Landas 18:2 (2004) 211-230

A BURDEN OF MEANS
An Overlooked Aspect of the PVS Debate

James T. Bretzke, S.J.

I met recently with Nancy and Gary, a wife and son who were struggling with making some possible changes in the ongoing care for Bob, a 68-year-old man diagnosed over eight years ago with an inoperable malignant brain tumor located in the center of his brain and which has since spread tentacles throughout the brain. At the time of his initial diagnosis, Bob had named his eldest and youngest sons—Gary, an attorney, and Chris, a doctor—as co-executors of his advanced health care directive. Bob and Nancy were high-school sweethearts and have been married for forty-five years. Gary told me at the outset that he and his youngest brother (Chris, the out-of-state physician) have virtually decided that it would be best to end Bob's anti-seizure medication but their mother was still not sure. While this medication gave Bob some relief and a higher quality of life some years ago, Bob's current situation is that he is bed-ridden, unaware of his surroundings, and suffering from painful bedsores and

---

*Lecture delivered during Theological Hour at Loyola School of Theology, Loyola Heights, Quezon City, on July 7, 2004. An earlier version of this paper was also presented to the Society of Christian Ethics, Pacific Section, at the San Francisco campus of the University of the Pacific on February 13, 2004.

incessant itching. Gary is worried about his mom who is the primary caregiver for Bob and who feels she must stay at home virtually non-stop (though there is a paid caregiver during the daytime). If the anti-seizure medication is terminated, Bob may begin to experience progressive seizures, one of which may ultimately combine with his other debilities that could lead to his death. If he remains on this medication though and nothing else changes, Bob's doctor has said that Bob will likely curl up in bed and withdraw into a fetal state while requiring a feeding tube to maintain life. Ultimately, in this scenario, Bob will probably contract pneumonia at some point and die.

Gary, the eldest son, is somewhat impatient with this whole discussion process, but has agreed to come with his mother because she has indicated that she wants to respect the Church's teaching in this area. Both Gary and his mother agree that the other members of the family will support whatever decision they make, and Chris, the youngest brother (the out-of-state physician), particularly believes that the anti-seizure medication should be terminated. Nancy turns to me and says that she knows that the Church would not require "extreme measures" but she just does not know what to do in this case. At this point, both Gary and his mother Nancy make a spontaneous reference to Terri Schiavo and say that they know that Bob would not want to end up like that. It was clear to me that the Schiavo case was playing a very significant role in the anguished deliberations of Bob's family.

Terri Schiavo's fifteen minutes of fame does seem to be going into double overtime. In the United States, the basic facts of the case are relatively well-known.[1] Theresa Marie Schindler was born in Pennsylvania on December 3, 1963, to Mary and Robert Schindler.

---

[1]An Internet search (e.g., through Google) will turn up scores of hits. For the best site on the side of Terry Schiavo's parents, Robert and Mary Schindler, see http://terrisfight.org/. This site is updated frequently with the latest legal developments in the case, and contains numerous documents and links that support the position of the Schindler family.

She married Michael Schiavo and on February 25, 1990, at the age of twenty-seven, collapsed in their home and went into cardiac arrest due to a severe potassium imbalance. Since her release from the hospital in August 1990, Terri lived in nursing homes with total and constant care, including being artificially fed and hydrated. She left no formal advanced health care directive and that just about concludes the "facts" that all parties will agree on. In 1998, Terri's husband petitioned the circuit courts of Pinellas County, Florida, to remove her feeding tube and the ups and downs of the legal battles have escalated over the years. Decisions were made, appealed, sustained, and/or reversed until Michael Schiavo finally won his case to have Terri's feeding tube removed. In its June 2003 decision affirming the lower trial court's decision to allow Michael Schiavo to have Terri's feeding tube removed, the Florida Second District Court, in reviewing Terri's medical condition, concluded that

> Over the span of this last decade, Theresa's brain has deteriorated because of the lack of oxygen it suffered at the time of the heart attack. By mid 1996, the CAT scans of her brain showed a severely abnormal structure. At this point, much of her cerebral cortex is simply gone and has been replaced by cerebral spinal fluid. Medicine cannot cure this condition. Unless an act of God, a true miracle, were to recreate her brain, Theresa will always remain in an unconscious, reflexive state, totally dependent upon others to feed her and care for her most private needs.[2]

In August 2003, the Florida Supreme Court refused to review the Second District Court's ruling, and Terri's parents then turned unsuccessfully to the federal courts. Finally, on October 15, 2003, Terri's feeding tube was removed, but five days later Florida Governor Jeb Bush and the Republican-controlled state legislature rushed

---

[2]Excerpts of the Court's decision, as well as a very helpful timeline of the legal developments in the Terri Schiavo case, are found on *Abstract Appeal* (http://abstractappeal.com/schiavo/infopage.html), a website devoted to Florida law and the Eleventh Circuit Court of Appeals. On January 30, 2004, the editorial position of the webmaster is stated as being in sympathy with both the Schindlers and Michael Schiavo.

to enact what is called "Terri's law" to overturn the court decision that gave Michael Schiavo the authority to have her feeding tube removed. The feeding tube was then reinserted and another round of legal challenges is underway as this article is being written.[3]

While many parts of this whole case read like an overly melodramatic daytime soap opera, there is one aspect of the case that has, frankly, not gotten the press coverage it deserves, and oddly enough, at the same time, is the locus of the side-debate among (mostly) Roman Catholic moral theologians and Church officials. This aspect of the case is what is usually called in Roman Catholic bioethical circles the distinction between "ordinary and extraordinary means" (henceforth, o/e). More specifically, I will argue that many problematic interpretations of this o/e tradition rely on an overly physicalist reading of the case, and pay insufficient attention to the broader meaning of the notion of "burden," which is key to a proper analysis and application of the o/e principle. To open up this discussion further, I will highlight what may be a potentially helpful insight from the Catholic bishops of the Philippines, which might move us in one direction, as well as to acknowledge the recent input from John Paul II in the form of an address given to a conference in March 2004, which might seem to move in a quite different direction. Thus, these seemingly competing magisterial documents raise some important issues as to just what Church Tradition is in this regard, and how it is meant to be used in coming to an informed decision in a concrete case.

[3]The actions of the Florida legislature and Governor Jeb Bush have been ruled unconstitutional by a judge, but this decision has been appealed to a higher court and, at this writing, no final decision has been rendered.

The Tradition of Ordinary and Extraordinary Means

To return to the encounter with Nancy and her son Gary, I turned to Nancy and asked her what she understood the Church's teaching to be in this regard. She responded that she knew the Church didn't require "extreme measures," but felt that in her husband's case his whole care, including the anti-seizure medication that was being re-evaluated, would not count as an "extreme measure," and therefore perhaps would be considered by the Church as morally mandatory. I suspect that Nancy's response would be the understanding that many people in the pew would have. And that understanding is incorrect.

Though the tradition of the o/e principle is lengthy, it might be helpful to turn to the *Catechism of the Catholic Church* for a concise definition:

> 2278 Discontinuing medical procedures that are burdensome, dangerous, extraordinary, or disproportionate to the expected outcome can be legitimate; it is the refusal of "over-zealous" treatment. Here one does not will to cause death; one's inability to impede it is merely accepted. The decisions should be made by the patient if he is competent and able or, if not, by those legally entitled to act for the patient, whose reasonable will and legitimate interests must always be respected.
>
> 2279 Even if death is thought imminent, the ordinary care owed to a sick person cannot be legitimately interrupted. The use of painkillers to alleviate the sufferings of the dying, even at the risk of shortening their days, can be morally in conformity with human dignity if death is not willed as either an end or a means, but only foreseen and tolerated as inevitable. Palliative care is a special form of disinterested charity. As such it should be encouraged.[4]

---

[4] *Catechism of the Catholic Church*, par. nos. 2278-79. Henceforth, CCC followed by the paragraph number(s). Unless otherwise indicated, I will be using the official English translation at http://www.vatican.va/archive/ENG0015/__P7Z.HTM.

Before moving to a closer analysis of this principle, it will be important to acknowledge the context in which the principle is found—both within the *Catechism* itself, as well as in the minds of many people. Here I am referring to the nagging suspicion that *any* termination of treatment, unless it is clearly "extreme," would be tantamount to passive euthanasia, as expressed in the paragraph that immediately precedes the *Catechism*'s section on ordinary and extraordinary means:

> 2277 Whatever its motives and means, direct euthanasia consists in putting an end to the lives of handicapped, sick, or dying persons. It is morally unacceptable. Thus an act or omission which, of itself or by intention, causes death in order to eliminate suffering constitutes a murder gravely contrary to the dignity of the human person and to the respect due to the living God, his Creator. The error of judgment into which one can fall in good faith does not change the nature of this murderous act, which must always be forbidden and excluded.

Both with Nancy and her husband's treatment, as well as with many arguing on behalf of maintaining the feeding tube for Terri Schiavo, the working assumption seems to be that termination of any treatment protocol that can help sustain biological life is, *ipso facto,* passive euthanasia and therefore morally wrong. Again, this common assumption is incorrect.

I suspect that one reason for the common misperception of what the o/e principle actually entails lies with the traditional vocabulary employed. The terms "ordinary" and "extraordinary" are commonplace in our everyday speech, but the usual meanings of these words do not accurately connote their precise significance in health care ethics. Too often, people like Nancy, Gary, and many arguing for the maintenance of the feeding tube for Terri Schiavo presume that "ordinary means" refers to any procedure that is relatively well-established in contemporary medical practice, safe, and effective in its intended usage. While a century ago blood transfusions might not have met these triple criteria of established practice, safety, and effectiveness, today they clearly would and so, many people would

conclude that a blood transfusion would virtually always constitute "ordinary means" and, therefore, would be morally obligatory if a patient's medical condition so indicated.

Because of the great facility for misunderstanding the o/e terminology, many ethicists—and even the Vatican's Congregation for the Doctrine of the Faith—have suggested using instead the terms "proportionate and disproportionate means." While this suggestion has merit, current usage tends to stick with the traditional vocabulary and thus the problem of fundamental misunderstanding is exacerbated.[5] This vocabulary grew out of the moral theology being done in Rome and perhaps a cross-cultural linguistic gloss may help in better grasping the terms' import. *Ordinario* and *straordinario* would be the equivalent terms in Italian, but they do *not* always convey the same range of meanings as their English counterparts. *Ordinario* involves the nuance of "full" and "permanent"; in contrast, *straordinario* is seen as temporary, supplemental, supernumerary, or somehow lacking the fullness and completeness of *ordinario*.[6] Thus, ordinary means refer to the full range of medical treatments expected for a complete moral treatment, while extraordinary means would refer to supplemental treatments that are not required. Neither term in this context

---

[5]The terminology of ordinary and extraordinary means dates back at least to the sixteenth century, and has been consistently used in modern times since the papacy of Pius XII (1939-1958) and through the present, as seen in John Paul II's 1995 encyclical *Evangelium vitae*. For a helpful overview of the principle, see Kevin Wildes, "Ordinary and Extraordinary Means and the Quality of Life," *Theological Studies* 57 (1996): 500-512. The Congregation of the Doctrine of the Faith noted the potential misunderstanding of the traditional terminology and suggested replacing it with proportionate and disproportionate means in its Declaration on Euthanasia *Jura et bona*, 5 May 1980, *AAS* 72:1 (1980): 542-52. English translation found in *Vatican Council II: More Post Conciliar Documents*, ed. Austin Flannery (Collegeville, MN: Liturgical Press, 1982): 510-17, and at http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19800505_euthanasia_en.html.

[6]An academic application may be helpful here. The Italian for "full professor" is *professore ordinario*. A *professore ordinario* has full active and passive voice,

means "routine" or "extreme" in the sense of the objective nature of the medical treatment protocols.

Carrying this distinction back to health care ethics, "ordinary means" can then be defined as all those treatment protocols, medicines, surgeries, etc., that are morally obligatory, and therefore *ipso facto* must always be done. "Extraordinary means," in contrast, can best be described as *not* being morally obligatory. What makes a means ordinary or extraordinary is primarily its relation to the particular individual patient. Thus, surgery to repair a perforated stomach in an otherwise healthy twenty-year old would usually be judged as ordinary means, while the exact same surgical intervention in a ninety-year old who has suffered a massive heart attack or stroke—and who very likely would not even survive the surgery—would clearly be extraordinary. The surgery itself, the so-called objective nature of the treatment, is virtually the same in both cases, but the individual patients' differences—the subjective nature of the equation—yield two quite different judgments: in the case of the twenty-year-old, we would judge the surgery to be morally required, whereas in the case of the ninety-year-old, it would not be obligatory.

The Criterion of Burden

What is the difference in these two cases? A number of things to be sure, but one key aspect that differs is the relative burden of the proposed medical intervention on each patient. Burden is necessarily subjective, i.e., centered on the person and his or her particular constitution, context, and matrix of relationships. There is no easy way to assess or quantify "burden" objectively, and perhaps for this reason the burden criterion in the o/e means principle has either been given insufficient attention or (and more problematically) read

---

and represents the highest academic rank in the university. A *professore straordinario* is equivalent to an associate professor, but with diminished active and passive voice; in other words, the *professore straordinario* does not have the same rights or responsibilities as the *ordinario*.

in a very narrow physicalist fashion. As evidence of this claim, let us turn to some representative opinions offered by some Church officials and theologians.

Terri Schiavo's diocesan bishop Robert N. Lynch of St. Petersburg, released a statement on August 12, 2003, in which he summarized the o/e principle in this fashion:

> We are obliged to preserve our own lives, and help others preserve theirs, by use of means that have a reasonable hope of sustaining life without imposing unreasonable burdens on those we seek to help, that is, on the patient and his or her family and community. In general, we are only required to use ordinary means that do not involve an excessive burden, for others or for ourselves. What may be too difficult for some may not be for others.[7]

His statement of the general principle is in full accord with the tradition and the formulation found in the *Catechism of the Catholic Church* quoted above, as well as the most recent version of the United States Bishops' "Ethical and Religious Directives for Catholic Health Care Services."[8]

However, as Thomas Aquinas noted in his treatise on the natural law, the more we descend from general ethical principles to concrete moral applications, both changeability and fallibility will be an unavoidable aspect of our conclusions.[9] Bishop Lynch concludes, how-

---

[7]Robert N. Lynch, "Statement of Bishop Robert N. Lynch Concerning the Terri Schiavo Case" (12 Aug 2003), http://www.dioceseofstpete.org/news_releases/statement_of_bishop_robert_n.htm.

[8]For the text, see *Origins* 31 (19 Jul 2001): 153, 155-68. These guidelines are a revision of the 1994 directives, published in *Origins* 24 (15 Dec 1994): 449-61, and note specifically that the issue of artificial hydration and nutrition in a persistent vegetative state (PVS) case is a matter of open theological debate (and thus would be an instance of the legitimate application of the principle of probabilism in terminating such treatment).

[9]See Thomas Aquinas, *Summa theologiae I-II*, Q. 94, art. 4. This crucial point is discussed in some detail in James T. Bretzke, *A Morally Complex World:*

ever, that "there should be a presumption in favor of providing medically assisted nutrition and hydration to all patients as long as it is of sufficient benefit to outweigh the burdens involved to the patient." He then goes on to explain his conclusion in reference to Terri's case in this way:

> If Terri's feeding tube is removed, it will undoubtedly be followed by her death. If it were to be removed because the nutrition which she receives from it is of no use to her, or because it is unreasonably burdensome for her and her family or her care givers, it could be seen as permissible. But if it were to be removed simply because she is not dying quickly enough and some believe she would be better off because of her low quality of life, this would be wrong.[10]

Lynch's own conclusion as to the application of the o/e principle is reiterated in almost the exact same wording by the collective statements of the Florida bishops issued two weeks later (which, in fact, refers to Lynch's original statement). What has happened though in the move from the statement of the general o/e principle to its application in the Schiavo case is that a judgment of passive euthanasia seems to be implied: "But if her feeding tube were to be removed to intentionally cause her death, or because her life is perceived to be useless, or because it is believed that the quality of her life is such that she would be better off, this would be wrong."[11]

Returning to the definition of passive euthanasia in the *Catechism* quoted fully above (CCC 2277: "direct euthanasia consists in putting an end to the lives of handicapped, sick, or dying persons"), the

---

Engaging Contemporary Moral Theology (Collegeville, MN: Liturgical Press, 2004), see especially 59-69.

[10]Lynch, "Statement of Bishop Robert N. Lynch Concerning the Terri Schiavo Case."

[11]Catholic Bishops of Florida, "Florida Bishops Urge Safer Course for Terri Schiavo: Statement of the Catholic Bishops of Florida" (27 Aug 2003), http://www.flacathconf.org/Publications/BishopsStatements/Bpst2000/TerriSchiavo.htm.

key elements in cases like that of Terri Schiavo would be the intentional withholding of some treatment that would be considered *in that particular given case* to be ordinary means with the aim of *directly* causing the death of the patient. Remember that ordinary means cannot be given in the abstract, and that what could be labeled "ordinary" in one patient's treatment would be "extraordinary" in another's. If extraordinary means are withheld from a patient, this would not, by itself, constitute passive euthanasia. Full assessment of benefit and burden is one crucial means of accurately determining whether a given treatment for a given patient constitutes ordinary or extraordinary means. This assessment always has to be made in reference to the particular patient; there is no appendix in the back of medical ethics textbooks that indicates whether treatments are considered ordinary or extraordinary.

The other important aspect of the definition highlighted here concerns the key word "direct" as this refers to the combination of the intention behind the act and the effect of the act itself. Only when taken together can the moral meaning of the action be adequately evaluated. In classic Roman Catholic moral theology, these two terms are labeled the *finis operis* (end of the act) and the *finis operantis* (end of the agent).[12] The *finis operis* looks more to the foreseen consequences of the action performed, while the *finis operantis* focuses on the motivating intention of the agent who performs the action. Thus, the modifier "direct(ly)" refers primarily to the *finis operantis* and not to the *finis operis*. For example, the removal of a fetus implanted in the fallopian tube in an ectopic pregnancy would not constitute a "direct" abortion from a moral standpoint, though it is clear that the *finis operis* of this intervention would clearly result in the death of the fetus, and which in the quite different circumstances of a normal pregnancy would otherwise be termed an abortion.

---

[12]For a fuller translation and discussion of these and similar Latin terms frequently found in theological writings, see James T. Bretzke, *Consecrated Phrases: A Latin Dictionary of Theological Terms*, 2nd ed. (Collegeville, MN: Liturgical Press, 1998, 2003).

What is important to bear in mind in this, and most moral cases, is that while the definitions of terms such as *finis operis* and *finis operantis* may seem clear and concise in the abstract, the realities behind them are usually much more opaque and complex. How can one judge an action that seems to have more than one *finis operis*? Principles such as the double effect can help here, but how do we overcome the difficulty of weighing the human heart involved in the *finis operantis*? What if attention to the *finis operis* seems to suggest one moral evaluation while concentration on the *finis operantis* provides a different judgment?

While there is no easy shortcut here and a rush to judgment usually will result in a serious misjudgment of the moral reality of the situation, the manualist tradition of moral theology, following Thomas Aquinas, used the axiom *finis operis semper reducitur in finem operantis* to provide some guidance in sorting out potentially contrasting ends of an action. I will freely translate this phrase as "the moral meaning of the act (*finis operis*) always ultimately comes down to (*semper reducitur*) the intention of the agent (*finis operantis*)." I hasten to admit that this tradition might be employed uncritically to suggest that *any* good intention *whatsoever* could justify any evil action. This axiom is not the casuistical equivalent of Augustine's *ama et fac quod vis* (love and do what you will), but requires that we look long and hard at what truly is going on in a complex case so as to determine as fully and accurately as we can what our intentions truly are. In cases like that of Terri Schiavo and Nancy's husband Bob, this fuller evaluation has to look more carefully at considerations of burden and benefit to help us realize what the various treatment options do—and do not—"directly" intend.

The media (especially the letters to the editor sections of Catholic newspapers and periodicals) are rife with charges that the projected removal of Terri Schiavo's feeding tube is tantamount to murder. While these clippings may build a case for better adult religious education, it is the smaller collection of opinions published by some theologians and Church officials, who one could hope really should know their tradition better, that is especially disturbing. One repre-

sentative of this latter group is Patrick Boyle, who states emphatically that, "The church teaches that the health condition of a sick person never enters into the decision whether to start or to withdraw life support."[13] Boyle tries to nuance what otherwise would be simply a ludicrous error of fact by separating the question of burden from the patient's medical condition:

> The central question is whether the medical treatment causes grave burdens. If it does, then the treatment is considered extraordinary means and therefore the choice of the sick person. If, on the other hand, the medical treatment does not cause grave burdens and is beneficial, the sick person has no choice but to accept the medical treatment because it is ordinary means.[14]

Thus, in Boyle's view, extraordinary means do in fact coincide with what my client Nancy had called "extreme measures" in reference to her husband Bob. Lest anyone misread that this is in fact his interpretation of the relevant principles in the Schiavo case, Boyle supplies his own application:

> Schiavo is fed by means of a gastrostomy tube. The questions to be asked are, "Does this medical procedure create grave burdens for her?" and "Is it useless?" The answers are no. Schiavo's burdens were caused by the brain damage resulting from her heart attack. They are not the result of the feeding tube. Barring complications, it is a burdenless medical treatment as it is certainly beneficial, since it has been keeping Schiavo alive for some thirteen years.[15]

---

[13]Patrick J. Boyle, "Wrong on Schiavo," *Commonweal* 130 (5 Dec 2003): 4. Boyle is professor of moral theology at the Archdiocese of Chicago's Mundelein Seminary. For a somewhat similar scholarly dispute over the reading of the tradition in the Schiavo case, see John J. Paris and James Keenan, "Ethical Analysis and the Facts," *America* 189 (22-29 Dec 2003): 15. These two ethicists carefully critique John Kavanaugh's Ethics Notebook column, "Food for Terri Schiavo," which originally appeared in *America* 189 (24 Nov 2003): 8. Kavanaugh also has a brief rejoinder on the same page as the Paris/Keenan article.

[14]Boyle, 4.

What has Boyle done here? At least three things it seems to me. First, he has separated the patient's own health condition from a consideration of burden and benefit; and then second, he looks *only* at the burdens and benefits of the treatment itself, *abstracted* from the patient's total context, in determining whether this treatment is ordinary or extraordinary. In other words, he is making a judgment about what constitutes burden and benefit only by looking at the patient as a biological organism, and without attention to his or her larger context. Third, Boyle, whose area of professional training is understandably not in the health care professions, seems to misread seriously the medical situation itself. I suspect most health care professionals would disagree strongly with Boyle's assertion that the feeding tube is a "burdenless medical treatment"; virtually every medical treatment, even the two aspirin we are enjoined to take before calling the doctor in the morning, involve some sort of burden. Thus, it seems that Boyle has redefined the burden criterion to refer only to a burden that is not physically grave in reference to the narrow scope of the procedure's intended effect. A similar concern has been raised some about the practical import of John Paul II's address in March 2004 to the congress held in Rome on "Life-sustaining Treatments and Vegetative State," but I suggest that the Pope's remarks should be read in a different light, and that certainly even the Vatican's own public statements to the media make it clear that this is *not* a case of *Roma locuta, causa finita.*[16] In statements released by various theologians connected with the Vatican in the days following this address, they made it clear that the papal address should *not* be considered an infallible teaching, and that the Pope was trying to enunciate some

---

[15]Ibid. A follow-up letter from Boyle appears in *Commonweal* 31 (16 Jan 2004): 6.

[16]See the address of John Paul II to the participants in the International Congress on "Life-sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas" (20 Mar 2004). *Origins* 33:43 (8 Apr 2004): 737-40, http://www.vatican.va/holy_father/john_paul_ii/speeches/2004/march/documents/hf_jp-ii_spe_20040320_congress-fiamc_en.html.

general principles in this debate. A close reading of *Lumen gentium* 25 on how to interpret magisterial teaching would be helpful here.[17]

At this point, the *Commonweal* editors reply not by engaging the burden criterion directly, but rather with a fuller consideration of the benefit side of the coin: "Has artificially keeping Terri Schiavo alive for thirteen years been a self-evident benefit to her. Such a reductive, physicalist understanding of benefit, pace Father Boyle, is not one the Catholic tradition embraces."[18] While I believe the editors have framed the benefit question correctly, I think this particular debate, and those like it, have suffered by not fleshing out the burden criterion more fully.[19]

---

[17]LG #25 gives three key interpretive criteria for assessing the relative authority of magisterial teaching: 1) the character of the teaching itself; 2) the manner in which the teaching has been promulgated; and 3) the frequency of repetition of the teaching. In the instance of the recent papal address, it is clear that the second and third criteria would significantly lessen the authoritative weight of this teaching. We also must keep in mind that even though it is less recent than the March 2004 address, as an encyclical, *Evangelium vitae* carries greater magisterial authority than an address to a meeting. Thus, the recent papal address should be read in light of the encyclical and not vice versa. For some guidelines to interpreting magisterial documents, see "Rules for Magisterial Exegesis" found at http://www.usfca.edu/fac-staff/bretzkesj/MagisterialExegesis.pdf (pdf) and/or http://www.usfca.edu/fac-staff/bretzkesj/MagisterialExegesis.htm (html).

[18]"The Editors Reply," *Commonweal* 130 (5 Dec 2003): 4.

[19]Since John Paul II's address on artificial hydration and nutrition, several helpful articles have appeared. See especially Ronald Hamel and Michael Panicola, "We Preserve Life? The Narrowing of Catholic Teaching," *America* (19-26 Apr 2004): 6-13; and Gerald Coleman "Moral Questions of Nutrition and Hydration," *Catholic San Francisco* (12 Dec 2003), http://catholic-sf.org/121203.html, or "Take and Eat: Morality and Medically Assisted Feeding," *America* (3 Apr 2004). Still quite helpful is Richard McCormick, "'Moral Considerations' Ill Considered," *America* 166 (14 Mar 1992): 210-14, which is also found in McCormick's *Corrective Vision: Explorations in Moral Theology* (Kansas City: Sheed & Ward, 1994).

Shouldering the Burden of Means

In the statements quoted above from Bishop Lynch of St. Petersburg and his brother bishops in Florida, it seems clear that they believe the use of the feeding tube in the Terri Schiavo case constitutes ordinary means and, therefore, is morally obligatory. Their statements raise a nettlesome ecclesial issue regarding the competency of the Magisterium to pronounce on concrete ethical issues. Traditionally, the Magisterium has followed the important distinction between the formulation of general principles and concrete applications of those principles. Usually the Magisterium has restricted itself to speaking about the former, and allowing those nearest the concrete case and/or those with particular expertise involved in the issue to discern how the general principles would be best applied to a specific case. This approach also respects the principle of subsidiarity, which was articulated well by Pius XI in his 1931 social encyclical *Quadragesimo anno* (cf. #79), reaffirmed by John XXIII and John Paul II in their respective encyclicals *Mater et Magistra* (1961, cf. #55) and *Centesimus annus* (1991, cf. #48), and restated as well in the *Catechism of the Catholic Church* (cf. #1894).

Now some might object that the principle of subsidiarity has only been used in connection with social issues and that the Schiavo case is a medical case involving a clear-cut decision that the Magisterium can pronounce upon. Two problems arise here though: one concerns the aforementioned competency of the Magisterium to pronounce on a concrete ethical application, and the second turns on whether the burden involved in the Schiavo case is shouldered just by herself and her immediate family and care givers, or whether this burden in fact is a larger burden that the wider community has to share. Let us briefly consider these two problems in turn.

The issue of the competency of the Magisterium to give definitive judgments on concrete moral applications has been hotly debated ever since Paul VI published his 1968 encyclical *Humanae vitae,* which condemned artificial contraception. It would be impossible even to summarize that debate here, but the eminent late Catholic

moral theologian Richard McCormick wisely observed with regard to the debate over artificial hydration and nutrition of Permament Vegetative State (PVS) patients that, "the bishops do not, indeed cannot, claim the same authority for applications as they do for their statement of general principles."[20] Additionally, what would happen though if a different individual or group within the Magisterium were to offer a counter-position? This is precisely what has already happened in the PVS debate with antithetical statements released by the Catholic Bishops of Pennsylvania and the Catholic Bishops of Texas.[21]

This whole affair highlights the danger of prematurely closing off discussion and debate through imposition of some sort of magisterial gag order. As I mentioned above, I do not believe that John Paul II's March 2004 address aimed at doing anything of the sort. Rather, I believe the pope's intention, which we see adumbrated in his usage of the twin metaphors of "culture of life" and "culture of death" in his 1995 encyclical *Evangelium vitae*, was to underscore once again the general principle that all human life is indeed sacred and deserving of respect and care. I think *Evangelium vitae* gives the proper hermeneutical framework for interpreting this later address, and it should be recalled that, in this encyclical, the pope states quite clearly that the Roman Catholic tradition is *not* governed by the principle of vitalism, which the pope unequivocally denounces.[22]

---

[20] Ibid., 211.

[21] McCormick critiques the Catholic Bishops of Pennsylvania statement ("Nutrition and Hydration: Moral Considerations," *Linacre Quarterly* 59 [1992]: 8-30), which argued that termination of nutrition and hydration of patients in PVS is "euthanasia by omission," and therefore cannot be morally tolerated. *Origins* 21 (30 Jan 1992): 541; 543-53. The counter-opinion was released by the Texas bishops, "On Withdrawing Artificial Hydration and Nutrition," *Origins* 20 (7 Jun 1990): 53-55. Similar statements issued by the bishops of Washington and Oregon follow the line of argumentation of the Texas bishops.

[22] This theme occurs in several places in *Evangelium vitae*, but see especially nos. 2, 65 and 67. For support for my reading of the pope's address see Norman Ford, "The Debate Goes On," *The Tablet* (1 May 2004): 8-9. While

While I think most would agree that we should attend to what the Magisterium is saying in this area, I would note here that some very good insights into overlooked aspects of the issue can be found by consulting more broadly. For example, consider the following statement found in the Catholic Bishops' Conference of the Philippines' official *Catechism for Filipino Catholics,* which gives an insight into the moral considerations of extraordinary means easily overlooked in the medical culture of the United States:

> However, when there is no real hope for the patient's genuine benefit, there is no moral obligation to prolong life artificially by the use of various drugs and machines. In fact, using *extraordinary means* to keep comatose or terminally ill patients artificially alive seems clearly to lack objective moral validity, especially in a society where the majority of the population do not enjoy even adequate elementary health care.[23]

It seems clear what position the Philippine bishops would take on the artificial hydration/nutrition debate in general and the Schiavo case in particular, and here I would emphasize what seems to be for them the key morally-relevant feature, namely the "justice" issue of distribution of limited medical resources in a society marked by what the bishops term the "glaring contradictions" between the rich and

---

agreeing "in principle" with John Paul II's position enunciated in the latter's 20 Mar 2004 address to the participants in the International Congress on "Life-sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas," Ford argues that a concrete medical assessment of a PVS patient's condition might warrant the withholding of artificial hydration and nutrition on the grounds that it is not—in this or that specific case—an instance of "ordinary means." Ford's brief piece is quite good for outlining some of the pertinent medical issues that need to be taken into consideration in assessing what constitutes burden and ordinary means in the PVS scenario. See also the articles published in *Origins* along with John Paul II's address, "Care for Patients in a 'Permanent' Vegetative State," *Origins* 33:43 (8 Apr 2004): 737, 739-52.

[23]Catholic Bishops' Conference of the Philippines [CBCP], *Catechism for Filipino Catholics* (Manila: ECCCE Word and Life Publications, 1997), no. 1039.

the poor as is the case in the contemporary Philippine context.[24] The bishops remind us about justice in our consideration of the usage or non-usage of extraordinary means.[25]

Pace Boyle, and with respectful disagreement with the line taken by the Florida bishops, I think the Philippine bishops see more clearly that there is no such thing as "burdenless" means when it comes to cases like that of Terri Schiavo. Faced with a harsher economic reality than is the case in the United States, I believe the Philippine bishops can discern the hidden social costs involved in health care and are not afraid to raise the question of who ultimately will shoulder this burden. Their cross-cultural ethical insight may help us to see more clearly that health care resources devoted to keeping a PVS patient alive for over a decade do in fact represent burdens on many levels, including the global. Finally then, the correct moral question should be whether this burden is proportionate to the case at hand, and *not* whether this is simply a burden that the patient and/or the family and care givers can physically endure. Proportionality speaks to what is reasonable, while endurance speaks rather simply to what is physically possible. The two terms are certainly not identical, nor even close synonyms, morally speaking.

If the term "extraordinary means" were to be equated with what my counseling client Nancy called "extreme measures," then that would mean that virtually every other treatment protocol would logically have to be classified as "ordinary means." This in fact seems to

---

[24]CBCP, no. 732.

[25]In an earlier version of this paper given at the Society of Christian Ethics Pacific Section annual convention on 13 Feb 2004, one person expressed unease with the position of the Philippine bishops, calling it essentially a form of social utilitarianism. I believe that this reading of the text is unwarranted, but do acknowledge that care must be taken so that this sort of formulation is not used in a utilitarian manner. Once again, I suspect it is precisely this sort of general concern that led to John Paul II's emphasis on maintaining artificial hydration and nutrition care in patients who could not feed themselves.

be what is happening in many circles and this *de facto* reclassification is a significant and troubling departure from the tradition.

Nancy told me that she could physically continue to care for her husband Bob even though it was exacting a fearsome toll on her physically, emotionally, and economically. She said it was a burden that *could* still be physically borne. I suggested that the o/e principle asked not whether the burden *could* be physically endured, but whether it *should* be shouldered, i.e., whether this burden was now still reasonable. Nancy was clearly startled by this new question. She and her family have not yet come to a decision, but I believe the proper focus of the o/e tradition will give them a helpful resource for further reflection. We can only hope that these same questions can continue to be asked in Florida, Manila, and elsewhere.

Finally, we must recall the central message of Christianity with regard to our life here on Earth. This is not our ultimate home, and thus, as Christian leaders from St. Paul to John Paul II remind us, our life here and now is only a penultimate reality.[26] This means that it is certainly an important aspect of Catholic moral theology to continue to insist not only on the sanctity of life, but also a dignified death.[27] Hopefully, this ongoing discussion on end-of-life health care decisions will strengthen and not weaken these central truths of our faith.

[26]Cf. John Paul II, *Evangelium vitae* 2.

[27]For a good treatment of the notion of a dignified death in the context of health care decisions, see two good articles by Thomas R. Kopfensteiner, "Protecting a Dignified Death: A Contemporary Challenge for Moral Reasoning," *New Theology Review* 6 (Nov 1993): 6-27; and "Death with Dignity: A Roman Catholic Perspective," *Linacre Quarterly* 63 (Nov 1996): 64-75.