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The Roman Catholic Church, Biopolitics, and the Vegetative State

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*Compelled by recent public and politicized cases in which withdrawal of nutrition and hydration were at issue, this essay examines recent Church statements and argues that the distinction between private and public forms of human life is being lost. Effacing the distinction between the sphere of the home (*oikos*), where the maintenance of life (*zoē*) occurs, and the city (*polis*), where political and public life (*bios*) occurs, may have unforeseen and unwanted consequences. Through their well-intentioned efforts to preserve the sanctity of life, certain bishops and the Congregation for the Doctrine of the Faith have unfortunately brought political considerations into the home, taking decision-making authority away from those most intimately related to the patient. Thus, the question of removing nutrition and hydration in the case of patients such as Schiavo and Englaro becomes politicized and abstract, in contrast with the Church's previous positions on the importance of proportionate means in the maintenance of life, local decision making, and its recognition of life as a penultimate end.*

Keywords: *biopolitics, Permanent Vegetative State, Persistent Vegetative State, Roman Catholic Church*

I. INTRODUCTION

Eluana Englaro died on February 9, 2009. Englaro had been in a permanent vegetative state (PVS)[1] since an automobile accident seventeen years earlier.

Englaro's father requested on several occasions that she be allowed to die by removing her feeding tube. Court proceedings were held in 1999 and 2005, in which the father's requests were denied. Finally, on July 9, 2008, the Milan Court of Appeal allowed her feeding tube to be removed. The Italian Parliament intervened, claiming that the Milan Court's decision was changing Italian law, moving the case to the highest court in Italy. Aligning itself with the center-right government, the Vatican also mobilized, and prominent officials within the Church argued that Englaro's feedings should be continued. The highest court finally sided with Englaro's father, granting him permission to remove the feeding tube. The Italian Prime Minister issued an order on February 6, 2009, that would have forced feeding to resume. Englaro died after Italy's President rejected the order, refusing to sign the decree. The withdrawal of Englaro's artificial nutrition and hydration was the culmination of extensive legal and political activity.[2]

The Englaro case is similar to that of Theresa Marie Schiavo, who on 25 February, 1990, collapsed and had what appeared to be a cardiac arrest. She sustained severe hypoxia with resultant anoxic brain injury. For several months, she persisted in a coma, and subsequently emerged into a sleep-wake cycle, and with no evidence of awareness of herself or her environment. At first, Schiavo was treated aggressively as the family was hoping for a cure. Over the ensuing months and years of her life, she showed no improvement. Her husband was made her legal guardian without objection from Schiavo's parents, four months after her injury. She was unable to eat or drink without risk of aspiration, and a percutaneous endoscopic gastrostomy (PEG) tube was placed in her stomach so that she could receive nourishment. At the end of 1990, Schiavo was diagnosed as being in a persistent vegetative state, a diagnostic category that had not been thoroughly defined at the time. Over the ensuing years, the patient's husband decided that his wife would not have wanted to live in such as state and pursued legal action to have the feeding tube removed. In March 2005, US government at both the state and federal levels became involved in the life of Terri Schiavo, including attempted interventions by the US Congress and the President. She died when her feeding tube was removed for the third time.[3]

The situation in which Englaro and Schiavo found themselves reminds us of the state's power at the end of life (Bishop 2009; Perry and Bishop, 2010), even if that power is divested back into the hands of the patient's family. It is odd that this power should not have already been in the family's hands to begin with. The Englaro and Schiavo cases forced a public and political confrontation between differing conceptions of the good life—conversations that necessarily invoked both moral and political choices about which lives are worthy of protection under the law. Yet, what is most interesting is the politicization of the bodies of these women. In fact, the power that medicine wields over life also creates the conditions to sustain life beyond the body's own capacities. And in so doing, medical technology forces the question

about the distinction between bare life and the good life—a biopolitical question.

In this essay, we shall demonstrate how certain understandings of bare life are made possible only through medical technologies and become naturalized such that they are thought to be required. Secondly, we shall argue that the Roman Catholic Church also participates in this process of naturalizing technology, and thereby participate in the politicization of bare life, as demonstrated in recent statements, such as those articulated by the Congregation of the Doctrine of the Faith (CDF), that artificial nutrition and hydration can achieve their proper finality, which is read as natural (CDF, 2007). However, in order to do so, we shall have to make a couple of rather complicated points along the way. First, we shall describe the medical features of the persistent vegetative state and PVS. Second, we shall articulate a particular definition of biopolitics, where the bodies of those in PVS become objects of political activity. Third, we shall turn to the recent history of the development of teaching in the Church with regard to artificial nutrition and hydration. This history is one where the discourses on the culture of life and death find themselves played out in the political arenas of the Unites States and in response to several movements in the Unites States to legalize euthanasia. In the development of these statements, the bishops in the United States can be seen to further collapse the distinction between bare life and politics. In the final section, we shall show that in the collapse of the distinction between bare life and the political nature of these decisions, the Church abandons the domain of bare life (the home) in order to more fully inscribe bare life in the domain of the polis.

II. THE PERSISTENT VEGETATIVE STATE

Once diseases and medical conditions are named and their classifications are ossified, it is sometimes difficult to imagine the chaos and disorientation at the threshold of changing classifications. Thus, it is good to review the history of the nomenclature and classification around a number of brain disorders. Prior to the invention and widespread use of the ventilator, most patients with severe brain injury died. As noted in 1959 by Mollaret and Goulon, and by the questions posed to Pius XII in 1957, it was only because of a new technology—the ventilator—that patients with severe brain injury survived. Thus, technology required a new diagnostic designation for this group of patients kept alive on the ventilators; that designation was *coma dépassé*—the beyond coma (Mollaret & Goulon, 1959). Although most scholars seem to assume that *coma dépassé* was the equivalent of brain death, there is little way that we can be sure of that, since criteria and tests were not yet developed to definitively define "brain death" (Machado et al., 2007). It would take several more years for brain death to emerge as a diagnosis—almost by fiat of the Harvard Ad Hoc Committee (1968; Giacomini, 1997)—distinguishable

from other forms severe brain trauma. As Giacomini (1997) and Lock (2002) have shown, brain death as a new diagnosis required the unfolding of various cultural forces—the medical establishment, legislative and judicial definitions, and the media—before brain death could emerge as a diagnostic state, one grounded not only in biology but also in social, legal, and political agreements.

Even while the formal medical definition of the persistent vegetative state would not come about until 1994, the term "persistent vegetative state" was first coined by Jenett and Plum much earlier, in 1972, and refers to one form of unconsciousness in which the sleep-wake cycle is uninterrupted (Jennett & Plum, 1972). In 1983, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research accepted Jenett and Plum's designation of PVS as an unconscious state with the presence of a sleep-wake cycle, lending further legitimacy to the definition. A Multi-Society Task Force formulated a definition and diagnostic criteria for PVS in 1994. The vegetative state is defined as:

> . . . 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. The condition may be transient, marking a stage in the recovery from severe acute or chronic brain damage, or permanent, as a consequence of the failure to recover from such injuries. The vegetative state can also occur as a result of the relentless progression of degenerative or metabolic neurologic diseases or from developmental malformations of the nervous system (MSTF, 1994a, 1500).

Despite numerous technological innovations, the diagnosis remains clinical. There is no definitive test for the condition, and thus certainty in diagnosis remains probabilistic and prognosis remains statistical.

Because of these difficulties, doctors created rigorously vetted criteria for a diagnosis to be made. The diagnosis is made according to the following clinical criteria:

> (1) no evidence of awareness of self or environment and an inability to interact with others; (2) no evidence of sustained, reproducible, purposeful, or voluntary behavioral responses to visual, auditory, tactile, or noxious stimuli; (3) no evidence of language comprehension or expression; (4) intermittent wakefulness manifested by the presence of sleep-wake cycles; (5) sufficiently preserved hypothalamic and brain-stem autonomic functions to permit survival with medical and nursing care; (6) bowel and bladder incontinence; and (7) variably preserved cranial-nerve reflexes (pupillary, oculocephalic, corneal, vestibulo-ocular, and gag) and spinal reflexes (MSTF, 1994a, 1500).

This diagnosis is made mostly on what is not present—rather than what is present—on the examination. A persistent vegetative state is often diagnosed when a patient has persisted in an unconscious state with an intact sleep-wake

cycle, for approximately one month after the initial injury (MSTF, 1994a, 1501).

Prognosis in patients in persistent vegetative state is dependent upon an intact brain stem and hypothalamic function, which assist in the regulation of heart rate, blood pressure, and breathing. In terms of recovery, mechanism of injury and amount of time in the persistent vegetative state are important factors. Those that do show recovery after twelve months will have severe disability, meaning that the patient is not capable of engaging in most of the previous social, person, and work activities (MSTF, 1994b, 1572). Extrapolating from the data presented by the Multi-Society Task Force, out of the next 1,000 patients diagnosed as being in a persistent vegetative state due to traumatic injury, at the end of 12 months, 330 will have died, 150 will persist in PVS, and 520 will have had some degree of recovery, ranging between good recovery without impairment to severe impairment. Most who recover will do so within the first few months rather than at the end of the twelve-month period. Of the 150 who will persist in the vegetative state beyond twelve months, seven patients can be expected to have some recovery at some point in the future, but will only emerge out of the PVS with severe neurological and cognitive impairment. There is no documented evidence of a patient emerging out of PVS after fifteen years. Thus, after one has persisted in an unconscious state (with intact sleep-wake cycle), one can expect a very small chance of recovery beyond the initial twelve months.

Those in the persistent vegetative state due to nontraumatic injury do much more poorly. Extrapolating from the data on nontraumatic injuries (MSTF, 1994b) of the next 1,000 patients in the persistent vegetative state, 320 will remain in a persistent vegetative state and 530 will have died after one year. Approximately, 150 patients will be expected to have recovered consciousness, with the majority of these still having severe disability.

Although there have been numerous recent attempts to better establish a "gold standard" for diagnosing and prognosticating PVS, none have proven definitive. Thus, diagnosis remains clinical, and prognosis relies on probabilities. Technology can only get us so far on diagnosis and prognosis. Clinical diagnostic criteria and technological diagnostic tools attempt to distinguish between those who have conscious states and those who do not. On the prognostic side, hope resides in the possibility of a distinction between those who will recover and those who will not. However, these are not the most crucial questions. The pertinent questions are those that are more nuanced in their meaning and significance. Of the 520 patients with traumatic injury and in the persistent vegetative state that showed signs of recovery in the first twelve months, few will have had good recovery and return to previous activities. Most will have varying degree of moderate to severe disability. Of the 150 that, in the first 12 months, recovered from the persistent vegetative state due to nontraumatic injury, most will have moderate to severe disability. What the tests, however technologically sophisticated and clinical relevant

they are, cannot tell us is whether those who emerge from the persistent vegetative state will or would conceive themselves as capable of living a good life. The tests cannot tell us if a mere life of biological necessity, without prospect for the good life, is possible or desirable.

Put differently, what the tests cannot reveal are the forms of life that are deserving of the protection of the law nor can they reveal what forms of life can be excluded from those protections. As demonstrated by the events surrounding the lives of Eluana Englaro and Terri Schiavo, these are precisely the questions that animated the political actions and movements around their lives. Those in the persistent vegetative state and the PVS are in a liminal state, not only in terms of their biological conditions but also in terms of the political place that they occupy. They are merely alive, slaves to their biological necessities; but they are not capable of the good life, whether that is understood politically or theologically. Before we can turn to how these questions have played themselves out in the Church's battle over artificial nutrition and hydration, we shall have to unpack the concept of biopolitics briefly.

The Politics of Life

Patients in PVS cannot take food or drink on their own, elements necessary for bare life. In this sense, they live in a state of biological necessity, dependent upon nutrients that they are not themselves capable of acquiring. In order to maintain their biological life, they require the placement of temporary feeding tubes often followed by permanent feeding tubes. If nutrition and hydration are maintained, biological function persists. In the case of these Englaro and Schiavo, there was no hope of recovery such that the possibilities open to those who have protections under the law to pursue the good life. As noted by Arendt (1958) and Agamben (1998), the relationship between the life of necessity, mere life (*zoē* in Greek) and the good life (*bios politkos*), and the life of freedom within the bounds of the law is as old as occidental political philosophy.

Aristotle's distinction between *zoē* and *bios* is well known; *bios* is always a qualified life—*bios theoretikos* (contemplative life), *bios apolaustikos* (life of pleasure), and *bios politikos* (political life) (Agamben, 1998, 1). *Zoē* is the life we have by virtue of being alive, but it is the life of necessity and not freedom for the good life. *Bios politikos* is the good life available only within the city. *Zoē* belongs to the sphere of *oikos*, or home, in ancient Greek and Roman thought, and not part of the sphere of the *polis*, or the city (Arendt, 1958, 12–14). *Zoē politike* would not have been understood neither by the Greeks (Agamben, 1998) nor by the Romans and medieval thinkers (Arendt, 1958, 12–14). As Arendt notes, a life of activity that was devoted to keeping the body biologically alive was not thought to be a life worthy of the term *bios* (Arendt, 1958, 13). *Zoē*, a life enslaved by the necessities of life, belongs

to the sphere of the home, where material and physical, as well as psychological and emotional necessities are met. We, the heirs of this tradition of politics, have focused on the political rights that we have by virtue of bare life, by virtue of being alive.

This distinction and relationship between the bare life of necessity within the home and the possibility of political life—where possibilities beyond necessity might come to fruition—shifted at the birth of modern political liberalism. For the ancient and medieval thinkers, *zoē* was seen as a life of enslavement to the necessities of biological life and the necessities that must be met before the good life became possible. *Zoē* was seen as a basis of for *bios politicos*. With the rise of early modern political philosophy, emphasis on the relationship between *zoē* and *bios politicos* shifted such that the political began to be thought of as a realm concerned with bare life; who, by virtue of possessing bare life, deserves the protections afforded by the law such that she might be able to pursue the good life.

After the French Revolution and after the statistician Francis Galton in the English-speaking world, the relationship between bare life and political life shifts further. Life becomes something managed by the state, and statistically quantified for the purposes of control. After the development of democratic systems of government, the sovereign is now absent and his or her power must be distributed through a system of law and administration. Foucault writes that in lopping off the head of the king, power is diffused along democratic lines for the purposes of controlling bodies. Thus, modern humans become subjects of power because subjected to power; their bodies and psyches become subjected to power structures, which both restrain and make possible the forms of life that become acceptable. For this reason, Agamben claims that, for us, bare life becomes inscribed within the political and subject to political calculation. Bare life becomes the object of political concern. In other words, where for the Greeks *zoē* and life within the *oikos* were thought to be the necessary conditions that must be met before *bios politicos* could be entered, for us *zoē* is now thought to be the object of politics.

One other point should be made. Agamben takes this whole discussion one step further by emphasizing the relationship between the founding of the political realm as requiring the exclusion of others. To use an example from Hobbes (1991), the Sovereign stands outside the polis in the state of nature, where he retains the power to kill or to allow a subject to die or to be killed, without himself being subject to the law. But in excluding himself from the law, the Sovereign creates the conditions for the possibility of law; he is the one who has the power of life and death. In excluding himself from the law, the sovereign preserves the power to exclude others from the protection of the law. In this sense, the Sovereign can place the subject outside the law, where normal prohibitions are suspended and a myriad of violence can be deployed against the outsider. And this is the question that

animated the discussions around the political status of Englaro and Schiavo. In fact, the question put by the father of Eluana Englaro and the husband of Terri Schiavo was whether their families could opt to have these feedings tubes that sustained bare life removed. A decision that had been once part of the realm of the home—concerned with the material necessities of life—has in our time become the political question par excellence. Put differently, the families began to question whether the artificial administration of nutrition and hydration was really a part of the ordinary care morally required for the family and began to feel that the feedings were too much of a burden to continue. The families of both Englaro and Schiavo had to appeal to the state—the realm of the polis—to ask if they could be set outside the normal protections afforded to those with bare life, striking a nerve at the very core of political liberalism.

For the moment, we shall set aside this discussion about bare life and the good life. Suffice it to say that medicine, by virtue of the power vested in it by the state, has the biological expertise to distinguish between those who are merely live and those who have capacities to live the good life. Yet, as already noted, the emphasis on diagnosis and prognosis that medicine has made possible only heightens the angst of decision precisely because decision is at the heart of politics. In the world of liberal democracies, where the head of the Sovereign has been lopped off, sovereignty moves out to each individual. In other words, each is his own Sovereign, both subject and object of that sovereignty. And as noted, it is the sovereign who has the power of life and death. No one but the sovereign can abandon one from the protections of the law. Both Englaro and Schiavo had lost their sovereignty to make such decisions because decision could not be exercised by them. And so the question became not one of sustenance and care offered by families, but one of political wrangling over what kinds of care of the body the state ought to enforce and require. We shall return to this question later. For now, we must explore the historical and political contexts from which the Church's teaching on the proper finality of nutrition and hydration emerged because it very much depended upon politics and biology.

III. DIVERGING OPINIONS AMONG BISHOPS IN THE US CONFERENCE

The teachings of the Church on the inestimable value of the human person are vast. From creation in the image of God through the teachings of the Fathers to the more recent *Evangelium Vitae* of Pope John Paul II, Church teaching consistently values human life in its varied forms. *Evangelium Vitae* states concerning the worth of human life on earth:

> Man is called to a fullness of life which far exceeds the dimensions of his earthly existence because it consists in sharing the very life of God. The loftiness of this supernatural vocation reveals the greatness and the inestimable value of human life

even in its temporal phase. Life in time, in fact, is the fundamental condition, the initial stage and an integral part of the entire unified process of human existence. It is a process which, unexpectedly and undeservedly, is enlightened by the promise and renewed by the gift of divine life, which will reach its full realization in eternity. At the same time, it is precisely this supernatural calling which highlights the relative character of each individual's earthly life. After all, life on earth is not an 'ultimate' but a 'penultimate' reality; even so, it remains a sacred reality entrusted to us, to be preserved with a sense of responsibility and brought to perfection in love and in the gift of ourselves to God and to our brothers and sisters (John Paul II, 1995, 4).

Whereas *Evangelium Vitae* does not make a statement concerning the specific issue of hydration and nutrition in the persistent vegetative state, it does make a broad statement against the taking of a life actively or passively if the intent is the death of the individual. The statement also points out that the overall trend toward the acceptance of euthanasia is a "tendency to value life only to the extent that it brings pleasure" (John Paul II, 1995, 115) and to value only those who are productive. *Evangelium Vitae* rightly states that secular society's move to radical autonomy and freedom of the human will begins to demand a "rightful liberation" from life when it begins to be unbearable or burdensome (John Paul II, 1995, 115). Many in society seem to have endorsed this implicitly in the past and are now beginning to endorse it explicitly, although the definitions of productive, unbearable, or burdensome remain contested and historically and culturally specific.

On the other hand, the encyclical endorses the right of the individual to forgo aggressive medical treatment in the event that the means are extraordinarily burdensome or disproportionate to the realistic hope of an acceptable outcome (John Paul II, 1995, 117). Moreover, as shown so clearly by Wildes (1996), these judgments are highly contextual and highly subjective; Wildes' argument will be examined more closely a little later in this paper. In other words, the patient may refuse forms of treatment that would only secure a precarious and burdensome prolongation of life, so long as the normal care due to the sick person in similar cases is not interrupted.

Church teaching has long held that there is a moral obligation to care for oneself and for families to care for their loved ones, and to allow oneself to be cared for, but this duty must take account of concrete circumstances. It needs to be determined not only whether the means of treatment available are objectively proportionate to the prospects for improvement but also whether the means are extraordinarily burdensome. To forgo extraordinarily burdensome means is not the equivalent of suicide or euthanasia; it rather expresses acceptance of the human condition in the face of death (John Paul II, 1995, 117–18).

The events leading up the most recent statement by the CDF are complex. Since the early 1990s, there have been three statements by various groups of American bishops on the issue of hydration and nutrition in persons who

are in the persistent vegetative state. The Texas bishops produced a well-reasoned statement. *On Withdrawing Artificial Nutrition and Hydration,* which was signed by sixteen of eighteen bishops, affirmed the value of the human person and the value of life given by God as outlined by John Paul II in *Evangelium Vitae*. It also outlined three basic moral principles that should be followed in the decision-making process to remove artificial hydration and nutrition. They are:

> 1) Although life always is a good, there are conditions which, if present, lessen or remove one's obligation to sustain life.
> 2) If the reasonable foreseen benefits to the patient in the use of any means outweigh the burdens to the patient or others, then those means are morally obligatory.
> 3) If the means used to prolong life are disproportionately burdensome compared with the benefits to the patient, then those means need not be used, they are morally optional (Texas Bishops, 1990, 53).

These criteria have been implicit in statements made by Pius XII and by the CDF's *Declaration on Euthanasia* when applied to, for example, experimental therapies and ventilation. The Texas bishops applied this to hydration and nutrition, something that had not yet been done. They viewed the persistent vegetative state as a lethal pathology, which, without artificial nutrition and hydration, will lead to death. Thus, the patient's family can use their judgment as to whether nutrition and hydration is extraordinary and thus optional. Patients in the persistent vegetative state "should be cared for lovingly [and] kept clean, warm, and treated with dignity" (Texas Bishops, 1990, 54).

In 1991, the Oregon and Washington bishops published a statement that is somewhat more restrictive. Their statement was written to give guidance in the face of legislative initiatives to legalize physician-assisted suicide. They noted that the withdrawal of nutrition and hydration is more complex than withdrawing a ventilator or a hemodialysis machine. They also noted that infants are utterly dependent on their mothers until they are able to nourish themselves. At the other end of life, the same dependence is seen. The bishops of the northwest stated that there is no consensus on the issue, noting that some moralists feel that the patient in the persistent vegetative state is not dying from disease or trauma and should therefore continue to receive nourishment. They went on to state that the decision to continue hydration and nutrition can be a powerful witness to the "value of life as God's precious gift" and to a "hope born out of true love for the unconscious person's recovery" (Oregon and Washington Bishops 1991, 350). The bishops of the northwestern United States also acknowledged that there are those who see artificial nutrition and hydration as no different than any other medical intervention. Since other therapies can be withdrawn, then fluid and nutrition can be withdrawn when it is believed by the parties involved to be extraordinarily burdensome or disproportionate to any benefit or hope to be achieved (Oregon and Washington Bishops 1991, 350).

However, the bishops went on to state that there is a presumption for hydration and nutrition to be achieved by whatever means is best tolerated by the patient. There was a concern on their part that the removal of hydration and nutrition would begin a decline down the "slippery slope," especially given that at the time of their writing, Oregon was considering whether to pass the country's first law allowing physician-assisted suicide. These bishops were attempting to give pastoral guidance in the midst of political discussions about euthanasia and physician-assisted suicide (Oregon and Washington Bishops, 1991, 349–50). They wrote:

> Decisions regarding artificially administered nutrition and hydration must also be made on a case-by-case basis, in light of the benefits and burdens they entail for the individual patient. In appropriate circumstances, the decision to withhold these means of life support can be in accord with Catholic moral reasoning and ought to be respected by medical caregivers and the laws of the land (Oregon and Washington Bishops, 1991, 350).

Thus, the Oregon and Washington bishops were rather more cautious than the Texas bishops, but noting at the same time the importance of "case-by-case" decisions and the respect due to the decision makers in such situations.

In 1992, a third group of American bishops articulated a rather more restrictive statement. The Pennsylvania bishops focused on biological factors, including the details of the persistent vegetative state and what neurological activity might be possible. They focused on the level of pain and suffering, and on the burden that the condition places on the patient. They stated that in patients with PVS, since the cerebral cortex is not functioning, the patient is not able to experience any pain or the affective response commonly referred to as suffering. They drew several conclusions. First, the patient has not undergone brain death, and for this reason, he or she remains alive. Second, because the patient cannot have the experience of pain or suffering, a burden does not exist for the patient in having the tubes in place for hydration and nutrition. Therefore, the argument that these tubes are an undue burden cannot apply. Third, the patient has no conscious understanding or affective response to pain. Therefore, if the patient cannot perceive pain or suffering, then it cannot be argued that they are forced to continue in a painful existence (Pennsylvania Bishops, 1992, 549–50).

The Pennsylvania bishops thus proposed and answered several medical questions with regard to the patient's medical condition. (1) "Is the procedure (supplying of nutrition and hydration) beneficial to the patient in terms of preservation of life or restoration of health?" (Pennsylvania Bishops, 1992, 548). Their answer was yes in that it sustains life, even if it does not restore health to a former state. (2) "Is it serving a life-saving purpose?" (Pennsylvania Bishops, 1992, 548). Their answer was yes, since the patient could not survive without it. (3) "Is it adding serious burden?" (Pennsylvania Bishops,

1992, 548). Their answer was no, in that the means of providing food "is simple . . . and without pain" (Pennsylvania Bishops, 1992, 548). (4) "Is death already imminent, so that the proposed procedures (supplying of nourishment in this case) may add briefly to the life span in such a way as simply to prolong the dying process without actually preserving life?" (Pennsylvania Bishops, 1992, 548). Their answer was yes, in that in the acute setting whatever has caused PVS might cause imminent death; but PVS is not itself life threatening, according to the bishops (Pennsylvania Bishops, 1992, 548). They have begun to see the PVS as an independent entity, a new way of being.

The bishops also point out that what distinguishes between allowing death and killing is in the intention of the will and in the methods used. Alleviation of suffering by killing is not acceptable and is contrary to the Christian vocation. The bishops argue that by removing hydration and nutrition, the intent would be to kill the patient in order to remove whatever indignity might exist. They state that it is not a case of allowing the patient to die because the patient is not in a terminal condition.

IV. ANALYSIS OF PENNSYLVANIA BISHOPS' STATEMENT

Although these are their strongest arguments, they do not stand up to scrutiny on several levels. First, it is true that PVS and brain death are not equivalent. But the moral and ethical weight of the brain death criteria have come under great fire ever since they were first articulated. It remains the case that brain death itself was defined through a series of political discussions, first held among the Harvard committee and secondly held among the President's Commission. Moreover, Giacomini (1997) has shown in no uncertain terms that this new diagnosis of brain death was hammered out as a response for the need of organs for transplantation. Lock (2002) has shown definitively that whole-brain death is as much a production of culture and social machinations as it is a hard and fast scientific truth. Whole-brain death was a more convenient place to draw a political line than the other places that were entertained. In truth, it is just the case that we can say diagnostically *that* this person is brain dead, but it is very difficult to say exactly *what* brain death is or what it means. It is nearly impossible to prove that brain death de facto defines the moment of death, even while de jure it has been defined as such.

Second, the Pennsylvania bishops rather arbitrarily find places to draw lines between terminal and nonterminal conditions. In point of fact, patients with whole-brain death, patients with brain stem death (with preservation of cortical function), and patients in the PVS all have terminal brain pathologies. Without medical interventions, patients with whole-brain death and brain stem death sustain cardiovascular death very rapidly because they are unable to breathe and to support cardiovascular function. In the absence of

medical intervention, people within the PVS and those with other brain pathologies, such as Creutzfeldt-Jakob and end-stage Alzheimer's dementia—just to name two—die less rapidly than those with whole-brain and brain stem death, but within a few days in the absence of medical technologies. In other words, many brain pathologies are in fact terminal except for medical interventions, such as antibiotics and intravascular volume repletion, a point no less true for cancer. Most patients with severe brain pathologies, including the PVS, die from volume depletion and circulatory collapse, rather than by starvation or dehydration. It should be noted that volume depletion and dehydration are physiologically distinct entities. In short, the natural course of life for people with brain pathologies is shortened. In fact, with the exception of whole-brain death, brain pathologies in and of themselves do not cause death. A natural death for patients with severe brain pathologies, including those in the PVS, is one where they are unable to take in fluids and they die from cardiovascular collapse from volume depletion, or they get an infection—pneumonia or urinary tract infections. They would die except for medical interventions requiring expert skill that cannot be provided without technological assistance.

Finally, it is true that patients within both the persistent vegetative state and PVS cannot experience the pain or suffering that might be associated with the means of supplying food and fluids, and it is true that, by sustaining their lives, one is not forcing a burdensome existence upon them. But it is also true that the brain centers required for perception of pain and suffering are the very brain centers that are required for the conscious worship of God, for the ability to respond to God's grace and to their family's loving care. To move to more speculative language, in some mysterious way the intact cortex is integral to, without being the locus of, physical, intellectual, and spiritual aspects of the person. Once the cortex is irreversibly damaged, there can be no hope of restoration of that integration. Although physiologic life, bare life, can be maintained by giving nutrition and hydration, the subjective, emotional, and affective value assigned to physical stimuli, including that of the communitarian nature of eating a meal, cannot be enjoyed by the person in an integrated fashion consistent with human flourishing. PVS, then, is the barest form of bare life, where material and physical necessities cannot be freely chosen and thus every decision is one that bears on bare life and its relationship to the goods of life.

Thus, it would seem that the increasingly more restrictive statements articulated by the bishops were a product of increased worries about the rise of physician-assisted suicide and turned increasingly to the biological features of the bare life that is the persistent vegetative state and PVS. It was during the early 1990s, about the time the Oregon and Washington bishops articulated their statement, that the first Oregon Death with Dignity act to legalize euthanasia was being introduced. In addition, Jack Kevorkian was a prominent figure promoting physician-assisted suicide and euthanasia. Moreover,

it is odd that increasingly the bishops begin to focus on the biological features of not only the disease but also of the means sustaining the biological processes of life itself.

We want to be clear; we are not in any way suggesting that all persons in a PVS ought to have nutrition and hydration stopped. We are suggesting that since life is a penultimate good, a family is permitted to decide whether the means to keep their loved one is extraordinary given the over all circumstances required to keep the person alive. It is the realm of *oikos*—the home, the family—that is closest to the concrete, "case-by-case" judgments that are to be made. It is within the home, where material necessities are met, that the decision should reside, not within the polis.

V. ORDINARY AND EXTRAORDINARY MEANS: A DECISION OF *OIKOS*

It is at the level of home, then, that the teaching on ordinary and extraordinary means is directed. In 1996, Kevin W. Wildes reevaluated the discussion of ordinary and extraordinary means, building on the work of Daniel Cronin in his 1958 dissertation. Wildes notes that Roman Catholic bioethicists and moral theologians should understand the importance of quality-of-life judgments in assessing when an intervention is an ordinary means or an extraordinary means of preserving life. Just because those with political bias against Christianity's views on moral issues often rely on "quality-of-life" language, that does not mean that quality-of-life language is not important in Catholic moral deliberation. He continues "If we fail to understand the importance of quality-of-life judgments, we run the risk of misunderstanding that distinction and the important moral commitments it implies—all in the interest of winning a political battle" (Wildes, 1996, 500). In short, the life of necessity and dependency, that is bare life, has to be weighed by those closest to those necessities and not at the level of the political arena.

Wildes reexamines extraordinary means summing up its elements under five headings (Wildes, 1996, 503). (1) If something is impossible either to obtain or to use if attainable, then the means is extraordinary. As Wildes describes it, Gerard Kelly notes that extraordinary means are hard to determine, and that it "is not computed according to a mathematical formula, but according to the reasonable judgments of prudent and conscientious men." (Kelly, 1958, 135; Wildes, 1996, 503–4). (2) The means is also extraordinary if the effort is too difficult to warrant carrying out the means. An example would be a very dangerous operation or a prolonged convalescence. (3) Another element to be considered is the level of pain that would be experienced in carrying out the means. (4) A fourth element is that of cost. Traditionally, cost was allowed to enter into the deliberation about extraordinary means, even while cost is relative to one's station in life. According to Wildes, what is extraordinary means to one person may be ordinary to another.

(5) Traditional teaching allowed for emotions of fear and repugnance to enter into the decision-making process as well. An example used by Cronin is that of amputation. If someone finds the thought of amputation repugnant, one is not required to go through with the procedure. In each of the above elements, it is the patient's response that determines if a treatment or procedure is extraordinary or disproportionate (Wildes, 1996, 504).

Certainly, ordinary means is distinguished from commonly accepted practices in medicine. In order for a means to be ordinary there must be (1) a reasonable hope of benefit in promoting health or prolonging life and the hope must be more than simply postponing the inevitable. (2) Wildes points out that standard of care or the availability of a treatment can be included in the test of ordinary means. Again (3) the cost is part of the assessment, as noted above, and (4) the treatment should be reasonably convenient and reasonable to employ. "In making a judgment about the difficulty of a treatment, traditional moral teaching tried to balance the serious demand of the natural law to conserve one's life with the proportionate difficulty of fulfilling the law" (Wildes, 1996, 504).

Wildes points out that in order for a treatment to be obligatory, there must be some hope of health and this is always subjectively determined. But although the hope of health is a necessary condition for a treatment to be ordinary, it is not alone sufficient. He continues:

> Absence of hope of health, however, is a sufficient condition for withholding or withdrawing a treatment. In assessing the benefit or burden ratio one assesses what the treatment does for the patient and others. A hope of benefit is a necessary, though not sufficient, condition for treatment. If a treatment is either physically or morally burdensome for the patient or others, a sufficient condition exists to withhold or withdraw the treatment. The assessment of the burdensome nature of a treatment is a quality of life judgment. Is the treatment itself a burden to the patient, or does the treatment leave the patient in a condition that the patient finds repugnant? Since there is no absolute standard by which to make these judgments, they will be relative to the patient's perception of his or her own life (Wildes, 1996, 506).

Though means may be objectively discernable, the decision of whether or not to proceed with a medical therapy is subjectively made in light of the life story and particular cultural, social, and economic circumstances of the person making the decision. Notice how concrete and close to the ground such decisions are.

Wildes also critiques another tendency in determining ordinary and extraordinary means. This is the tendency to limit withdrawal of care to those situations where, as John Paul II states in *Evangelium Vitae*, death is "clearly imminent and inevitable" (117). Wildes points out that the language of ordinary and extraordinary means has not "traditionally been tied to closeness of death, but to a judgment about the treatment's benefits and burdens" (Wildes, 1996, 509). And, death is much more imminent in the brain pathology

of the PVS than it is in many terminal cancer patients, whose families routinely judge whether an intervention is or is not warranted.

Wildes applies this more traditional interpretation to the persistent vegetative state. He notes that the language of both the Oregon and Washington and the Pennsylvania bishops avoids terms like "quality of life" because the proponents of abortion and assisted suicide have used them. This political motivation may very well be undermining the intent of the initial framers of the elements of ordinary and extraordinary means. In addition, Wildes notes that the Pennsylvania bishops are falling into the very same trap that modem medicine has created and itself fallen into the overspecialization of medicine. Medicine has sub-specialized to the point of specializing not only by body systems but also by disease and stages of an individual life. This overspecialization is the result of a mechanical understanding of life, a merely physiological understanding of bare life. What is lost in the mix is the patient, as a whole and integrated person with his or her own psychosocial makeup. "These bishops reflect this tendency by looking at medical interventions in isolation from the whole patient" (Wildes, 1996, 510); and we are claiming that the holistic judgment must also be understood within the context of the home, the family, and the *oikos*. The biological necessities of bare life were traditionally vetted and meted out at this level. By attempting to objectify the requirements of care, the bishops, and the CDF, have forgotten the subjective nature of discerning the benefits and burdens of bare life within the context of home. The decision is not made "by some social standard, but by seeing the life and the treatment in the context of one's relationship to God" (Wildes, 1996, 511). Decisions about ordinary and extraordinary means of supporting bare life, then, are decisions best made by those closest to the ground.

VI. CDF STATEMENT ON ARTIFICIAL NUTRITION AND HYDRATION

This brief history brings us to the most recent statement by the CDF. In 2007, the CDF reinvigorated concerns over the Church's analysis of nutrition and hydration in the support of people who are in the PVS. The CDF answered two questions put to them by the US Conference of Catholic Bishops. The first question concerned whether or not nutrition and hydration for a patient in a "vegetative state" is morally obligatory except under limited conditions such as when the patient cannot assimilate the same, or if the supply of nutrition and hydration causes significant physical discomfort to the patient. To this question, the CDF responded yes, and stated that, in principle, the administration of food and water by any means is an ordinary and proportionate means of preserving life. The CDF further stated that this treatment is obligatory as long as it is shown to accomplish its proper "finality," which is hydration and nourishment of the patient.

The second question addressed whether or not a patient in PVS may have nutrition and hydration by artificial means discontinued when competent physicians judge that the patient will never regain consciousness. To this, the CDF said no, affirming that the patient in a PVS is a person with fundamental human dignity. Because of this, the patient should be given "ordinary and proportionate care" which includes the administration of food and water, even if by artificial means. The theological rationales were not extensively articulated.[4]

Reactions to the CDF's statements were swift, and several articles in *America* outline the criticisms and affirmations of the *Response*. Several authors have suggested that the *Response* is a strangely abstract document and unconcerned with the ways in which questions about PVS are not theoretical conundrums to be settled by the Curia, but are experienced in the everyday lives of the faithful. For example, Hardt (2008) provides a compelling analysis of his father's own wishes should he develop PVS. Hardt's father argues that he should be "let go," refusing medical interventions that prolong his biological life. His father believes that such a request would reduce the suffering of his family and reduce the strains on their financial security in the case that he never recovers consciousness. Hardt argues that his father's wishes are consistent with traditional Catholic moral teachings in that he is acknowledging the finitude of the human condition. Further, the tradition affirms that, ". . . while biological life is an important value, it is not an absolute good" (2008). We strongly agree with the more ancient Christian tradition on this point, and believe that, in concert with the *Response*, statements from bishops in Oregon and Washington, as well as Pennsylvania, and most especially the CDF's 2007 statement, all err on the side of privileging medicine's technological abilities to sustain "bare life," politicizing the possession and dispossession of human life.

Shannon (2008) argues that the CDF statement is at variance with the common Catholic tradition that had previously sought to balance an intervention's benefits with its burdens. Recalling the CDF's 1980 *Declaration on Euthanasia* as a reference, Shannon argues that the Church has traditionally sought the proportional use of medical care. In addition, the dignity of the human person and the Christian concept of life is threatened by an overly technologized attitude. Shannon notes that the CDF's statement might violate "the dignity of the person, because it defines and reduces their personhood solely to terms of biological functioning. It is physical reductionism, a form of materialism that benefits neither them nor society. And the position seems to confer on physical life an almost absolute value" (CDF, 2007).

In point of fact, the CDF naturalizes what are clearly technological interventions. PEGs and other gastric tubes require specialized skills and technological prowess to carry them out. By focusing on the mere materiality, right down to the proper finality of carbon and water, nutrition and hydration, the CDF has accepted a kind of physicalism, where material existence becomes

part of deliberations of the Church and of political decision making. In the cases of Schiavo and Englaro, attempts were made by their family members to make decisions about nutrition and hydration, a decision traditionally belonging to the sphere of *oikos*, the home. Yet, both sets of families felt the need to appeal to the political and legal structures of society, suggesting again that life itself is an object of political interest due to the encroachment of the realm of the *polis* into the realm of the *oikos*. Indeed, the Church itself seemed to support these political interventions. Moreover, as we have shown, the Church seems to be making statements so as to be in the best political position to prevent the legalization of other actions—like physician-assisted suicide and euthanasia—that clearly violate moral doctrines on life. Thus, it would seem that the Church has ceased giving advice to families—those closest to the ground and whose authority is directed at the necessities of bare life. It is in the home, then, rather than at the abstract level of doctrinal teaching or the level of the polis, that such decisions are most properly made.

VII. CONCLUSIONS

The CDF's own documents, especially the *Declaration on Euthanasia* continues the spirit of Pope Pius XII's statement on the prolongation of life, both allowing one to judge whether a treatment is ordinary or extraordinary by studying not only the risks or proposed benefits of the intervention but also its costs—financial, social, psychological—and the possibilities of using it, in light of one's moral and material resources. Moreover, neither the *Declaration* nor Pius XII emphasized the materialist position of the CDF's 2007 statement. Using the logic of the most recent CDF statement, it could be argued that ventilators should not be turned off because they deliver oxygen; ventilators are the means for oxygen to achieve its proper finality.

However, Pius XII's statement in fact is quick to see the ordering of human goods, physical life being a penultimate rather than an ultimate good, as essential in decision making. Thus, the *Declaration* continues the Catholic moral tradition of seeking to determine whether a treatment is extraordinary by evaluating its impact on the whole person, not merely the proper finality of life's material constituents, like oxygen, carbon, and water. Rather, these material constituents, achieving their proper finality, are themselves to be ordered to the higher functioning of the body, ordered by the family, ordered by the praying community, all ordered to the worship of God—the proper finality of all human action biological or otherwise. Traditional Christianity recognizes that death is inextricably bound together with life, even while we are not created for death. Traditional Christianity proclaims that in our deaths, we participate in the death of Christ. Thus, a question arises as to whether the 2007 statement of the CDF may be substituting a call

for the maintenance of bare life at the expense of the final cause of human life—human life's proper finality, its *summum bonum*—the continual worship of God in the Church triumphant.

NOTES

1. For the purposes of this paper, we will use PVS to designate the *permanent* vegetative state.

2. This summary is a compilation of several news wire accounts including: Italy man wins life support plea. *BBC News*, November 13, 2008; Vatican cardinal pleads for life of Italian "Terri Schiavo." *Catholic News Agency*, November 13, 2008; Donadio, R. 2009, Feb. 9. Death ends coma case that set off furor in Italy. *New York Times*; Day, M. 2009, Feb. 8. Italy faces constitutional crisis over coma woman. *Guardian*; Owen, R. 2008, Nov. 13. Top Italian court clears way for death of Eluana Englaro. *Times Online*.

3. This summary is the result of several news wire reports and other scholarly articles. For details, see Bishop, J. P. 2009. Biopolitics, Terri Schiavo, and the sovereign subject of death. *Journal of Medicine and Philosophy* 33:338–57.

4. The commentary associated with the "Responses" referred to Pope John Paul II's October 1998 speech to bishops of California, Nevada, and Hawaii. John Paul stated that in the case of PVS, the presumption should be in favor of providing nutrition and hydration to all patients who need them. We simply note here that this presumption does not seem to imply that the provision of artificial nutrition and hydration are mandatory in all cases of PVS. See Congregation for the Doctrine of the Faith. Responses. op. cit.

REFERENCES

Arendt, H. 1958. *The Human Condition*. Chicago: University of Chicago Press.

Ad Hoc Committee of the Harvard Medical School. 1968. A definition of irreversible coma. *Journal of the American Medical Association* 205:337–40.

Agamben, G. 1998. *Homo Sacer: Sovereign Power and Bare Life*. Translated by D. l. Heller-Roazen. Stanford, CA: Stanford University Press. Originally published under the title: *Homo sacer: Il potere sovrano e la nuda vita* (1995) in Italy by G. Einaudi. editore s.p.a.

Bishop, J. P. 2008. Biopolitics, Terri Schiavo, and the sovereign subject of death. *Journal of Medicine and Philosophy* 33:538–57.

———. 2009. Foucauldian diagnostics: Space, time, and the metaphysics of medicine. *Journal of Medicine and Philosophy* 34:328–49.

Congregation for the Doctrine of the Faith (CDF). 2007, Sept. 14. Responses to certain questions of the United States Conference of Catholic Bishops concerning artificial nutrition and hydration. Vatican Press Office Bulletin.

Day, M. 2009, Feb. 8. Italy faces constitutional crisis over coma woman. *Guardian*.

Donadio, R. 2009, Feb. 2. Death ends coma case that set off furor in Italy. *New York Times*.

Giacomini, M. 1997. A change of heart and a change of mind? Technology and the redefinition of death in 1968. *Social Science and Medicine* 44:1465–82.

Hardt, J. J. 2008, Jan. 21. Church teaching and my father's choice: 'medically ordinary' does not always mean morally ordinary . *America*.

Hobbes, T. 1991. *Leviathan*, ed. R. Tuck. Cambridge: Cambridge University Press. Originally published under the same title in 1651.

Italy man wins life support plea. BBC News, November 13, 2008.

Jennett, B., and F. Plum. 1972. Persistent vegetative state after brain damage: A syndrome in search of a name. *Lancet* 1:734–7.

John Paul, II. 1995. *Evangelium vitae: On the value and inviolability of human life.* Available: http://www.vatican.va/holy_father/john_paul_ii/encyclicals/documents/hf_jp-ii_enc_25031995_evangelium-vitae_en.html Accessed on August 2, 2011.

Kelly, G. 1958. *Medico-moral problems.* St. Louis, MI: Catholic Hospital Association.

Lock, M. 2002. *Twice dead: Organ transplants and the reinvention of death.* Berkley: University of California Press.

Machado, C., J. Kerein, Y. Ferrer, L. Portela, M. de la C. Garcia, and J. M. Manero. 2007. The concept of brain death did not evolve to benefit organ transplants. *Journal of Medical Ethics* 33:197–200.

Mollaret, P., and M. Goulon. 1959. Le coma dépassé. *Revue Neurologique* 101:3–15.

Multi-Society Task Force (MSTF) on PVS. 1994a. Medical aspects of the persistent vegetative state (first of two parts). *New England Journal of Medicine* 330:1499–508.

Multi-Society Task Force (MSTF) on PVS. 1994b. Medical aspects of the persistent vegetative state (second of two parts). *New England Journal of Medicine* 330:1572–9.

Oregon and Washington Bishops. 1991. Living and dying well. *Origins* 21:345–52.

Owen, R. 2008, Nov. 13. Top Italian court clears way for death of Eluana Englaro. *Times Online.*

Pennsylvania Bishops. 1992. Nutrition and hydration: Moral considerations. *Origins* 21:541–53.

Perry, J. E., and J. P. Bishop. 2010. Life, death (panels), and the body politic. *Syracuse Law Review* 61:25–47.

Shannon, T. A. 2008, Feb. 18. At the end of life: Are feeding tubes now obligatory? *America.*

Texas Bishops. 1990. On withdrawing artificial nutrition and hydration. *Origins* 20:53–5.

Vatican cardinal pleads for life of Italian "Terri Schiavo." Catholic News Agency. November 18, 2008.

Wildes, K. W. 1996. Ordinary and extraordinary means and the quality of life. *Theological Studies* 57:500–12.