are fully aware of this principle, but when assessing the care of persons in PVS, they seldom invoke it. Instead they depend upon the concepts which we consider in the next issue of *Ethics & Medics*.

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(To Be Continued Next Issue)

On the Care of "Vegetative" Patients

A Response to William E. May's "Tube Feeding and the 'Vegetative' State"

Second of Two Parts

In last month's article, Fr. O'Rourke argued that determining whether or not artificial hydration and nutrition (AHN) are ordinary or extraordinary medical means depends upon whether their administration would assist the patient in striving for the purpose of life. Since one in a persistent vegetative state (PVS) cannot perform human acts of intellect and will that fulfill life's purpose, Fr. O'Rourke concluded that the provision of AHN is not obligatory—Ed.

In his essays (*Ethics and Medics* [23.12 and 24.1]) Professor May made a distinction between normal care and medical treatment and maintained that because AHN (artificial hydration and nutrition) is normal care it must be utilized for all patients in PVS (persistent vegetative state). In my first essay I stressed that no matter what it is called, AHN does prolong the life of a patient in PVS. For this reason, it must be evaluated in accord with the proper theological criteria: does it offer hope of benefit, does it impose an excessive burden? In this essay, I shall address the three main objections that May offers to my opinion. It is interesting to note that these objections are concerned with AHN as a medical treatment, even though he insists it is normal care.

Incommensurable Goods

The first and most fundamental source of disagreement is that May maintains that human life for a patient in PVS is "an intrinsic good and a great good." From this concept he sets forth the conviction that the life of a PVS patient must be prolonged if this a physical possibility. Thus, he quotes with approval the statement of Robert Barry, O.P., that AHN should be utilized for PVS patients "as long as such food can be assimilated by the digestive tract."

However, because human life is an intrinsic good does not mean that it must be prolonged as long as is physically possible. Catholic theologians for the past four hundred years considered life a basic human good, but they did not insist that death must be a physical certainty before allowing withdrawal of life support. Rather, they presented cases which considered the moral impossibility of prolonging life (Cronin, *Conserving Human Life*, Pope John Center [1989] 99). Why then does May make the swift transition from human life as an intrinsic good to the fact that it must be prolonged as long as this is physically possible? This transition is based upon the moral system of Germain Grisez (*Christian Moral Principles* I [1983] ch. 5), which May endorses. Grisez maintains, along with Saint Thomas, that there are some goods toward which human beings have a natural inclination.

But unlike Saint Thomas, Grisez maintains that these goods are "incommensurable," that is, they are so important for "integral human fulfillment" that in so far as they are final causes of human activity, they are independent of one another. Grisez believes that it is dualism to conceive of human life being ordered at some times and under some circumstances to another human good. Saint Thomas on the other hand maintains that the goods toward which we have a natural inclination may at times be subordinate to other human goods. Recall that in the moral system of Saint Thomas proximate goods are subordinate to our ultimate goal or good; we cannot have several final goals (*Summa Theologica*, I–II, Q. 1.5). These proximate goods are evaluated morally in so far as they are proportionate to striving for the objective ultimate good: knowing and loving God.

As Ralph McInerny, Director of the Jacques Maritain Center at the University of Notre Dame, points out in a yet to be published article ("Grisez and Thomism"), Grisez knowingly disagrees with the moral vision of Saint Thomas in regard to the subordination of basic human goods. Grisez is free to continue holding the theory of "incommensurable goods." But it seems his followers should be slow to apply this theory to the removal of life support which for centuries has been solved by following the Thomistic theory of proximate and ultimate goals of human life. To sum up, Benedict Ashley, O.P., notes that "[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" (*Moral Truths and Moral Traditions* [1994] 73)?

Imminent and Inevitable Death

A second source of disagreement is contained in May's assertion that PVS patients do not suffer from a fatal pathology. He makes this assertion because *after* AHN has been utilized for PVS patients, they "are not in immediate danger of death, and may live for many years." But whether a person has a fatal pathology and is thus in danger of death is be determined *before* the means to alleviate or circumvent the pathology has been utilized. Once a woman and her physician determine that she has a cancerous growth in her breast, it is clear that she suffers from a fatal pathology. They will, at least implicitly, use the two moral criteria, hope of benefit and excessive burden, to determine whether and what therapy to use in order to alleviate or remove the fatal pathology. If the therapy is successful, the woman will no longer suffer from the fatal pathology.

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In like manner, PVS is a fatal pathology because it results in an inability to chew and swallow. Left untreated this condition will result in death. This condition can be circumvented by AHN, even indefinitely. However, the moral question is whether it should be circumvented? To answer this question, one invokes the aforementioned moral criteria. It is simply irrelevant to state that PVS is not a fatal pathology *after* life support has been utilized. May is concerned about the presence of a fatal pathology because he believes that life support may not be removed unless death is "imminent and inevitable." But the requirement that death must be imminent and inevitable before life support is removed has never been part of Catholic teaching (Cronin, 100). The quest to distinguish ordinary from extraordinary means to prolong life always maintained that human life is not an absolute good to be prolonged at all costs, a teaching which is repeated in our day as well (*Evangelium vitae*, n. 47; *Ethical and Religious Directives* [1995] Part 5).

I am aware that two recent documents emanating from the Vatican seemed to indicate that life support may be removed only if death is imminent and inevitable (*Evangelium vitae*, n. 65; *Charter for Health Care Workers*, 97). However, both statements cite the *Declaration on Euthanasia* (CDF [1980]) as the source for their statements. The *Declaration on Euthanasia* asks the question "Is it necessary in all circumstances to have recourse to all possible remedies"; it answers this question by mentioning at least three other scenarios which justify the decision to forgo life support. All of these additional scenarios require a fatal pathology, but not that death be imminent and inevitable. Thus the statements in the recent Vatican documents mention an obvious occasion to remove life support, but this mention is not taxative.

Medical Means in the Abstract

A third source of disagreement arises from the tendency of May to judge medical means to prolong life in the abstract. When discussing the great good that results from utilizing AHN for PVS patients May prescinds from the condition of the individual patient and indicates that medical treatment can be designated as mandatory (ordinary) or optional (extraordinary) without considering the effects of this prolongation upon the patient or the family. Unfortunately, this tendency is present in many of the public statements issued in regard to cases which become notorious because they are settled in court, for example, the Cruzan and Finn cases. The history of theological investigation concerning the use or forgoing of life support demonstrates that no decision should be made about medical therapy until the condition of the patient is known (Cronin, 21). Otherwise, how can the proportionate benefit or burden be evaluated?

As Pope Pius XII said when determining whether the life of comatose persons had to be prolonged by the use of respirators, decisions of this nature must take into consideration "the circumstances of persons, place, times, and culture" (*The Pope Speaks* [4.4] 395). Would it make any difference if the woman with cancer mentioned above were thirty years old with a husband and three young children as opposed to being ninety-eight, widowed, demented and bed ridden for five years before contracting cancer?

Is there Life after Death?

For over ten years I have asked people throughout the country if they would like to have their physiological function prolonged if ever in a PVS condition. Judging from their reaction, May's opinion does not pass the test of common sense. While the following is an *ad hominem* argument, I think the words of Richard McCormick (*America* [3/14/92] 214) in regard to this issue speak for many people:

> 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?"

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