Book Reviews

Artificial Nutrition and Hydration and the Permanently Unconscious Patient: The Catholic Debate.

Edited by Ronald P. Hamel and James J. Walter. Washington, DC, Georgetown University Press; 2007. Pp. ix+294.

Artificial Nutrition and Hydration: The New Catholic Debate.

Edited by Christopher Tollefsen. Philosophy and Medicine 93. Dordrecht, Springer; 2008. Pp. vii+229.

For some decades now, our society has debated the moral and legal issues that concern the use of—and withholding of or withdrawal from—various forms of life-sustaining treatment or care, especially for patients in a so-called persistent vegetative state (PVS). For instance, the Karen Ann Quinlan case played itself out in the courts in 1975–1976, though after her 1976 removal from mechanical ventilation, she lived for another nine years with the help of artificial nutrition and hydration (ANH). ANH itself was the issue in the Terri Schiavo case, beginning in the 1990s and continuing until her death on March 31, 2005—two days before the death of Pope (now Saint) John Paul II. During this time period, Catholic theologians, and sometimes bishops, were debating the underlying issue of the provision of ANH to those in a PVS. While the Schiavo case was receiving considerable attention, on March 20, 2004, Pope John Paul gave an address “to the participants in the international congress on ‘Life-Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas,’ ” in which he taught that ANH for PVS patients is “in principle ordinary and proportionate, and hence obligatory.” Subsequently (on August 1, 2007), in a response (with accompanying commentary)¹ to questions submitted by the United

States Conference of Catholic Bishops (USCCB), the Congregation for the Doctrine of the Faith (CDF) underscored this teaching (with some further clarification).

The volumes under review collect several ecclesiastical documents (going back to Pope Pius XII’s 1958 “The Prolongation of Life”) that provide context for Pope John Paul II’s address, and a number of essays by theologians and others on the topic of PVS/ANH—some written before Pope John Paul’s address, others responding directly to him; some defending the position that ANH should normally be provided to PVS patients, others disagreeing with it. Ronald Hamel and James Walter’s anthology is helpful in that it includes the aforementioned documents: Pope Pius XII’s teaching (Chapter 6), and also the CDF’s “Declaration on Euthanasia” (Chapter 7); a statement by the Pontifical Academy of Sciences (Chapter 8); a statement by the Texas bishops (Chapter 9); a statement by the (then) National Conference of Catholic Bishops (now the USCCB) Committee for Pro-Life Activities (Chapter 10); the relevant portion of the USCCB’s “Ethical and Religious Directives for Catholic Health Care Services” (Chapter 11); and Pope John Paul II’s address itself (Chapter 15). The Texas bishops’ statement (from 1990,

i.e., some years before Pope John Paul's address) is the only one of these that takes the position that ANH for PVS patients is not morally obligatory. Additionally, Hamel and Walter include the American Academy of Neurology's position paper on the topic (Chapter 1), according to which PVS patients are unconscious, and ANH may be forgone when the patient clearly would not want it, but ANH should be used initially until a patient is clearly in a PVS.

A number of the other essays in the Hamel and Walter volume defend, or at least come close to defending, what is now the clear teaching of the Catholic Church (that ANH for those in a PVS is obligatory). Myles Sheehan (Chapter 2) notes that there are some contraindications for the use of ANH and that the mortality rate for ANH patients is high because many patients who are given ANH are dying in any case. Sheehan also argues, however, that there should be a presumption in favor of providing ANH and that facility staffing plans and patient care plans should ensure that patients' needs (including ANH) are met. Donald Henke (Chapter 4) provides a good history of the distinction in Catholic thought between "ordinary" and "extraordinary" means of sustaining life, going back to Francisco de Vitoria and Dominic Soto (1500s) and rooted even in the thought of St. Thomas Aquinas (1200s), and continuing into the twentieth century and beyond. Henke concludes that "in the case of the PVS patient, the decision of the Catholic Church to promote the provision of AAHN [artificially assisted hydration and nutrition] to sustain the patient's life is more in line with respect for the person than is a position that advocates the removal of AAHN."

Germain Grisez (Chapter 13) writes that although he had previously "thought that it is not reasonable to provide food to *comatose* patients," he changed his mind for six reasons. Among these are the discoveries that tube feeding—as distinct

from "the total cost of caring for" the patient—"costs very little" and likewise requires little time, and that caring for a family member serves not only the good of that person's life but also "the good of *human solidarity*." Grisez continues to allow that the practical judgment in favor of feeding comatose patients might be different in a very poor society, or in the case of a patient who, when still competent, clearly rejected ANH should she ever become comatose. He also notes—importantly, I think—that withholding ANH in order to eliminate the burden inherent in the total care required by a patient necessarily means willing (not simply accepting) the patient's death, since it is only by means of causing her death that withholding ANH eliminates the burden of providing the other care also needed by the patient. Grisez argues, further, that bodily life "is an intrinsic part of one's personal reality" and hence does remain a good (and something against which one may not will) even when cognitive function has ceased (as when one is comatose, or—perhaps—when one is in a PVS). He contends that the alternative view amounts to a kind of dualism.

Grisez is, as we shall see, not the only contributor to these volumes who charges his opponents with person-body dualism (most, but not all, of the contributors who do so are those arguing in favor of providing ANH to PVS patients and others with severe/permanent neurological deficits). I have long wondered about whether this is the most fruitful way in which to frame the controversy. It would, it seems to me, be possible (even though mistaken) for someone to deny that bodily life is intrinsically good based on a claim that the unified person ceases to exist when cognitive function is no longer possible (and, at the other end of life, that the unified person does not yet exist until cognitive function becomes possible). This claim would be different

from the dualistic one that the person is not a unified body-soul entity.

This position would, to put it differently, suggest a close analogy between PVS patients and those who are brain dead (and we might recall here that Pope John Paul II, who was surely aware that many organ systems continue to function together even after brain death, and who over the years had thought as much about philosophical anthropology as anyone has, nevertheless taught in a 2000 address that the use of neurological criteria for determining death “does not seem to conflict with the essential elements of a sound anthropology” so that we have “moral certainty” that those so determined to be dead are in fact dead). It seems to me, then, that a more philosophically helpful way in which to respond to those who think that bodily life is no longer a good for those in a PVS would be one that seeks to show how some (even if minimal) “potential” (in the philosophical sense of the term) for cognitive function remains in PVS patients (unlike in those who are brain dead); in other words, how the cases of PVS and brain death are not philosophically (nor medically) analogous (more below on the question of what brain function may remain in PVS patients). (Alternatively, of course, one could try to argue that brain death is not the death of the human person, in which case any similarity between brain death and PVS would not serve to establish that PVS patients need not receive life-sustaining care. I am, however, not among those who think that the Church’s teaching still permits this view regarding brain death, or that it is a philosophically sound view, even though respectful questioning about the teaching is certainly legitimate.)

Richard Doerflinger (Chapter 16), long of the USCCB’s Secretariat for Pro-Life Activities, makes a brief argument that Pope John Paul II’s 2004 teaching “is not

a radical shift but the culmination of a longstanding trend at the Vatican,” referring to Pope John Paul’s 1995 encyclical *Evangelium vitae*, the 1995 *Charter for Health Care Workers* by the Pontifical Council for Pastoral Assistance to Health Care Workers, and a 1998 *ad limina* address by Pope John Paul to a group of U.S. bishops. Mark Repenshek and John Paul Slosar (Chapter 17) rehearse some of the history of Catholic thought about the distinction between “ordinary” and “extraordinary” life-sustaining care (overlapping with Chapter 4), and show some sympathy for the criticism that Pope John Paul II’s address is at odds with how this distinction had previously been interpreted, but nevertheless reject the criticism on the grounds that Pope John Paul (even while establishing a presumption in favor of ANH for PVS patients) “does not necessarily preclude health care workers from honoring advance directives or appropriate surrogate decisions to refuse” ANH. It is not clear what Repenshek and Slosar would regard as “appropriate surrogate decisions”; any elaboration of their claim would have to take into account Pope John Paul’s words in his address: “to admit that decisions regarding man’s life can be based on the external acknowledgment of its quality, is the same as acknowledging that increasing and decreasing levels of quality of life, and therefore of human dignity, can be attributed from an external perspective to any subject, thus introducing into social relations a discriminatory and eugenic principle.” (It would seem that a surrogate decision would be an “external” one, though perhaps it could be based on something other than “quality of life” criteria.)

Finally, John R. Connery, SJ (Chapter 20) discusses a court case having to do with ANH for a comatose patient. Connery’s essay culminates in a look at the

testimony supplied in that case (and apparently crucial in leading to the court's decision that treatment could be withdrawn) by John Paris, SJ, that permanently unconscious patients have low quality of life because they "have exhausted their potential for value and for living," and that the CDF's "Declaration on Euthanasia" supports this view. Connery takes issue with his brother Jesuit's testimony, arguing that preserving even unconscious life is a benefit and that the CDF does not suggest otherwise. This observation about the "Declaration on Euthanasia" is important, I think, given that some authors (e.g., some of those I will be treating next) suggest that Pope John Paul II's teaching is at odds with that found in the "Declaration."

The other essays collected by Hamel and Walter are more critical of the Church's teaching and the arguments of some theologians that PVS patients ought "in principle" to receive ANH. Michael Panicola (Chapter 3), and Hamel and Panicola (Chapter 5), cover some of the same history of Catholic thought as other chapters, and contend that prolongation of life in a PVS patient does not count as a "benefit" and therefore that the position that PVS patients ought to receive ANH is at odds with the traditional Catholic understanding that treatments that are more burdensome than beneficial are not obligatory. While, as I have said, I am not sure that I agree that this position necessarily/always entails "dualism," I do think that it is mistaken. For one thing, as Grisez and others have pointed out, the burdens imposed by ANH itself (as distinct from the other burdens associated with a PVS patient's underlying condition) are usually fairly minimal. Hence, even if ANH is only minimally beneficial, the benefits would still outweigh the burdens. For another, for (at least) as long as some brain life/function (even if not "consciousness")

remains, it seems hasty and premature (at best) to judge that the patient's body has lost all capacity for participating in rational life (as is, I think, the case in brain death) and therefore has lost the value otherwise attached to the body of a living human person. (Although this is not the crucial point, let me also mention that I am not sure that we can know that a PVS patient is not "conscious." It seems to me that the burden of proof is on those who would deny this, that the neurological arguments that such a patient is not conscious are not wholly convincing, and that arguments based on behavior or lack thereof are especially unconvincing—more concerning which later.) Along the way, Hamel and Panicola also assert that Pope John Paul II proposes a "limited physical understanding of benefit." The word "limited" here seems misleading; it is Hamel and Panicola and others who share their view who want to "limit" what "counts" as benefit (so that bodily life would not so count).

Thomas Shannon and Walter (Chapter 12) report at some length the responses of U.S. bishops to a survey regarding diocesan policies on ANH. As Shannon and Walter conclude, diocesan policies differ considerably on this issue. Shannon and Walter then argue that ANH for PVS patients can be disproportionate and optional. Among other things, they contend that the life sustained by ANH can be a burdensome life. Furthermore, they claim that for the purposes of distinguishing between proportionate and disproportionate care,

burden is to be assessed not only from the perspective of the burdensome effects of the technology itself but ... also from the perspective "of the burdens that an individual experiences in pursuing the goals or ends of life" as a result of the intervention of the medical technology.

It is not entirely clear to me how they can reconcile this claim with their insistence

that withdrawing ANH does not entail intending death. Again, if ANH is withdrawn in order to relieve burdens other than those that are effects of ANH, then the withdrawing of ANH succeeds in accomplishing the relief of those other burdens only by means of causing the patient's death. In other words, the patient's death is within the intention of the one who withdraws the ANH. Shannon and Walter would likely disagree with my account of "intention," inasmuch as they are clearly employing proportionalist terminology (e.g., "ontic value") and methodology, which has its own way of defining "intention" and the like (and which is rejected by the Church, as especially in Pope John Paul II's 1993 encyclical *Veritatis Splendor*). They also say the sorts of things that might be interpreted as dualism ("it is necessary to distinguish clearly and consistently between physical or biological life and personal life (personhood)").

Daniel Sulmasy, OFM (Chapter 14) argues that even when a treatment like ANH offers a benefit, it may still be significantly burdensome. He agrees that it is not (itself) costly, but points out that other forms of life-sustaining treatment, such as continuous ambulatory peritoneal dialysis (CAPD) at home, are becoming similarly inexpensive. He does not seem to address the question, though, of whether CAPD might impose other kinds of burdens that ANH does not. If it does, then the teaching that ANH is in principle proportionate and obligatory would not entail a similar conclusion regarding CAPD. If it (unlike outpatient hemodialysis) does not, though, then it is not clear why the conclusion that it is proportionate and obligatory would be a problem (Sulmasy seems to assume that this conclusion would be a problem and therefore that if the obligatory nature of ANH would also entail the obligatory nature of

CAPD, then ANH cannot be obligatory). Sulmasy also claims that even an unconscious patient on ANH might, in a sense, be "suffering." But is the suffering to which he refers the result of the ANH, or of the patient's underlying condition? Again, if the latter, then removing ANH to relieve it would involve intending death.

Shannon and Walter author another essay (Chapter 18) that (like several others) rehearses the history of the Catholic tradition and that refers to Pope John Paul II's teaching as "revisionist" in relation to this tradition. This argument turns on the claim that ANH for PVS patients is in fact more burdensome than beneficial; if (as other authors here), argue, that is not the case, then the discontinuity is not real. It is not true (as Shannon and Walter contend) that Pope John Paul resolves the issue simply "by definition or stipulation" that ANH is ordinary and proportionate (and obligatory). Rather, Pope John Paul teaches that life is always a good, and recognizes that, in fact, the burdens usually associated with ANH itself do not outweigh the benefit of sustaining life. Kevin O'Rourke, OP (Chapter 19) makes a similar, though more respectful, argument. O'Rourke's essay is also printed in the Tollefsen volume, and will be considered below.

Richard McCormick, SJ (Chapter 21) takes an interesting approach. On the one hand, in the final pages of his essay, he seems to suggest that ANH might not be obligatory. He says that patients who need it "may be classified broadly as dying" (the word "broadly" seems to do a lot of "work" in that statement), that ANH "is a medical procedure," "that its discontinuance need not involve aiming at ... death," and that quality of life is a relevant consideration. On the other hand, though, he sees that "the potential for abuse" is enormous and that "the progression [regarding what sorts of care will be withheld from

what sorts of patients, as he documents in the main part of his essay] is obvious, and obviously dangerous.” He concludes that “it is best to err, if at all, in favor of preserving life.”

Christopher Tollefsen has collected essays that, for the most part, support the Church’s teaching that ANH is generally obligatory for PVS patients. Many share Tollefsen’s own philosophical perspective, namely, that of the “new natural law” theory of Germain Grisez and John Finnis. Bishop Anthony Fisher, OP (Chapter 1) draws from this perspective as well as that of Alasdair MacIntyre in arguing that those who are dependant, rather than autonomous, still enjoy human dignity and inviolability and hence should, as the Church has taught, be provided with nutrition and hydration. Fisher also notes the role of eating and drinking in the Gospels, and in the Church. He links the philosophical concept of human dignity with the Christian notion of sanctity of life, while suggesting that the latter “has most bite at the margins, i.e., when it is hardest to hold on to the principle of not killing the innocent.” Bishop Fisher concludes with responses to some criticisms of the view that he defends.

Michael Degnan (Chapter 2), drawing from the work of Alan Shewmon, MD, contends, convincingly (to me), that neurological (as well as behavioral) evidence supports the view that “vegetative state” patients are in fact able to feel pain. He notes also that patients in this state are sometimes diagnosed as being in a PVS prematurely, i.e., even while they still have (statistically speaking) a significant hope of recovery (during the first year). With these clarifications in mind, he argues (drawing, like Fisher, from MacIntyre), further, that a community must provide ordinary/proportionate care to its members as part of its commitment to the common good, the commitment without which its authority

over its members is illegitimate; and that ANH (even when not curative) offers a variety of benefits to the patient and also to the community. Like Fisher, Degnan responds to some criticisms.

William May (Chapter 3) summarizes some responses to Pope John Paul II’s 2004 address and then, drawing from Shewmon and Grisez (May is Grisez’s frequent coauthor), briefly comments on and responds to criticisms of this address. Jacqueline Laing (Chapter 4) criticizes a 2005 law in England and Wales that requires ANH withdrawal in certain cases.

Alfonso Gómez-Lobo (Chapter 5) distinguishes the view that life is a basic good from the claim that it is an absolute good to be preserved at all costs, and also recognizes that withdrawing ANH does not always entail intending death. His argument on the latter point, however, draws from what he calls “traditional action theory,” with its notion of the *finis operis* (“the objective of the action itself”) as well as the *finis operantis* (“the further purpose of the agent”). It is true that the second of the three determinants of the morality of the action is the agent’s intention (*finis operantis*). Scholarship over the last four to five decades, however, has, I think, convincingly demonstrated that the first determinant of an action’s morality is not the action’s *objective*, but rather the act itself that is chosen (and that this is the authentically “traditional” position). This is what the term “object” refers to when one speaks of an action’s “object, intention, and circumstances.” Gómez-Lobo’s argument would perhaps be aided by an incorporation of this development in action theory. He also expresses the concern that the development of ever more non-burdensome means of prolonging life might mean that all such means will always be proportionate, ordinary, and obligatory (compare Sulmasy’s point, summarized above, about CAPD). I am not

sure that this is as obviously “paradoxical and unpalatable” as he thinks it is. I am even less sure that we will be so successful in developing such means. Hence, I am not particularly worried about the possible future consequences of the traditional (and current) ways of thinking about life-sustaining treatments.

Joseph Boyle (another of Grisez’s frequent coauthors) offers (Chapter 6) some comments on Pope John Paul II’s address, notes that “in principle” does not mean “always,” and contends that some cases in which ANH is needed if life is to be sustained are sufficiently different from PVS cases that ANH may not be obligatory in those other cases (even though the same underlying principles continue to apply). He adds that an advance directive rejecting ANH is not necessarily suicidal (does not necessarily intend death). J.L.A. Garcia (Chapter 7) also offers a possible interpretation, and a defense, of Pope John Paul’s address, again with some indications regarding when ANH would not be morally obligatory.

Peter Cataldo (Chapter 8) responds to Garcia, largely agreeing with him while suggesting what I think are some helpful clarifications and additions. For one, Cataldo offers a reconciliation of Pope John Paul’s statements in his 2004 address that ANH is both an “artificial means” of providing water and food and a “natural means” of preserving life. Cataldo notes that providing food and water is an action that “naturally” (*per se*) tends toward the preservation of life, even when the action employs such “artificial” means as a tube. For Cataldo, this point is an important one, inasmuch as the “natural” tendency of food and water to preserve life relates to the proper manner of judging whether ANH is, in a particular case, excessively burdensome. If ANH in a particular case (*per accidens*) does not accomplish this natural purpose because the patient is

unable to assimilate food and water, or (again, *per accidens*) causes complications and suffering, then it is not obligatory. For another clarification, Cataldo denies that Pope John Paul would always require that a patient’s directive rejecting ANH be honored. Rather, Cataldo argues, it is only a right use of patient autonomy that needs to be respected; a misuse of this autonomy may legitimately be corrected by a patient’s caregivers.

For still another, he links Pope Saint John Paul II’s March 2004 address on ANH/PVS with a letter that the late Pope wrote in November of the same year, “on the Occasion of the 23rd National Congress of the Italian Catholic Physicians’ Association.” In this letter, Pope John Paul writes:

It is impossible to speak of a human being who is no longer a person or has yet to become one: personal dignity is a radical feature of each human being and disparity is neither acceptable nor justifiable!

Cataldo is correct, it seems to me, that this is a development of Catholic teaching; furthermore, it is an explicit rejection of person–body dualism and the like (perhaps even the sort of non-dualistic rejection of the “personhood” of the PVS patient that I sketched out above). At the same time, though, there remains a need to continue to clarify who does (and does not) “count” as a living human being, since some critics might “bite the bullet” and try to argue that a PVS patient is no longer a living human being (based on a claim that the neurological insult that causes PVS is such a biological discontinuity that it renders one no longer the same organism, with the same nature, as one was before suffering this insult).

The next section of the Tollefsen volume is a “Symposium on the Views of Fr. Kevin O’Rourke, O.P.” O’Rourke’s

initial reflections on Pope John Paul II's 2004 address (the same reflections published in the Hamel and Walter volume, as mentioned above) make up Chapter 9. This is followed by a response by my Franciscan University of Steubenville colleague Patrick Lee (Chapter 10), then a response to Lee by O'Rourke (Chapter 11), and then a further response to O'Rourke by Mark Latkovic (Chapter 12). O'Rourke seeks to express some disagreements with Pope John Paul in a manner consistent with the norms found in the CDF's "Instruction on the Ecclesial Vocation of the Theologian." In particular, O'Rourke disagrees with what he calls Pope John Paul's

assumption ... that there is some hope of benefit from prolonging life for a patient in a [PVS], even if it is unlikely that the patient will recover.

Secondly, O'Rourke disagrees with the "assumption" that various "medical facts and findings" regarding the unlikelihood of recovery from PVS are not to be regarded as valid. Additionally, he adds as "positive reasons for disagreement with the teaching" his longtime contention that PVS patients can no longer pursue the purpose of human life—friendship with God—and therefore that there is no obligation to sustain their lives.

Lee's response notes, correctly, that it is not an "assumption" of Pope John Paul II's teaching, but rather a part of that teaching, that sustaining life is in any case beneficial. He also notes that "to rely on some scientists rather than others is very different from ignoring" the others, and that "the Pope's central teaching does not logically depend upon these statements" about the prognosis of PVS patients. As to why sustaining bodily life is always beneficial, Lee makes the point that friendship with God is something in which we participate, already in this life, and as a body-soul composite. This is

surely correct. Lee states that the contrary position would be dualism; for the reasons I have indicated above (and other reasons also, e.g., someone might try to argue that bodily participation, here and now, in friendship with God depends upon consciousness), I am not sure that this is necessarily true. He adds also a defense of Pope John Paul's statement that withholding ANH is "euthanasia": namely, that the purpose of withholding it can only be to avoid the burdens of the patient's continued life. This argument needs, I think, some qualification. In some cases, it is possible that ANH is withheld based on a (mistaken) judgment that it is itself disproportionately burdensome (either because it is greatly burdensome or because the patient's continued life is not greatly beneficial). In these cases, the withholding of ANH would be wrong (just insofar as the judgments about benefits/burdens are mistaken ones), but it would not involve intentional killing (as end or means), and so would not be euthanasia.

O'Rourke's response in turn expresses confidence that the PVS diagnosis can be made with moral certitude, and that when there is such certitude, ANH can be withheld as more burdensome than beneficial. In the course of making this response, he tries to turn the charge of "dualism" back against those who make it:

If anyone can be accused of dualism, it would be Grisez and followers because they make the "mere biological function of the body," (Lee's terminology) an absolute value.

If I am *unsure* that O'Rourke, Shannon, Walter, and others with similar views *are* dualists, I am *sure* that Grisez and Lee are *not* dualists (this despite some disagreements on my part with their philosophical anthropology). O'Rourke's argument seems a *non sequitur*. Additionally, it is hard to sustain the claim that Grisez and Lee make bodily life an "absolute" value;

not only do they deny doing so, but they argue in ways that would be inconsistent with doing so when they defend the view that truly disproportionate treatments may be forgone. O'Rourke also tries to counter the argument that ANH is not burdensome by stating that

the usual care for PVS patients is in hospital or a long term care facility, and it is very expensive. ... Even if a family occasionally seeks to care for a PVS patient at home, it requires constantly changing and turning the patient.

But O'Rourke is referring here to the burdens associated with PVS, not to any additional burdens imposed directly by the use of ANH. If ANH is forgone to avoid the burdens to which O'Rourke refers, then we have euthanasia in the precise sense, as Pope John Paul II indicates.

Latkovic (like Lee, a Grisez-Finnis follower), in his response to O'Rourke, makes several points (including also along the way the charge of dualism). For one, PVS patients are not dying in the usual sense (it cannot be maintained that denying them ANH simply allows them to die from their underlying condition). For another, maintaining unconscious bodily life (if PVS patients are in fact unconscious—Latkovic offers contrary evidence, adding to that mentioned by Degnan) is not without benefit since even the unconscious retain their capacity for friendship with God (as indicated by the fact that the Church offers them several of the sacraments). For yet another, even if life is a subordinate good in relation to others (which Grisez, Latkovic, and others of their school deny, but which I affirm), it does not follow that the good of life may licitly be directly contradicted. With regard to the matter of the burdens that might be associated with caring for a PVS patient, Latkovic endorses the position of John Finnis that someone making an advance directive (to apply in the event of PVS)

could [rightly] 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.

This seems correct. And as Latkovic notes, Pope John Paul II calls for various specific forms of "support" for families who need to provide such care to a member. O'Rourke ignores this.

Tollefsen concludes the volume (Chapter 13) with an essay titled "Ten Errors Regarding End of Life Issues, and Especially Artificial Nutrition and Hydration." The errors are as follows: (1) "It is permissible to act with the intention of letting someone die"; (2) "The relevant distinction is between acting and omitting"; (3) "ANH is futile care"; (4) "It is permissible to accept futile care"; (5) "All rejection of 'ordinary care' is suicidal"; (6) "No rejection of 'extraordinary' means is suicidal"; (7) "It is permissible to accept extraordinary treatment"; (8) "It is never permissible to withdraw artificial nutrition and hydration"; (9) "The burdens that might permissibly be avoided include the burdens of the condition itself"; and (10) "The burdens that may permissibly be avoided in removing ANH include the burden of care for the patient." For the most part, I agree with Tollefsen's categorization of these as errors and his explanation of why they are errors. Let me lodge two possible disagreements, however, concerning numbers 7 and 8.

If "extraordinary" treatment refers to treatment that *will certainly be* disproportionately burdensome, then Tollefsen is correct to argue that it accepting it would be unreasonable and impermissible. But one might note the words of the CDF's *Declaration on Euthanasia*: "it will be possible to make a correct judgment as to the means by studying the type of treatment to be used, its degree of complexity or risk, its cost and the possibilities of using

it, and comparing these elements with the result that can be expected, taking into account the state of the sick person and his or her physical and moral resources.” Note the references to “risk” and to “the result that can be expected.” It seems to me that a “disproportionate” treatment is one that imposes a high “risk” of burdens and a low “expectation” of benefits. Indeed, in many cases, one cannot have certainty (or even something close to certainty) that a treatment will be more burdensome than beneficial; one can only know that this is possible or likely. If “disproportionate” and hence “extraordinary” are defined in terms of probabilities rather than certainties, then it could be permissible to accept an extraordinary means of treatment. The CDF even goes on to say:

If there are no other sufficient remedies, it is permitted, with the patient’s consent, to have recourse to the means provided by the most advanced medical techniques, even if these means are still at the experimental stage and are not without a certain risk. By accepting them, the patient can even show generosity in the service of humanity.

Such means would seem to be among those that would normally be called “extraordinary” ones. One could perhaps try to define the problem away by referring to “generosity in the service of humanity” as the benefit that makes the burdens less than disproportionate, and the treatment ordinary, but I am not sure that this would be convincing.

Tollefsen also argues, not only that withdrawing ANH could be permissible (I agree), but also that it would be morally obligatory for doctors and family members to act in accordance with patients’ wishes to refuse ANH. While it is true that such wishes can be morally upright, in some cases they may not be, and furthermore in some cases it may be clear that they are not

—as if a person making an advance directive states clearly and explicitly that she would not want to live in a PVS and *for that reason* would not want ANH if in a PVS. In such cases, I think that Cataldo’s view (discussed above) regarding the limits of patient autonomy is more plausible. Tollefsen correctly notes that acting contrary to a patient’s wishes in such a case would amount to civil disobedience, and comments:

surely, if [Pope John Paul II] thought that following the requirements of the law in these matters was morally impermissible, he would have said so.

I am not convinced by this argument from silence, Tollefsen’s “surely” notwithstanding. This is so especially because in *Evangelium vitae*, Pope John Paul three times (nn. 73, 74, and 89) speaks of the need for conscientious objection against laws unjustly providing for euthanasia (as well as abortion). Why should the 2004 address (with its mention of euthanasia) not be read in the light of these statements in *Evangelium vitae*?

Although Hamel and Walter’s volume is fairly well balanced between opponents and proponents of the view that ANH ought normally to be provided to PVS patients, there is perhaps more repetition among a number of its chapters (e.g., on the history of Catholic thought about life-sustaining care) than would have been optimal. I would also suggest that the volume’s title—referring to “the permanently unconscious patient”—is question-begging and tendentious, since one of the questions (if not the most important one) that needs to be explored in discussions of treatment for PVS patients is precisely whether they are “unconscious.” Regarding Tollefsen’s volume, although not all of the essays in it are written from the perspective of the Grisez “new natural law” school (e.g., Garcia is not a member of this school),

the volume is nevertheless “tilted” fairly heavily toward this approach. It might have been good for the collection to have included somewhat more material that reflects alternative perspectives while supporting and explaining the Church’s teaching.

But both of these volumes have their significant merits. A collection of material that includes some of the important ecclesiastical documents having to do with ANH/PVS can be useful. Also, especially those Catholics who would like to take part in defending the Church’s teaching might benefit from encountering opponents’ arguments in their own words. The more one understands the details of the dissenting position, the more one might be able to formulate convincing responses. For these reasons, Hamel and Walter’s *Artificial Nutrition and Hydration and the Permanently Unconscious Patient* has a role to play. There are also many people who would benefit from reading a number of essays all of which are sympathetic to what Pope John Paul II said about ANH/PVS in his 2004 address, and which seek in various ways (reflecting varied interests and somewhat varied legitimate philosophical/theological perspectives) to explain

the Church’s teaching from that position of assent. These people would profit from reading Tollefsen’s *Artificial Nutrition and Hydration*.

ENDNOTE

1. Both the response and the commentary, as well as several other Vatican documents to be mentioned in this review, are available on the Holy See’s web site, <http://www.vatican.va>.

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BIOGRAPHICAL NOTE

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