THE ENDS OF MEDICINE AT THE END OF LIFE: UNDERSTANDING THE ORDINARY-EXTRAORDINARY MEANS DISTINCTION IN AN AGE OF PERVASIVE TECHNOLOGY

Aimee Patterson

Faculty of Religious Studies, McGill University

Montreal, Quebec

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Abstract

An enduring issue in Christian bioethics is locating respect for human life between two extremes: an absolute valuation and a valuation entirely conditional on life's quality. This issue finds expression in the use of the ordinary-extraordinary means distinction (OEMD), a burden-benefit calculus employed by Catholic and Protestant ethicists to judge the appropriateness of available life preserving means in particular cases. With the increasing accessibility of new technologies and procedures for extending life, unique threats to the usefulness of the OEMD are posed. In particular, humans have the novel capacity to stabilize and sustain life indefinitely in grave and unprecedented conditions. Disagreements result within and between Christian communities over how far the possibilities for preserving life should be taken. The advent of the persistent vegetative state (PVS) has caused such a disagreement.

In examining the practical problem and its particular manifestation in the PVS, it is argued that reasonable measures for preserving human life are properly determined first of all in light of what is beneficial for the human being. Establishing what constitutes human benefit in the medical arena requires a philosophy of medicine reliant upon a substantive concept of the human being. A theological anthropology foundational for the OEMD and the ends of medicine is uncovered, underscoring the tension between given human ontological value and the possible realization of human ends without digressing into dualism.

This anthropology also attends to the undue influence of technology in the present day. Protecting the efficacy of the OEMD and remaining consistent with its underlying anthropology require that new technological means of preserving life not be assumed to provide benefit prior to a moral examination of such means undertaken in the practical context. Moral obligation must not be allowed to expand in direct proportion to growing technological capacities to preserve life. Rather, medicine is best understood as a species of care. As a specialized type of care, it remains subject to the ends of nonspecialized care. A proper application of the OEMD today reveals that medical means are not the only (or even always the most appropriate) way to care for the perishing human body.

Résumé

Situer le respect de la vie humaine entre deux pôles extrêmes – une valeur absolue et une valeur entièrement subordonnée à la qualité de vie – est une problématique persistante en bioéthique chrétienne. Elle est exprimée, notamment, par l'utilisation dans le milieu des éthiciens catholiques et protestants d'une grille pour distinguer les moyens ordinaires des moyens extraordinaires de maintenir une personne en vie dans des situations particulières, basée sur un calcul fardeau-avantages. Suivant l'accessibilité croissante de nouvelles technologies et procédures, cette grille de distinction entre moyens ordinaires et extraordinaires (DMOE) et son utilité font face à des menaces uniques. Notamment, les humains ont dorénavant la capacité de stabiliser et de maintenir la vie dans des conditions graves et jamais vues auparavant. Ce phénomène donne naissance à des divergences au sein des communautés chrétiennes : jusqu'où doit-on étendre la possibilité de maintenir un humain en vie? Et l'avènement de l'état végétatif chronique (ÉVC) a provoqué divergences.

Dans l'examen de ce problème pratique et de sa manifestation particulière, l'état végétatif chronique, l'auteure fait valoir que les mesures raisonnables de maintien de la vie humaine doivent d'abord être déterminées à la lumière de ce qui est bénéfique pour l'être humain. Pour établir ce qui constitue un bienfait pour l'être humain dans la sphère médicale, il faut une philosophie de la médecine reposant sur un concept fondamental de ce qu'est l'être humain. Un fondement anthropothéologique sur lequel appuyer la grille DMOE et la finalité de la médecine est élaboré, mettant en relief la tension entre une valeur humaine ontologique donnée et la réalisation possible de la finalité humaine, et ce, sans digresser vers le dualisme.

Ce fondement anthropologique rend également compte de l'influence indue de la technologique de nos jours. Pour protéger l'efficacité de la grille DMOE et rester fidèle à son anthropologie sous-jacente, on ne doit pas supposer que les nouveaux moyens technologiques de maintien en vie engendrent nécessairement des avantages. Il faut d'abord procéder à l'examen moral de ces moyens mis en œuvre dans une situation pratique. L'obligation morale ne doit pas s'étendre de façon directement proportionnelle à l'accroissement des capacités de maintenir un humain en vie. Plutôt, la médecine est mieux comprise comme une espèce de soins. En tant que catégorie spécialisée de soins,

elle demeure assujettie à des buts non spécialisés de soins. Une application adéquate de la grille DMOE aujourd'hui révèle que les moyens médicaux ne sont pas la seule façon (ni toujours la façon la plus appropriée) de prendre soin d'un corps humain dépérissant.

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Finally, many thanks to my husband, my parents, my extended family, and my friends who have provided the "compassion and spiritual and affective support" I needed to keep researching and writing. This thesis is dedicated to them.

We are all creatures of time and place, and...the bioethical concerns of the present and future require seeing man's permanent problems in light of changing technological and social conditions, and in light of those philosophical orthodoxies that reign supreme in both our bioethics institutions and the culture as a whole. Yet the deepest problems of the age are always connected to the deepest problems of every age....

Eric Cohen,
"In Whose Image Shall We Die?" *New Atlantis* 15 (Winter 2007), 38.

Introduction
Situating the Problem

Intro.1 Prelude to a Debate

At the meeting place of medicine's capacity to preserve life and the ethical directives for end-of-life care recognized in Christian bioethics lies the influence of technology over human living and dying. The ambiguity of the value of life-preserving means is often heightened by unclear assertions in the Catholic and Protestant traditions about the nature of what is being preserved, and why and when it is necessary to preserve it medically. In what follows I propose to examine the ordinary-extraordinary means distinction, a burden-benefit calculus that serves as the primary tool in Christian bioethics for judging available courses of action at the end of life and in other critical care scenarios. This analysis will consider the distinction as it is applied today against the background of the value commitments that determine its constitution and application. The relevance of such work becomes clear when one recognizes the technological changes that have taken place in clinical medicine since the time of the inception of this distinction in the sixteenth century.

An enduring issue in Christian bioethics is locating respect for human life between two extremes, both of which tend to extract human beings from their relationship to God. The first extreme is disregard for the intrinsic goodness of life, thereby admitting euthanasia and suicide without qualification. Christians view human life as contingent on God's creative action. The ensuing sense of responsibility for life, a responsibility whose source is not human but divine, makes its conservation incumbent upon the individual and, to a considerable extent, other people as well. But the admission of life as intrinsically good is held together with a refusal to admit of a second extreme, that is, to regard life as an absolute good—a vitalist position. For Christians, only God has absolute value. Moreover, the availability of a host of medical and technological means for extending life at its end has made it evident to bioethicists and medical practitioners alike that medicine has potential both to heal and harm, and even harm while healing. If human value is a limited good, and if medicine can impose grave burdens, there are occasions when it is acceptable to refrain from imposing life-sustaining medicine even at the risk of the patient's death; one is not obligated to do everything possible in the effort to preserve

life. Instead, what is sought in Christian bioethics is a *reasonable* standard of preservation; the valuation of life is a duty, but it is not meant to be an overly taxing one. The problematic this thesis takes into account is that practical circumstances and changing contexts mean that disagreements can arise within and between Christian communities over which course of action best represents this reasonable standard in particular cases.

Seeking out a reasonable standard of preservation was important even in a period when the available medical technologies were minimal. Early on in medical history, the limited goodness of human life allowed Christian moralists to recognize the need to judge between those measures of life preservation that are acceptable and those that are disproportionately "aggressive" or generally unsuitable in order that the one who refused a certain means might not be accused of suicide. The ordinary-extraordinary means distinction (OEMD), first fashioned in the sixteenth century, became the ethical tool used to evaluate available life-preserving means. This burden-benefit calculus is still considered by many Christian bioethicists to be helpful for discerning appropriate actions in the clinical context. The OEMD locates the proper expression of respect for life in the application of those life-preserving means that are morally ordinary, so morally extraordinary treatments are not obligatory. Determining under which category a means falls is a matter of considering the potential benefits and burdens offered by the means to the patient in question. Essentially, morally ordinary means are those that a) offer a reasonable hope of success and benefit, and b) are not unreasonably burdensome to the patient (in terms of the levels of difficulty, pain, expense, and abhorrence they produce). Morally extraordinary means violate *either* a) or b) or *both* a) and b). To illustrate this, the OEMD is sometimes used to justify "Do Not Resuscitate" orders for frail and declining patients or the removal of ventilators from patients lingering in intractable pain.

Upon noting these typical examples, it is also important to recognize that the moral status of a particular occasion of intervention is not determined apart from context. It cannot be said that a means is *per se* morally ordinary or extraordinary, and this adds a level of complexity and even subjectivity to the analysis. As will become clear, I am not concerned with making such judgements simpler or less contextual, but I do perceive that the background against which such decisions are made has been complicated by the

increase in use of medical technology toward the end of life. Decisions about the validity of foregoing life-sustaining means are increasing with the availability of new technologies and procedures. Unique threats to the usefulness of the OEMD are posed in an age of medical technology's pervasive influence.[1]

Specifically, the novel powers humans have to stabilize and sustain life indefinitely in grave and unprecedented conditions represent a significant change in the context for medical and moral action. This change is produced by a basic characteristic of contemporary medical technology: it has the ability to make those means appear ordinary that until very recently were almost invariably extraordinary. Some such developments are overwhelmingly positive. For instance, the development of medical anaesthesia has removed the burden of extreme pain during surgical operations. Others, however, are dubious. Medical technologies can create opportunities for preserving life that impose burdens not addressed by the OEMD, simply because such burdens were never before medical possibilities. Moreover, they offer success in terms of treatment efficacy but not in the more conventional sense of recovery or significant improvement of health.

Intro.2 Overview of a Debate

I have come to recognize this changed context for action through a study of one of the technologically enabled medical conditions that has become a source of controversy in Christian bioethics, the persistent vegetative state. This condition, together with the technological apparatus that sustains it, serves as the practical case study that illustrates the theoretical work at hand. The vegetative state is a clinically-diagnosed condition that can follow after a period of coma and is the result of severe brain damage due to developmental malformation, degenerative or metabolic disorder, or acute traumatic or nontraumatic cerebral injury.[2] Patients in a vegetative state are "awake but not aware." They remain unconscious, lacking any ability to experience their environment or an

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[1] "Ethics in an Age of Pervasive Technology" was the title of a 1974 international symposium in which Hans Jonas delivered an address on "The Heuristics of Fear." In *Ethics in an Age of Pervasive Technology*, ed. Melvin Kranzberg (Boulder: Westview Press, 1980), 213-21.

[2] The latter group of causative factors is the most significant as in the period directly following acute injury there are marked possibilities for both full recovery and long-term vegetative stability. Traumatic injury refers to physical trauma to the brain, and causes of nontraumatic injury include hypoxia, tumour, and stroke, among others.

"inner life."[3] However, unlike in coma, cardiorespiratory function along with hypothalamic and brainstem autonomic functions, such as a "sleep-wake cycle," breathing, blinking, and reflexive responses, are completely or partially preserved. When not the result of a degenerative condition or developmental malformation the vegetative state can allow for internal regulation over the long term. Required for survival is artificial nutrition and hydration (ANH).[4] Despite the fact that the swallowing reflex can remain intact, vegetative patients are unable to coordinate chewing with swallowing. Although other kinds of dignity and nursing care are offered to such patients, ANH is primarily responsible for stabilizing and maintaining this condition. Without them the patient would not survive long enough to progress from coma to persistent vegetation.

A patient is diagnosed as persistently vegetative if the vegetative state neither proves to be a transient stage of recovery nor leads to the patient's death. Persistent vegetative state (PVS), the label given to the condition after several weeks, signifies the chronic nature of the state but does not indicate prognosis. Patients are only considered permanently or irreversibly vegetative after a period of some months, the precise time of which depends largely on causation.[5] For example, if the cause is traumatic injury, at three months the chances that adult patients will recover with severe disability are 19 out of 100. They also have a 16% chance of recovery with no to moderate disability. At six months these probabilities reduce to 12% and 4%, respectively, and at twelve months the probability for any kind of recovery is less than 1%. In the case of an adult having experienced a nontraumatic injury, the statistics are graver still. If, at three months, the patient has not expired or emerged from the vegetative state, the probability of recovery with severe disability is approximately 6%, and the probability of good to moderate recovery is estimated at 1%. After this point, the probability of recovery with or without

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[3] Multi-Society Task Force on PVS, "Medical Aspects of the Persistent Vegetative State," part 1, *New England Journal of Medicine* 330, no. 21 (1994): 1499-1508, http://content.nejm.org/cgi/content/full/330/21/1499. This report carries great weight in the medical community as it represents the opinions of the American Academy of Neurology, the American Neurological Association, the Child Neurology Society, the American Association of Neurological Surgeons, and the American Academy of Pediatrics.

[4] Patients fed and hydrated artificially over the long term require the insertion of a percutaneous endoscopic gastrostomy (PEG) tube into the stomach through the abdomen wall.

[5] Multi-Society Task Force on PVS, "Medical Aspects of the Persistent Vegetative State," part 2, *New England Journal of Medicine* 330, no. 22 (1994): 1572-79, http://content.nejm.org/cgi/content/full/330/22/1572. Prognostic estimations are based on statistical data.

disability reduces to nil. Thus, at twelve months following traumatic injury and at three months following nontraumatic injury, the condition is expected to be permanent.

Currently, the medical possibilities for treating these patients are limited to sustaining life in this condition by ANH without offering any expectancy for emergence or recovery for those whose condition is permanent. Studies indicate that the average life expectancy of the PVS patient is two to five years, the direct cause of death being a complication arising from the PVS, often something as banal as pneumonia or a urinary tract infection.[6] However, such infections are often treatable, so this statistic might not accurately reflect the limits of the capacity of ANH to prolong the PVS. Prominent long-lived PVS patients whose condition resulted from nontraumatic cerebral injury, including Karen Ann Quinlan and Terri Schiavo, indicate the possibility for the indefinite protraction of the PVS. It should also be noted that progressive atrophy of the brain is observed over the long term, marking cerebral cell loss that occurs with disuse. So, although PVS patients may remain robust in other ways, their neurological condition does worsen with time.[7]

Whether the long-term medical support of a persistently vegetative patient is ethically warranted has been the subject of much debate in Western bioethics. This debate has taken on particular characteristics in Protestant and Catholic communities that can be observed in a review of the literature.[8] In the latter community, various interpretations of what it means to provide benefit and avoid overly burdensome care in administering ANH were made possible by a vague directive of the *Ethical and Religious Directives for Catholic Health Care Services*. The directive reads: "There should be a presumption in favor of providing nutrition and hydration to all patients, including patients who require medically assisted nutrition and hydration, as long as this is of sufficient benefit to

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[6] Ibid. The latter complication arises as a result of neurogenic bladder or lack of sphincter control. See Ben-Zion Krimchansky et al., "Bladder Tone in Patients in Post-traumatic Vegetative State," *Brain Injury* 13, no. 11 (1999): 899-903.

[7] Bryan Jennett, *The Vegetative State: Medical Facts, Ethics and Legal Dilemmas* (Cambridge: Cambridge University Press, 2002), 53.

[8] The Catholic debate is clearly more developed than its Protestant counterpart. In comparing the various Christian positions to that of the magisterium I do not wish to suggest alignment with the latter. The magisterial position simply serves as a helpful reference point for comprehending the debates.

outweigh the burdens involved to the patient."[9] The document notes that at the time of writing the question of applying ANH to PVS patients had not been officially resolved and the authors do not seem to be at pains to resolve it. However, the document also indicates an opinion that ANH is not obligatory when it cannot be assimilated by the patient or, importantly, when it provides no comfort to the patient (as it would not for an unconscious patient).[10] The debate only came to a head in Christian circles (most notably within the Catholic context) with the promulgation of a 2004 papal allocution that included controversial interpretations of the vegetative state, the treatment in question, and the OEMD itself.[11] For instance, the administration of food and water, whether done in the conventional sense or in a formula through tubes, is reckoned

> a *natural means* of preserving life, not a *medical act*. . . [thus] in principle, *ordinary* and *proportionate*, and as such morally obligatory, insofar as and until it is seen to have attained its proper finality.[12]

That is to say, so long as obtaining this treatment is not overly difficult, and so long as the treatment keeps the PVS patient alive, it is achieving its goal and providing a great benefit to the patient. Its removal from the PVS patient is thus denounced as euthanasia. The allocution's conclusions are premised on two notable assertions. The first is that the "proper finality" of feeding is the maintenance of life. The second is that human life itself is a fundamental good, and that PVS patients remain human, retaining the "image of God" or full human dignity. These two premises were repeated by the Congregation for the Doctrine of the Faith in its authoritative response to the United States Bishops' questions about the allocution.[13] The implication is that that those who object to this

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[9] United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 4th ed. (Washington, D.C.: United States Conference of Catholic Bishops, Inc., 2001), Directive 58.

[10] Ibid., Part Five, Introduction. Notably, at the time of this writing, the document is undergoing revisions to reflect the more recent magisterial statements on ANH.

[11] John Paul II, "To the Participants in the International Congress on 'Life-Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas,'" (March 20, 2004), http://www.vatican.va/holy_father/john_paul_ii/speeches/2004/march/documents/hf_jp-ii_spe_20040320_congress-fiamc_en.html. (Hereafter: "Life-Sustaining Treatments and Vegetative State.") For helpful collections pertaining to the Catholic debate see Ronald P. Hamel and James J. Walter, eds., *Artificial Nutrition and Hydration and the Permanently Unconscious Patient: The Catholic Debate* (Washington, D.C.: Georgetown University Press, 2007); and Christopher Tollefsen, ed., *Artificial Nutrition and Hydration: The New Catholic Debate* (Dordrecht: Springer, 2008).

[12] John Paul II, "Life-Sustaining Treatments and Vegetative State," (2004), §4. Emphases in original.

[13] Congregation for the Doctrine of the Faith, "Responses to Certain Questions of the United States Conference of Catholic Bishops Concerning Artificial Nutrition and Hydration," (August 1, 2007),

application of ANH are aligned with secular interpretations of human "personhood": they consider these patients to be in some way less than human, or as having lives of such a low quality as to make them not worth living. The position asserted by the Vatican has long been held by some notable Catholic academics, many of whom are identified as new natural law theorists.[14] Other Catholics, often American academics and medical practitioners, strongly oppose the allocution's conclusions and deny this implication, claiming that their judgement does not stem from ontological dualism or an understanding of human dignity as solely dependent on quality of life. Two prominent representatives of this divergent view are Kevin Wildes and Kevin O'Rourke.[15] Those who diverge from the papal view on the matter do not comprise a particular school of Catholic thought and often justify their conclusions with differing premises. However, quite often, dissident viewpoints are grounded in the assertion that the conclusions of the papal allocution are vitalist when brought against the following words from a 1957 address by Pope Pius XII pertaining to the OEMD:

> Normally one is held to use only ordinary means—according to circumstances of persons, places, times, and culture—that is to say, means that do not involve any grave burden for oneself or another. A more strict obligation would be too burdensome for most men and would render the attainment of the higher, more important good too difficult. Life, health, all temporal activities are in fact subordinated to spiritual ends.[16]

However, Catholic scholars and clerics disagree as to the proper interpretation of this passage, especially with regard to the nature of "spiritual ends," and a thorough and cogent explanation of the anthropological underpinnings of the position counter to the magisterium has not surfaced. Although the 2004 allocution remains the official position of the Catholic Church, in addition to the marked dissent of certain theologians and physicians, it is not always accepted without question by Catholic bishops. For instance, despite conformity to the allocution, the Bishops of Maryland have shown discomfort

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http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_0070801_risposte-usa_en.html.

[14] See the document proceeding from the Pope John XXIII Center. William E. May, Robert Barry, Orville Griese, Germain Grisez, Brian Johnstone, Thomas J. Marzen, James T. McHugh, Gilbert Meilaender, Mark Siegler, and William Smith, "Feeding and Hydrating the Permanently Unconscious and Other Vulnerable Persons," *Issues in Law and Medicine* 3, no. 3 (1987): 203-18.

[15] See Kevin W. Wildes, "When Does Quality of Life Count? A Response to Gilbert Meilaender," *Theological Studies* 59, no. 3 (1998): 505-08; and Kevin D. O'Rourke, "Father O'Rourke Responds," *National Catholic Bioethics Quarterly* 3, no. 1 (2003): 15-18.

[16] Pius XII, "The Prolongation of Life," *The Pope Speaks*, 4, no. 4 (1958): 395-6.

with the idea of "a universal statement that medically assisted nutrition and hydration must be given to all who cannot feed themselves."[17] A statement indicating more radical differences with the allocution was delivered years earlier by the Bishops of Texas, who claimed that any treatment decisions should be reflective of the patient's wishes.[18] Also quite significant is the fact that the United States Catholic Health Association departs from the conclusions of the papal allocution.[19]

The corresponding Protestant discussion is not so intense or clearly dichotomized. However, several Protestant bioethicists and churches have considered this question. They have done so independently of the Catholic debate, although they often retain the benefit-burden calculus aspect of the OEMD. Some denominational policies indicate consistency with the established Catholic position. For example, though not addressing PVS directly, the Southern Baptist Convention opposes efforts to identify ANH as extraordinary and, moreover, discourages any action that "of itself or by intention" causes a patient's death.[20] Its statement incorporates the Catholic definition of euthanasia proffered by the Congregation for the Doctrine of the Faith, which reads: "we reject as appropriate any action which, of itself or by intention, causes a person's death."[21] Similarly, another conservative body, the Evangelical Fellowship of Canada, opposes "intentionally causing death by withholding or withdrawing necessary and ordinary (usual and customary) care or food and water."[22] It also claims: "Where people are not able to

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[17] Bishops of Maryland, "Comfort and Consolation: Care of the Sick and Dying," (June 2007), 17, http://www.mdcathcon.org/library/resources/Documents/Publications/COMFCONSInsideFinal.pdf.

[18] Texas Bishops and the Texas Conference of Catholic Health Care Facilities, "On Withdrawing Artificial Nutrition and Hydration," in *Artificial Nutrition and Hydration and the Permanently Unconscious Patient*, ed. Hamel and Walter, 109-13. Reprinted from *Origins* 20 (June 7, 1990): 53-55.

[19] Ronald P. Hamel, "The Catholic Health Association's Response to the Papal Allocution on Artificial Nutrition and Hydration," *Virtual Mentor: American Medical Association Journal of Ethics* 9, no. 5 (2007): 388-92.

[20] Southern Baptist Convention, "Resolution on Euthanasia and Assisted Suicide," (June 9-11, 1992), http://www.sbc.net/resolutions/amResolution.asp?ID=493.

[21] Congregation for the Doctrine of the Faith, *Declaration on Euthanasia*, (May 5, 1980), §2, http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19800505_euthanasia_en.html.

[22] Evangelical Fellowship of Canada, "Euthanasia and Assisted Suicide: Defining Terms," http://www.evangelicalfellowship.ca/NetCommunity/Page.aspx?pid=624. Two things should be noted about this description of what is here called "passive euthanasia." First, its source of origin is the International Task Force on Euthanasia and Assisted Suicide, "Euthanasia Definitions," http://euthanasia.com/definitions.html, and it was subsequently taken up by the Catholic Education Resource Center in "Definitions on Euthanasia: International Task Force on Euthanasia and Assisted Suicide," http://catholiceducation.org/articles/euthanasia/eu0018.html. Second, it appears to alter the

feed themselves, provision of food and someone to feed the person should not be considered medical treatment. Yet there have been instances in which food has been withdrawn under the guise of 'cessation of medical treatment.'"[23] Noted bioethicist Gilbert Meilaender, who employs his own modified version of the OEMD, is also well known for affirming both the moral obligation of feeding and the abiding dignity of the PVS patient.[24] Meilaender adopted this position early on along with vocal Catholic academics.[25] Others have added that the PVS patient is not dead, dying, or a nonperson, but rather profoundly disabled and deserves to be valued alongside others with disabilities.[26] At the opposite extreme, some Protestant bioethicists diverging from this view deny that the PVS patient retains any dignity at all. They insist on this basis that there is no moral obligation to keep such patients alive.[27] For the most part, however, those Protestant voices that deny the obligation to sustain the lives of PVS patients also affirm the abiding dignity of the patients and refuse to equate the withdrawal of ANH with patient abandonment. Member bodies of the Anglican Communion are particularly vocal in affirming all human life to have intrinsic worth and in interpreting ANH explicitly as medical intervention, rather than likening it to standard eating and drinking.[28] They, like Meilaender, tend to draw on the OEMD in constructing a burden-benefit assessment.[29] A similar reference of the use of a burden-benefit calculus in treatment

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meaning of "ordinary" from "morally indicated" to "medically indicated," the secular medical understanding of the term. I return to this distinction in the third chapter.

[23] Social Action Commission of the Evangelical Fellowship of Canada, *A Matter of Life and Death: A Discussion Paper on Euthanasia*, (March 1994), 4, http://files.efc-canada.net/si/Euthanasia/Euth-Matter_Life_Death.pdf.

[24] Gilbert Meilaender, "Living Life's End," *First Things* 153 (May 2005): 17-21; and *Bioethics: A Primer for Christians*, 2nd ed. (Grand Rapids: William B. Eerdmans, 2005), 68ff.

[25] He is listed as a coauthor along with William E. May et al. in "Feeding and Hydrating the Permanently Unconscious and Other Vulnerable Persons."

[26] For example, see Dónal P. O'Mathúna, "Responding to Patients in the Persistent Vegetative State," *Philosophia Christi* 19, no. 2 (1996): 55-83.

[27] Peter Alan Emmett, "The Image of God and the Ending of Life," *Asbury Theological Journal* 47, no. 1 (1992): 53-62; and Robert V. Rakestraw, "The Persistent Vegetative State and the Withdrawal of Nutrition and Hydration," *Journal of the Evangelical Theological Society* 35, no. 3 (1992): 389-405.

[28] "Resolution I.14.d," in *The Official Report of the Lambeth Conference 1998* (Harrisburg: Morehouse, 1999). A singular divergence from this view was articulated by the Task Force on Assisted Suicide, Episcopal Diocese of Newark, *Report of the Task Force on Assisted Suicide to the 122nd Convention of the Episcopal Diocese of Newark*, (January 27, 1996), http://www.dioceseofnewark.org/report.html.

[29] See Task Group of the Faith, Worship and Ministry Committee, Anglican Church of Canada, *Care in Dying: A Consideration of the Practices of Euthanasia and Physician Assisted Suicide* (Toronto: Anglican Church of Canada, 1998), 6 and 42 nt. 2; Committee on Medical Ethics, Episcopal Diocese of Washington, *Toward a Good Christian Death: Crucial Treatment Choices* (Harrisburg: Morehouse, 1999), 31-32; and

decisions has been made by the Canadian Council of Churches, although this body does not directly address ANH or PVS.[30] Finally, the United States Christian Medical and Dental Associations, recognizing "that God is not dependent on our technology to effect His perfect plan," allow for the foregoing of ANH for PVS patients. However, they demonstrate greater concern for the way in which the decision is taken than for the final conclusion itself.[31]

The diversity of conclusions represented amongst Protestants suggests a great divide between foundational considerations. Although here there is no authoritative word to react against or adopt, I submit that this confusion is indicative of a need for ethical discussion about the value commitments represented by Protestant conclusions.

Intro.3 An Alternative Perspective

The normative judgement of the 2004 papal allocution, echoed by various Catholic and Protestant voices, has particularly troubling implications for contemporary medicine. Questions arise, such as whether life preserving means that are "natural" differ in the moral obligations they present from those means that are technological or "artificial." Reactions against the allocution stem from acute feelings of discomfort on the parts of those who value the lives of those with severe disabilities. Often there is great unease at the prospect of the indefinite maintenance of patients who are unlikely to recover from PVS—a condition not possible apart from a very simple intervention of medical technology. This unease prompts a probing of basic ethical concepts associated with a benefit-burden assessment. What does it mean for life-preserving means to be *successful* or provide *benefit*? Is it appropriate that success and benefit be determined in direct relation to the proximate end of the technological means applied, such as the success of a feeding tube in providing life sustaining nourishment? Or should success be

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End of Life Task Force, General Convention of the Episcopal Church, *Faithful Living, Faithful Dying: Anglican Reflections on End of Life Care* (Harrisburg: Morehouse Publishing, 2000), 43. Also see Robin Gill, *Health Care and Christian Ethics* (Cambridge: Cambridge University Press, 2006), 108-23.

[30] Commission on Faith and Witness, Canadian Council of Churches, "Statement of Convergence on Euthanasia and Assisted Suicide," (December 1996), http://www.ccc-cce.ca/english/faith/euthanasia.htm.

[31] Christian Medical and Dental Associations, "Vegetative State," (May 2, 1998), http://www.cmda.org/AM/Template.cfm?Section=Assisted_Suicide_Euthanasia&CONTENTID=3990&TEMPLATE=/CM/ContentDisplay.cfm.

Not many other denominational statements are available on the particular question of treating the PVS patient, but for one additional example see the Department for Studies, Division for Church in Society, Evangelical Lutheran Church in America, "End of Life Decisions," (November 9, 1992), http://www.elca.org/What-We-Believe/Social-Issues/Messages/End-of-Life-Decisions.aspx.

measured in light of the current state of medical technology, and the novel situations that are the products of medical intrusion? Basically speaking, in reference to what are the limits of medical technology to be determined? I regard these questions as having major significance for contemporary Christian bioethics.

However, those who employ the OEMD and variant benefit-burden assessments often neglect such questions. I propose that a combination of two factors has deflected the attention of many bioethicists, displacing careful reasoning from foundations with pragmatic conclusions. The first factor is the technological element of medicine, including the idea of progress, and the second regards the socio-political dimension of Christian engagement in bioethics. Doubtless medicine has always employed some kind of technology, but the technologies available and the ways in which they are applied have changed considerably in recent years. In anticipation of a more thorough explanation of these changes, let it be said that, whereas the limitations of premodern medicine often meant that care for the sick was emphasized over curative or ameliorative action, increased abilities to preserve life have enabled modern medicine to reverse this emphasis. Modern medicine can be typified by its favouring of intervention over nonintervention when it comes to therapeutic treatment and the preservation of life. In the secular context, the expansion of therapeutic abilities has led to a perceived expansion of moral obligation: the aim of medicine is now "to relieve the human condition of subjection to the whims of fortune or the bonds of natural necessity."[32] This is combined with what is commonly understood as the technological imperative: in a reversal of the Kantian dictum, "can implies ought." So if something is technologically possible, it is morally obligatory.[33] Despite its frequent appearance in the practical arena, this principle is generally recognized as fallacious. In the Christian ethical context there is an additional reason for asserting this: the ends of medicine are governed by a particular portrait of the human being, including a normative understanding of human nature and the kind of end that is fitting for humans. Given this context, the rationale behind the OEMD is the need

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[32] Gerald P. McKenny, *To Relieve the Human Condition: Bioethics, Technology, and the Body* (Albany: State University of New York Press, 1997), 2.

[33] Hasan Ozbekhan, "The Triumph of Technology: 'Can Implies Ought,'" in *Planning for Diversity and Choice: Possible Futures and Their Relations to the Man-controlled Environment*, ed. Stanford Anderson (Cambridge: MIT Press, 1968), 204-19.

to discern which medical, technological aids (and nonmedical, nontechnological aids) to human health are appropriate to apply in particular situations.

Certainly, few Christian ethicists would accept the technological imperative without question or expand the ends of medicine to the biological perfection of humanity. In spite of this, there have been changes in the way Christian ethicists regard life preserving technologies. Modern technology can be characterized by its very subtle abstraction from human ends, a movement all the more difficult to detect when the gains it makes, such as the saving of human life, seem legitimate or pressing. When the focus is on the apparent benefit of preserving life, attention is diverted from technology's capacity to replace human ends entirely with an independent paradigm of value characterized only by technological progress. An intermediate step in this radical movement is the shifting of ends such that they still appear human, all the while coming into closer correspondence with the kinds of possibilities medical technology makes available. For instance, one of the ideas I defend is that a basic level of human health has traditionally been seen in the Christian context as a prerequisite for the pursuit of all other human goods. Clearly, then, there is a general moral obligation to preserve health, and medical aids are seen as intended by God to supplement natural efforts in providing this benefit. For a long time this interpretation was compelling, as the limits of medicine entailed that whatever possibilities there were for preserving human life also improved health; the two could essentially be taken as commensurate. However, a transformation in the technological situation means that now much can be done to detach health from life. Not only are there new possibilities for burdens but also new implications for determining benefit. Contemporary "halfway technologies,"[34] those that postpone death without improving a patient's condition, can make the success of treatment distinct from the achievement of a standard of health conducive to a patient's pursuit of human ends. I would add that technological progress also extends to "halfway applications." The gift of time provided by treatments like ventilators and ANH can be necessary constituents of a course of therapy offering hope of benefit to many kinds of patients. But to others, nothing beyond time is added to pain-racked or unconscious life.

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[34] The term was coined by Lewis Thomas, *Lives of a Cell: Notes of a Biology Watcher* (New York: Viking Press, 1974), 33-36.

This challenges the legitimacy of the notion found in the papal allocution that all feeding, whether within or outside the medical context, is properly oriented to the maintenance of human life as its end. In preserving life apart from health, medicines and medical technologies reach their proximate goals of effectiveness without giving rise to the possibility of a patient's fulfilment of further ends. And yet certain Christian bioethicists and moral theologians insist there is a moral obligation to apply such treatments when they do not impose any of the traditionally recognized burdens. So, although it is inaccurate to say that a technological imperative runs rampant in Christian bioethics, it is critical to observe the subtle changes technology has brought to the understanding of the role of medicine in human living. At one time, medicine was understood as necessary on select occasions to assist in the human being's overall effort of pursuing the kind of life good for human beings, taking into consideration a larger context that included a divinely prescribed direction for human life. It is now being allowed to serve as the primary means by which the physiological is governed. At the end of life, moreover, moral obligation is being re-presented largely in reference to the extent of medicine's ability to sustain life. In the case of PVS, I argue that this amounts to the arresting of the course of a pathology rather than the provision of a physiological foundation requisite for the pursuit of human ends. In response to the new medical reality, this thesis takes the position that the OEMD, including the benefits and burdens it observes, must be re-examined. Account must be taken of its response to the culture of medical technology that surrounded its initial proponents; attempts must be made to transpose this response in terms relevant to the present day.

The debate over treating PVS patients can be more fully understood when one examines the second factor deflecting bioethical vision, the socio-political context. Although not itself a focal point of this thesis, this context bears exposition as it reveals the need for a return to foundational considerations, including anthropology. Christian "prolife" groups have come to view the Western political and social spheres as being engaged in what Pope John Paul II labelled a "culture of death."[35] Society, it is argued, through its economic, cultural, and political currents, and exemplified in its increasing

[35] John Paul II, *Evangelium Vitae*, (March 25, 1995), §12, http://www.vatican.va/holy_father/john_paul_ii/encyclicals/documents/hf_jp-ii_enc_25031995_evangelium-vitae_en.html.

approval of abortion and euthanasia, now encourages an ethics of efficiency to the exclusion of both a valuation of all human life and the solidarity of the strong with the weak. What has resulted in this culture clash is that the terms "sanctity of life" and "quality of life" have become diametrically opposed and thoroughly rhetoricized, with the former being made into an absolute value and the latter understood as a code word for preference utilitarianism. Many "prolife" groups preoccupied with countering this "conspiracy against life" work in part through a strategy of avoiding any kind of practical assessment that might be mistaken for a mere means-end process of reasoning made apart from an underlying principle of the intrinsic value of human life. But this principle, I will argue, has been broadened since its original articulation in the Christian tradition from one indicating respect for (basically healthy) life as a good foundational to the realization of other goods and a general presumption against killing, to one that makes human life a near absolute good effectively exempt from comparison with other basic goods. This strategy has led to the "prolife" stance against withdrawing ANH from PVS patients, which Catholic physician and ethicist Daniel Sulmasy has identified as "an extreme position to counter extreme positions supporting euthanasia" and "an opportunity to draw a line in the sand far on the side of preserving life."[36]

Concern for the vulnerable in society is undoubtedly warranted in the Christian context. However, it is problematic that the ethical significance of refraining from imposing unreasonable treatments on patients has come to be implicitly viewed as secondary in importance to or even problematic for the effort to combat euthanasia. This has meant that the reaches of the OEMD, once extending to any occasion for application of life preserving means, now tend largely to be constricted to those times when the death of the patient is imminent and inevitable and to those means that are "medical" rather than "natural." Part of my task is to demonstrate that these restrictions are out of character with the original thrust of the OEMD, and that they are blind to new risks arising from the change in context for action brought about by medical technology.

One of the guiding principles of ethical reason necessary to adopt here is that achieving clarity in the ethics of end-of-life care depends on the ability to keep separate

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[36] Daniel P. Sulmasy, "Preserving Life? The Vatican & PVS," *Commonweal* 134, no. 21 (2007): 17.

those issues that are by nature distinct.[37] Often questions concerning treatment withdrawal are obfuscated by assumptions made about the ill intentions of the agent. But the fact that an action can in one instance be wrongly motivated does not necessarily invalidate all instances of that action. For example, arguments for the legitimacy of the definition of brain death are compromised when intimately associated with society's demand for organs. One begins to suspect that the definition is only a pragmatic one—that the concern is with organ harvesting and not accuracy in diagnosis. But this does not mean that a brain death diagnosis is medically or ethically invalid. Rather, its justification is found in the amplified technological capacity to maintain cardiorespiratory function beyond the cessation of brain function, thus changing the way people die. Likewise, I consider it crucial to interpret the benefits and burdens addressed by the OEMD in light of the changing technological situation, and not as fundamentally correlative of the pragmatic political strategies undertaken in the euthanasia debate. Although treatment can be withdrawn out of a desire simply to be done with the patient, this is not the motive that concerns my argument. What is at stake, rather, is the limitation that needs to be put on medicine in light of a proper understanding of human nature. Making this argument is not a capitulation to the cultural devaluation of vulnerable human life but a restoration of the appropriate valuation of humanity in Christian bioethics as an intrinsic but limited good.

Intro.4 Outlining the Argument

For the OEMD, both burden and benefit are important criteria of moral judgement. Still, it is the element of benefit that is the foundational rationale for the use of any life preserving means; grave burdens simply present legitimate exceptions to the duty to preserve life once benefit has been established. Thus, in addressing the role of ANH vis-à-vis the PVS, what is required first and foremost is a more detailed and contextual assessment of what it means for medicine to provide benefit to the patient. As should be evident, each of the two factors addressed in the preceding section, the technological and the socio-political, is caught up with alternative expressions of the foundations of Christian bioethics, including Christian anthropology and the ends of medicine. I submit that an accurate interpretation of benefit and a proper application of the OEMD require

[37] Stanley Hauerwas, "The Ethics of Death: Letting Die or Putting to Death?" in *Vision and Virtue: Essays in Christian Ethical Reflection* (Notre Dame: University of Notre Dame Press, 1974), 168-69.

not only reference to the particularities of the contemporary medical and technological situation but also grounding in a basic understanding of the nature and value of human life that is suggestive of the proper direction and limitations of medicine. However, even within the confines of Christian ethics, there are considerable differences in the ways that these are articulated. This being the case, the first chapter of this work will streamline the ethical methodology used to approach the practical question. In light of the status of the OEMD as a tool for ethical decision-making, I take account of the relationship of the ethical aim to the moral norm, also considering the role of practical wisdom in moral deliberation. In this methodological presentation, I receive assistance from narrative theologians and philosophers, including Alasdair MacIntyre, Stanley Hauerwas, and Paul Ricœur, whose work helps show why recognizing the distinctiveness of a particular worldview is significant for understanding and speaking to the various sides of a practical argument contained therein.

In the second chapter, I turn to the important task of winnowing out a theological anthropology[38] that bears consistency with conventional Christian expressions and also relevancy to the new problems posed for human life in end-of-life ethics. Here I engage an Aristotelian-Thomistic anthropology. Although this is not the only anthropological perspective available in Christian theology and ethics, it is widely (though not exclusively) used in the Catholic context and adopted, from time to time, by Protestant bioethicists. Further, this anthropology, along with derivative accounts of ontological nondualism, is often used to *defend* the decision to apply ANH to PVS patients. I challenge the notion that such anthropology necessarily leads to such a practical conclusion, and I critically assess this anthropological resource in light of the practical case study. Here, I address the basic notion of intrinsic value and how it relates to the ends proper to human life by referring to Aristotle's capacity-activity distinction and what Aquinas calls properly human activity. Reconciling nature and activity in this way is important for offering a precise statement of the reasons why human life is to be preserved. Such a general outline reveals telling disagreements on this score, especially regarding the requirements for action occasioned by human dignity. Despite such

[38] Theological anthropology, a discipline common in Catholic theology but not unheard of in Protestant thought, differs from anthropology as a social science. It takes into account the nature and constitution of the human being in relation to God.

disagreements, I am led to some normative evaluations. According to Christian ethics, it is not the extrinsic value given to a patient that determines appropriate treatment; human life should not be neglected when it is vulnerable because the individual remains loved by God. However, the ways in which respect is demonstrated to those who, despite medical intervention, are no longer able to pursue human ends can be very different from how it is demonstrated to those retaining this ability. In light of this, and in anticipation of arguments to be made in subsequent chapters, the proper place to draw the line between preserving life and allowing death from an underlying condition is not always the point at which medicine can only offer one or two more excruciatingly painful days of life. It can also be the point at which medicine can no longer support particularly human activities, or the point at which one is no longer capable of actively participating in relationship with oneself, others, and God.[39]

In chapter three I examine the OEMD, a tool that guides practical wisdom in applying the ethical aim to the particular context. First, I offer a historical account of the development and use of the OEMD in Catholicism, also considering the derivative burden-benefit calculi in Protestantism. For this task, and for defining the constituent terms "morally ordinary" and "morally extraordinary," I rely on the work of Catholic moralist Daniel Cronin. Second, I draw attention to significant changes in the way the OEMD is now perceived and applied by the Catholic magisterium and others, and how these changes can skew the moral interpretation of contextual situations.

Many of these changes are encouraged by the new possibilities of medical technology. In chapter four, I make a case for submitting technology to ethics, rather than expanding moral obligation in direct proportion to technological capacities. A cautionary principle for technological development and application is given in light of the anthropological outline of the second chapter. This is filled out in reference to the work of Jewish philosopher Hans Jonas. Included here is a discussion of the formal and substantive dynamics of technology he outlines, as well as his notion of the concept of ethical responsibility as a correlate of human power. Jonas affirms the importance of ensuring that technological capacities yield to a concept of human nature and ends;

[39] That the PVS is a condition distinct from conditions of disability in that it absolutely and permanently inhibits this active engagement is a subject that is taken up in the final chapter.

technologies are often useful in the pursuit of such ends, but their influence must not be allowed to infringe upon efforts to define these ends. This being the case, I interpret his project not as formulating a new ethics of technology, but as attending to the need to discern the changes in traditional values and ends that technology can encourage.

Taking this contextual change into account, in chapter five I embark on the constructive work of outlining the ends of medicine. I focus on the virtue account of medicine that is prevalent in Christian bioethics and carefully outlined by Edmund Pellegrino and David Thomasma. I affirm the idea that medicine is a practice that, among other things, pursues human health and, by implication, preserves life; however, medicine must remain a clearly defined enterprise, one whose value is nonabsolute and whose exercise is sometimes unavoidably tragic. Medicine is best appreciated, then, as a species of care. Together with this, the long-held understanding of (unspecialized) care for the ill must be upheld. Determining which goal—preserving life or only caring for the dying—is appropriate at a given time requires practical wisdom. By placing the role of the friend alongside that of health care practitioner, the importance of the ethical activity of being present for the fundamentally vulnerable or dying patient is brought to light.

Periodic references are made to the problem of PVS where appropriate throughout the thesis, but the argument culminates in chapter six with a fuller account of the consequences for applying the OEMD in such cases. The remaining medical and moral controversies are treated here. I begin by examining the debates over the diagnostic and prognostic judgements made regarding the vegetative state and the relevance of consciousness to the pursuit of human ends. Whereas for patients in any other living condition, even extreme disability, there remain possibilities for active participation in relationship with the self, others, and God, I argue that no such possibilities are available for patients who are permanently unconscious. Controversial burdens relevant to PVS are also taken up and addressed in the contemporary medical context. As the application of ANH to the patient in a PVS is the only means by which such a condition can be induced and sustained, this condition is technologically dependent. Although Christians are not excluded from a moral responsibility to maintain patients simply because their lives are

technologically dependent,[40] in this case, the liminal nature of permanent unconsciousness apart from any reasonable possibility of returning to a basic standard of health makes the fact of technological agency an important factor in moral deliberation.

Throughout this work I will be pointing out that, when faced with a novel situation, moral tools and norms providing moral guidance can seem inadequate measures for realizing the values that are foundational to them. What is recognized as being at issue is that the unforeseen factors of this medical situation are causing two values, or two expressions of value, to clash. In this instance, the dignity of human life appears to clash with the goals of human life that extend beyond physiological continuance. However, if Christian bioethicists are correct in understanding their system of value, stemming from a theological construal of the world, to be an accurate one, these values are not incommensurate at all. It is rather that their proper relationship to one another must be refined in light of this new context for action, leading to a modification of the strategy by which each is realized and respected. If this is accepted, the OEMD, a guide for moral action that upholds both the values of the sanctity and quality of life in its considerations of benefit and burden, may well be able to appeal to situations of permanent and terminal unconsciousness.

[40] For instance, Christian bioethicists support kidney dialysis and recognize this as an occasion in which technological intervention supports human pursuits.

Chapter 1
Toward an Ecumenical Methodology

Having defined the contours of the practical problem I now turn to consider the ethical methodologies in play that can promote various conclusions. Others have expressed the ethical controversy over PVS in terms of the history of documents and discussions that have made for a vigorous debate at the practical level, and throughout this work I will take account of the variant voices that have been raised both in the Catholic and Protestant milieus. However, a more valuable occupation in the initial stage is to sketch out the foundational ethical methodologies that help shape these positions. This sketch will aid an understanding of the nuances at work in the opposing sides and even bring to light equivocations in their respective conclusions.

The second task of this chapter is to outline the ethical framework that will guide my own approach to the problem. This framework is meant to be "ecumenical" in that it gleans various ethical resources espoused by different Christian groups, seeking the largest possible overlap, and applies them in a cooperative manner. This is in keeping with my observation that the conceptual tools for reasoning out ethical problems that have been conceived and systematized in Catholic moral theology extend also to Protestant bioethics. At the same time, it is evident that ethical procedures tend to differ from ethicist to ethicist, a freedom that at best leads to a rich diversity of resources for consideration. At worst it results in negligence when it comes to supporting applied judgements with a foundational ethical methodology. This diversity—even disarray—is undeniable among Protestant ethicists, but it is also present, if to a less marked extent, in Catholic moral theology, especially in the academy, where coherence with the magisterial position is not always found. This being the case, no single ethical system I could proffer would represent an "orthodox" Christian approach. I will, however, attempt in this chapter to employ resources that are common and, where significant, identify points at which more than one interpretation of these resources exist, defending my own choice of interpretation. In highlighting what I consider to be characteristically Christian ethical resources and methods, this chapter is also partially aimed at revealing why a resolution of the practical problem at hand cannot be viewed as the same as one arrived at in a secular context or in the context of another religion, even if the final action taken is the

same. Nonetheless, this does not make my work irrelevant for "public square" bioethical conversations. Indeed, I appreciate the continuity between Aristotle's philosophical notion of the natural human end and Aquinas' theological fulfillment of this in the supernatural end; this is representative of a certain common ground between secular philosophy and theology. Rather, this work raises criticisms of dominant secular rationales for removing treatment, including utilitarianism, in an effort to reveal what I am persuaded is a more complete portrayal of the human being.

On occasion I will shore up my efforts with references to thinkers outside of the Christian tradition or whose work is more explicitly philosophical than theological. However, at no point do I aim to alter the tradition or impose on it with alien ideas. Doing so would be tantamount to saying that Christian bioethics on its own is inadequate in facing certain contemporary clinical problems, and I am not convinced this is the case. Instead, I aim to recover what is already present, also engaging external resources to bring attention to aspects that, though present in Christian thought, might be underemphasized in Christian bioethics. (This also holds true for the third chapter, centred on philosopher Hans Jonas, who is of Jewish origin; my intention is merely to reveal openings in Christian bioethics for the insights Jonas offers.)

The ecumenical method also recovers roles for two major and often opposed ethical traditions, that is, teleology (closely related to an Aristotelian-Thomistic account of *telos* and virtue) and deontology (derived from a Kantian heritage) by integrating them in narrative unity. By its nature, the act of incorporating these theories means eschewing an overly strict adherence to the limits of either of them; but this, I think, is justified in that each has featured significantly in Christian ethics and not necessarily to the exclusion of the other. There are Kantian Christian ethicists and Aristotelian Christian ethicists; however, the narrative of the Christian tradition set out in theological language identifies an end to be pursued and justifies a search for appropriate means by which to pursue it, allowing for the latter to be articulated in terms of the norms derived when virtue is applied to a practical context. Holding aims and norms together directs this ethical examination of the OEMD. I situate the latter as a conceptual tool that sets out normative guidelines for action at the end of life within the context of a broader appreciation of what

human life is about—a view of life that offers content to the normative understanding of a "reasonable" standard of preservation.

1.1 Bioethics: Catholic and Protestant Contexts

The OEMD is a component of medical moral reasoning that developed in the context of Catholic moral theology and continues to be accepted by the Catholic Church as a component of ethical deliberation. Catholics remain divided on the question of how this distinction is properly applied, especially as it concerns ANH. Prominent Protestant bioethicists have also adopted the OEMD to greater and lesser degrees without granting the same level of authority to the tradition that gave rise to it. A similar debate about application goes on in Protestant circles, although the lack of an authoritarian structure means that there is no normative position to which one can refer. In order to perceive how such disagreements can arise in a religion that can, from the outside, seem univocal in its moral judgements, here I outline some of the salient sources and features of Catholic moral theology and Protestant ethics.[1]

1.1.1 Catholic Moral Theology

Catholic ethics, called moral theology (in distinction from theology *simpliciter*), is a longstanding and systematic tradition whose involvement with medicine far predates the rise of contemporary secular bioethics. Sketching out this history will yield a background account of the milieu in which the OEMD arose. Much attention has been given to medicine in Catholic moral theology because of the longstanding Christian practice of caring for the ill, a tradition that has led to the proliferation of Catholic hospitals even today.[2] From early on, medicine was deemed a valuable enterprise because, although it was assumed that God was the ultimate authority on life and death, humans were understood to play a mediating role in realizing God's purposes for the world.[3] As with

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[1] Although I delineate the contours of these traditions, the scope of this project prevents me from detailing formative debates, such as those over probabilism, physicalism, and proportionalism in Catholicism, and those over biblical hermeneutics in Protestantism.

[2] Cf. John Collins Harvey, "A Brief History of Medical Ethics from the Roman Catholic Perspective: Comments on the Essays of Fuchs, Demmer, Cahill and Hellwig," in *Catholic Perspectives on Medical Morals: Foundational Issues,* ed. Edmund D. Pellegrino, John P. Langan, and John Collins Harvey (Dordrecht: Kluwer Academic Publishers, 1981), 131.

[3] See Basil the Great, "The Long Rules," in *St. Basil: Ascetical Works,* vol. 9, *The Fathers of the Church: A New Translation*, trans. M. Monica Wagner (Washington: Catholic University of America Press, 1962), q.55.

all other aspects of practical living, medicine was to be provided in a directed way that placed restrictions on its exercise. The Catholic magisterium has been active in affirming that direction. Pope Pius XII showed particular interest in speaking on matters relating to clinical medicine and health research.[4] Pope John Paul II was similarly engaged and, of course, responsible for the 2004 allocution on the application of ANH to patients in a vegetative state.

Although earlier works of Catholic moral theology often made reference to ethical matters relating to medicine, the first book dedicated entirely to a systematic treatment of Catholic medical morals is attributed to Paulo Zacchia in 1621.[5] This treatment was a contribution to classical moral theology or manualism, a textual tradition established at the time of the Council of Trent in the mid-sixteenth century, in the context of the Counter-Reformation, and lasting until the Second Vatican Council (1962-65). No longer in use, the manuals have a residual impact on Catholic moral theology, particularly medical moral theology, for two reasons. First, the proliferation of medical manuals increased in the nineteenth and twentieth centuries with the rise of modern medicine. Second, many of the specific tools for ethical reasoning developed in them are still employed, including the OEMD. However, the initial role of the manuals was not so much pedagogical as ecclesiastical and even juridical.[6] Like the Code of Canon Law, which outlines legal offenses against the Catholic Church and their associated punishments, the manuals acted as catalogues of moral offenses that would guide priests hearing confession. Criteria were outlined for judging whether a transgression had been committed, and, if so, what kind of transgression was committed; they also specified the appropriate measures of penance. Methodologically speaking, the manuals generally followed the casuist theory advanced by the Jesuits between the mid-sixteenth and mid-seventeenth centuries.[7] Casuists would take particular kinds of situations, or paradigms, into account, identifying the morally salient features, and indicate guidance for action (or

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[4] Excerpts of these are collected in Monks of Solesmes, eds., *The Human Body* (Boston: St. Paul Editions, 1979).
[5] Harvey, "A Brief History of Medical Ethics," 134.
[6] James M. Gustafson, *Protestant and Roman Catholic Ethics: Prospects for Rapprochement* (Chicago: University of Chicago Press, 1978), 1-2. Also see John A. Gallagher, *Time Past, Time Future: An Historical Study of Catholic Moral Theology* (New York: Paulist Press, 1990), 31.
[7] Albert Jonson and Stephen Toulmin, *The Abuse of Casuistry* (Berkeley: University of California Press, 1987), 137 and 250.

evaluate the action already taken). The reasoning of one case was transposed onto another if certain critical moral considerations were common to them both. Casuistry was viewed as one way to determine which principles, often drawn from interpretations of Aquinas, applied to a practical situation. Manualists came to look upon themselves as experts in a kind of science of moral deduction.[8]

Aside from the OEMD, two principles in particular remain influential for Catholic bioethical reasoning. The first is that of the totality of the human body, originating in the *Summa Theologica*, which prioritizes the good of a whole entity over its parts and is directly applied to cases of medical mutilation, now called surgery.[9] Amputation would still be considered an offence against the obligation one has to protect the integrity of the body were it not for this principle, which weighs the value of human life as greater than the disvalue of the loss of an unhealthy body part. A second principle that is still in use is the rule or doctrine of double effect, inspired by Aquinas' discussion of killing in self-defence in which he shows that it is possible for an action to have both good and evil consequences and yet remain acceptable.[10] Double effect continues to be integrated in deliberations about the application of pain relief measures when such action might hasten the death of a patient.[11] Here Aquinas' reasoning on the matter of self-defence is extended to medical instances of killing, the common element being the primacy of considering the agent's intentionality, which should pertain to the good effect, over the agent's foresight,

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[8] Gerald Kelly, *Medico-Moral Problems* (St. Louis: Catholic Hospital Association, 1958), 34. I am more sympathetic to Aristotle's well known claim that the nature of ethics as a discipline does not admit of exactness in every case. *Nicomachean Ethics*, 2nd ed., trans. Terence Irwin (Indianapolis: Hackett, 1999), 2.2.1103b34-1104a7 and 1.3.1094b13-15.

[9] Thomas Aquinas, *Summa Theologica*, II-II, trans. Fathers of the English Dominican Province (New York: Benziger Brothers, 1947), q.65 a.1. It is evident that this principle has been reinterpreted in significant ways in order to respond to the new medical possibility of organ transplantation. For an insightful account of this see Raphael Gallagher, "Catholic Medical Ethics: A Tradition which Progresses," in *Change in Official Catholic Moral Teachings*, no. 13 in *Readings in Moral Theology*, ed. Charles E. Curran (New York: Paulist Press, 2003), 306-18.

[10] Aquinas, *Summa Theologica*, II-II, q.64 a.7.

[11] It is also incorrectly used, often by secular bioethicists, as a justification for withholding or withdrawing means of life preservation. For example, see Timothy E. Quill, Rebecca Dresser, and Dan W. Brock, "The Rule of Double Effect: A Critique of Its Role in End-of-life Decision Making," *New England Journal of Medicine* 337, no. 24 (1997): 1768-71. Also see Daniel P. Sulmasy and Edmund D. Pellegrino, "The Rule of Double Effect: Clearing Up the Double Talk," *Archives of Internal Medicine* 159, no. 6 (1999): 545-50. They point out that, although both the OEMD and the doctrine of double effect are derived from Aquinas, the manualist formulization and medical application of the OEMD predate the formulization and application of the latter. Although double effect became helpful for deliberations about certain applications of treatment that might threaten a patient's life, the OEMD has always been a sufficient judge about instances of removing life preserving means.

which anticipates the evil side effect. In both cases, the action remains possibly acceptable since its direct aim is not the death of the individual but an avoidance of other harms, be it one's own death or a patient's suffering.

However, the suitability of the manualist adaptation of Thomistic discussions has not gone unquestioned. Some have taken issue with the formulization of these discussions into tests, the validity of which is justified in its own right, divorced from the foundation of Aquinas' natural law theology.[12] Further, it is arguable that Aquinas' discussion is taken out of context or, more accurately, that in generalizing Aquinas' reasoning to apply to any act with two inextricably intertwined and conflicting effects, what is retained is removed from the context of *discussion*. What Aquinas aims to achieve in his treatment of the question of the moral acceptability of killing in self-defence is to show through example that an appropriate understanding of the variety of vice is contingent on a prior appreciation of virtue.[13] In other words, he maintains that ethical discernment has more to do with a formative concept of moral excellence facilitated by virtues, such as justice and charity, than with the dutiful following of a step-by-step conceptual procedure to guard against vice. But, of course, it is the latter focus on law and transgression that is more useful for a text outlining the procedure for administering the sacrament of penance. Observing the gap between theological and ethical foundations and the moral directives of the manuals, John Berkman has observed the doctrine of double effect in particular to be "in a state of epistemological crisis."[14]

This epistemological gap became especially apparent as the manuals came to be used for other purposes, including providing more general direction for the moral life. One such extension of their use was the instruction of medical practitioners on the moral boundaries of their professional activity. That the manuals were limited to providing moral direction in terms of what is obligatory or forbidden, but not what is advisable or noble, gave the impression that the ethical life was about adherence to law and its abstract, universal rules, rather than the integration of positive ethical good with the fitting means by which to pursue it. On this subject Berkman notes, "Since classical moral

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[12] For instance, see Gallagher, *Time Past, Time Future*, 101.
[13] John Berkman, "How Important is the Doctrine of Double Effect for Moral Theology? Contextualizing the Controversy," *Christian Bioethics* 3, no. 2 (1997): 95-96.
[14] Ibid., 90. Berkman adopts this concept from Alasdair MacIntyre's *Whose Justice? Which Rationality?* (Notre Dame: University of Notre Dame Press, 1988), 349.

theology's conceptual resources were limited to assessing the Christian's duties and obligations, and distinguishing the permissible from the impermissible, its vision of the moral life was—compared to that of Aquinas and other medieval syntheses—hopelessly reductionistic."[15] This reductionism, I think, is in part responsible for the fact that the philosophy of medicine, which outlines those positive goals of medicine that influence subsequent boundaries of action, is only of recent concern in Christian and Catholic thought.[16] Finally, at Vatican II, manualist methodology, as well as certain absolutes established in the manuals, were brought into question, and the tradition was dissolved in favour of an approach that took greater account of the scriptural and theological underpinnings of moral theology, including Thomistic natural law, and that viewed the moral life in terms of aspiring toward what is noble, and not merely avoiding what is evil.[17] Mechanical obedience to externally imposed rules was eschewed in favour of a theory of conscience—an internal, even subjective, process of moral reasoning, the kind that I later show is operative in the OEMD.[18] This latter approach has since been taken up by Catholic moral theologians, as well as by the Catholic magisterium.

My own approach to ethical theory responds to the factors that led to the termination of the manualist tradition. The use of concepts relating to obligation as a primary means of conceiving ethics invariably forgets the more substantive accounts that give rise to them. I challenge the notion that aspects of moral prescription, including rules and norms, stand alone. I maintain that in the Christian tradition they are necessarily connected to a foundational account of nature and value that stems from a tradition of interpretation of scripture and theology. Despite the fact that the OEMD extends from a system invalidated by an epistemological crisis, it is not my intent to dispute the value of the distinction. Rather, I will attempt to restore the OEMD's validity and achieve a proper

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[15] Berkman, "How Important is the Doctrine of Double Effect for Moral Theology?" 92. Also see Richard A. McCormick, *Notes on Moral Theology, 1965 through 1980* (Washington, D.C.: University Press of America, 1981), 423.

[16] For instance, see Edmund D. Pellegrino and David C. Thomasma, *A Philosophical Basis of Medical Practice: Toward a Philosophy and Ethic of the Healing Professions* (New York: Oxford University Press, 1981), viii.

[17] Fathers of the Sacred Council for Everlasting Memory, "Decree on Priestly Formation (*Optatam Totius*)," in *Documents of Vatican II*, ed. Walter M. Abbott, trans. Joseph Gallagher (New York: Guild Press, 1966), §16.

[18] Paul VI, *Gaudium et Spes*, (December 7, 1965), §16, http://www.vatican.va/archive/hist_councils/ii_vatican_council/documents/vat-ii_cons_19651207_gaudium-et-spes_en.html.

application of it by resituating it in its proper moral and medical context. Outlining this approach is important because, despite the recognized failure of manualism, many Catholic moral theologians continue to prefer ideas of duty and permissibility to the larger ethical scope available to them. This is certainly true in the case of the OEMD.

1.1.2 Protestant Bioethics

Protestant bioethics, the counterpart of Catholic medical moral theology, developed much later and in a very different way, due not only to differences in moral theory but also to a dissimilar ecclesiastical structure. In Protestantism there is no separate priestly order, no prescribed individual confession to a priest, no sacrament of penance, and thus no catalogue of sins. Transgression and discipline are not foreign concepts in the Protestant churches, but a liturgical practice of corporate confession exists that encourages individuals to reflect not only on their particular moral offenses but also, and more significantly, on their general condition of sinfulness.[19] An emphasis on the latter does not negate the importance of seeking direction for moral action in specific circumstances. Instead, this kind of direction finds its place in the academy and in community discussions. The church, though having a level of prescriptive authority, generally asserts this authority in terms of its conformity to scripture as the word of God.

Protestants share the Catholic concern for caring for the ill as is evident in the title of the first major Protestant bioethical work, Paul Ramsey's *The Patient as Person*.[20] Although there is a general decline of Protestant hospitals today, concern for the practice of medicine and how it affects human lives continues through hospital chaplaincy, the proliferation of denominational positional statements on medical matters, and academic bioethics. Moral direction, though, has tended to develop in an *ad hoc* way. Whereas Catholicism has an authoritative philosophical and theological tradition to guide its deliberation, Protestant ethics is not tied to one interpretive structure, in keeping with the tenor of the Protestant Reformation. Protestant bioethicists are more concerned with providing timely responses to the dilemmas that arise in contemporary medicine and speaking to them in ways persuasive to those inside and outside the Christian religion.

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[19] The theological distinctions between the Catholic and Protestant traditions that have led to their respective emphases on particular sins and sinfulness are taken up by Gustafson in *Protestant and Roman Catholic Ethics,* 1-12.

[20] Paul Ramsey, *The Patient as Person: Explorations in Medical Ethics* (New Haven: Yale University Press, 1970). There has since been a second edition: (New Haven: Yale University Press, 2002).

The natural law tradition of Catholicism also seeks to persuade and supposes that any rational being can understand and concur with its conclusions. However, Protestant ethicists are often more comfortable than Catholics with speaking in terms borrowed from secular ethics in order to gain influence, sometimes refraining altogether from explicit appeals to theological foundations.[21] Whereas these ethicists have a community context that is both social and historical to consider, they work on the basis of individual reasoning and are free to incorporate various influential sources, most notably Christian scriptures, but also theology, human experience, and church tradition, as they see fit. For instance, reflection on Aquinas is not absent in Protestant ethics, if not given the same weight as in Catholicism.[22] This being the case, the OEMD and other Catholic moral principles, including double effect, have often been taken as tools that can be employed when helpful and modified when necessary.

All of this is to say that, although it is easy to point to documents promulgated by the magisterium as representative of the official Catholic position on a matter, often there is no authoritative, consistent, or unanimous opinion issuing from Protestant bioethics.[23] How scripture is to be interpreted can differ according to denominational tradition or even the particular insights of one's own process of reasoning.[24] Nevertheless, it is widely understood that the Bible does not often speak directly to the ethical issues that arise in contemporary medical practice. With rare sectarian exceptions, the applications of biblical teachings to the current scene are made somewhat thematically or analogously. But even this does not prevent disagreement. There certainly are common principles and rules in Protestant ethics (for instance, "You shall not bear false witness," derived from the Decalogue), but interpretations of the nature of particular transgressions (such as, What counts as bearing false witness?) and assessments of when certain rules apply (for instance, Are there circumstances under which lying might be acceptable?) vary widely.

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[21] Albert R. Jonson, "A History of Religion and Bioethics," in *Handbook of Bioethics and Religion*, ed. David E. Guinn (New York: Oxford University Press, 2006), 28-29.
[22] For example, see Stanley Hauerwas, *Character and the Christian Life: A Study in Theological Ethics* (San Antonio: Trinity University Press, 1975). Elsewhere he justifies his Thomistic focus with tongue in cheek: "Aquinas did not even know he was a Roman Catholic." "The Importance of Being Catholic: A Protestant View," *First Things* 1 (March 1990): 24.
[23] Gustafson, *Protestant and Roman Catholic Ethics*, 5.
[24] On the difficulties of biblical hermeneutics in Christian bioethics see Allen Verhey, "What Makes Christian Bioethics Christian? Bible, Story, and Communal Discernment," *Christian Bioethics* 11, no. 3 (2005): 297-315.

Compounding this is the plethora of ethical methodologies represented among Protestants, including deontological approaches[25] and related divine command theories,[26] character-based approaches,[27] and even consequentialism.[28] Often Protestant ethicists incorporate more than one of these theories into their applied ethics, an indication of the flexibility characteristic of Protestant thought, if also, on occasion, a lack of theoretical rigour.

Despite my separate treatment of these two traditions, it is apparent that the debate over the role of medical technology at the end of life cannot be divided easily along Catholic and Protestant lines. A variety of perspectives and positions is held among Protestant bioethicists, and although the Catholic magisterium has a firmly established judgement, there exists a lively academic interchange among Catholic scholars and medical practitioners that penetrates not only clinical medicine but also Christian anthropological and ethical foundations. Unresolved issues that span these traditions include whether a vegetative patient is a "person," or whether one's biographical life is more fundamental than one's biological life. They also include whether ANH is classified as medical technology or "basic care," and, if the latter, whether there are exceptions to the obligation to feed the hungry. These disagreements are largely dependent on very focused interpretations of the practical and moral facts of the clinical situation, but narrowing the debate to these questions can lead to the neglect of careful consideration of why medicine is important in the first place. My own ethical methodology, along with the descriptions of Christian anthropology and the relevance of technology for ethics in chapters to follow, pays close attention to the importance of the larger context for ethical deliberation on the matter of the OEMD.

1.2 An Ecumenical Ethical Theory

The approach I adopt in this work is characterized by an ecumenical, or small-c catholic, intent that 1) indicates prominent features and tools of Christian ethics, both

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[25] Paul Ramsey, *Basic Christian Ethics* (New York: Scribner's, 1950).
[26] Karl Barth, *Church Dogmatics*, II:2, ed. G. W. Bromily and T. F. Torrance (London: T&T Clark International, 2004), 509-781.
[27] Stanley Hauerwas, *Character and the Christian Life.*
[28] Joseph Fletcher, *Situation Ethics: The New Morality* (Louisville: Westminster John Knox Press, 1966). Fletcher later renounced his Christian foundations, and consequentialism does tend to be eschewed in Christian ethics.

theoretical and applied; 2) elucidates a characterization of action in the world that proceeds from a catholic Christian perspective; and 3) is particularly relevant to the bioethical problem at hand while showing awareness of the broader foundations of Christian ethics. The first two points have been introduced in the beginning of this chapter. I adopt an Aristotelian-Thomistic basis, in keeping with the Catholic tradition, but without rigidly adhering to the interpretations of natural law that are exclusively Catholic. In other words, I am open to Protestant interpreters of this tradition as well.

On the third point I wish to note that different arenas of applied ethics often give prominence to different scriptural considerations and theological doctrines in their reasoning, which can at times make their efforts incompatible. A primary example of this is a major discrepancy I observe to be rising between Christian environmental ethics and bioethics. It is seldom recognized that the word "bioethics" was originally coined as an umbrella term for medical ethics and environmental ethics—truly an "ethics of life."[29] This unified perspective was not taken up by others, perhaps because it entails a breadth and consistency in ethical foundations not amenable to casuistic and often time-sensitive discussions pertaining to procedures and policies to be applied in the public arena. But the separation of the two applications of an ethics of life has led to confusion when it comes to articulating the value of human nature vis-à-vis the value of nature. It is generally agreed amongst Christian ethicists that humans have special significance in creation and that God has a particular concern for or occupation with the human situation. I do not take issue with this. However, questions of human value should not be taken as unrelated to questions of the value of the rest of the natural world. Perhaps the most penetrating criticism by environmental ethicists has been against the radically anthropocentric tendencies of the bioethical enterprise.[30] The counsel proceeding from Christian environmental ethicists has been that the value of human life is not diminished when set

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[29] The term was first introduced by Van Rensselaer Potter in "Bioethics, the Science of Survival," *Perspectives in Biology and Medicine* 13 (1970): 127-53. Also see Peter J. Whitehouse, "The Rebirth of Bioethics: Extending the Original Formulations of Van Rensselaer Potter," *American Journal of Bioethics* 3, no. 4 (2003): W26-W31.

[30] I do not assert that ethics can entirely avoid anthropocentrism, as the subject of ethical action is the human being. However, as there is value beyond the human, and as the objects of ethical action include nonhumans, ethics must take on a qualified anthropocentrism. On this see Hans Jonas, whose ethics pertains first and foremost to humanity as bearers of responsibility for human and nonhuman nature. *The Imperative of Responsibility: In Search of an Ethics for the Technological Age*, trans. Hans Jonas and David Herr (Chicago: University of Chicago Press, 1984).

alongside that of nature. Rather, it is appreciated in its fullest sense. It has been an asset to Christian ethics that those concerned with the environment have recognized that the foundational text for the value given to human life—Genesis 1:27, which claims that humans are made in the image of God and blessed—occurs in a narrative account of creation in which *all* aspects of creation together are declared by God to be very good. Though perhaps not as prominent as it should be, this expanded scope of value is beginning to receive greater hold in Christian theology. A 1990 message by Pope John Paul II juxtaposes the "abilities and gifts which distinguish the human being from all other creatures" with the call given to humanity "to share in the unfolding of God's plan of creation."[31] This idea of a *telos* that includes all of creation has significance for the construction of Christian ethics in general. As Gustafson puts it, "We must see the place of man in the whole creation, and ought to conduct human life accordingly."[32]

Historically separated from this context, however, bioethics has become reductionist not only in terms of its anthropocentric bias but also in its confining the questions of human value and welfare to the medical arena. This has resulted, firstly, in its neglect of the value of non-health related human concerns and pursuits, or the subordination of these to the value of human health. Secondly, bioethics has directed all health-related concerns to the specialized practice of medicine. I will expand on the latter in my inquiry into the ends of medicine in chapter 5, affirming the notion that extending human life at its end is not the only way—and sometimes not the right way—to honour the goodness of the human being or even that of the human body itself. At present I call attention to the weakness of bioethics in narrowing its view such that those values that compete with human health are set aside. This compromises not only the descriptive task of bioethics but also its ability to make fitting normative prescriptions. Questions of resource allocation, for example, are at times broadened to consider the resources required by other social endeavours that aim to meet additional human needs, such as education and anti-poverty measures. However, solutions to these problems seldom come

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[31] John Paul II, "Peace with God the Creator, Peace with All of Creation," (January 1, 1990), §3, http://www.vatican.va/holy_father/john_paul_ii/messages/peace/documents/hf_jp-ii_mes_19891208_xxiii-world-day-for-peace_en.html.

[32] James M. Gustafson, "Ethical Issues in the Human Future," in *How Humans Adapt: A Biocultural Odyssey*, ed. Donald J. Ortner (Washington, D.C.: Smithsonian Press, 1983), 503. For a general analysis of the development of environmental ethics in Protestant thought see Robert Booth Fowler, *The Greening of Protestant Thought* (Chapel Hill: University of North Carolina Press, 1995).

to grips with the idea that the value given to human life, though inherent and to be respected, is not infinite. Although a systematic reconciliation of the practical conclusions of environmental ethics and bioethics would be fruitful, a more elemental step (and one within the scope of this study) is to engage the foundations that should span these fields. My own inquiry perceives the scope of value in Christian ethics as extending to all creation. Moreover, it intentionally submits that value to its source, God, rather than artificially inflating human life, health, or any other proximate value as the centre of concern.

1.2.1 Narrative Unity

I premise this approach on the idea that Christian ethics proceeds from a metanarrative that begins with an account of creation and relates all things to God. Although I am not alone in engaging Christian ethics from a narrative perspective, and expressions of narrative theory are varied, I interpret narrative ethics in a particular way, making reference to ethicists engaged in this kind of pursuit whose theoretical deliberations are influenced by the Aristotelian-Thomistic perspective. I engage the importance of narrative for the hermeneutical task of understanding action. However, my approach does not primarily concern the individual patient case study outline often used in clinical narrative ethics. Instead, I am occupied with highlighting the contexualizing factor made available by the metanarrative to members of religious communities in general, and the ethical agent in particular, in the attempt to interpret values and norms. Typically, a narrative arc is taken to span an individual's life. Personal unity, or a coherent understanding of oneself and one's actions, moreover, is an aim of narrative ethics. Alasdair MacIntyre defines the concept of narrative identity in terms of the storyline of birth (beginning), life (middle), and death (end).[33] However, this "narrative quest" of life is ultimately achieved in relation to a transcendent goal.[34] This entails that the limits of the narrative not be constrained by the birth and death of the individual but expanded to a broader perspective: "The key question for men is not about their own authorship; I can only answer the question 'What am I to do?' if I can answer the prior

[33] Alasdair MacIntyre, *After Virtue: A Study in Moral Theory*, 2nd ed. (Notre Dame: University of Notre Dame Press, 1984), 206.
[34] Ibid., 219.

question 'Of what story or stories do I find myself a part?'"[35] These stories represent the inherited places individuals hold in life and are indicative of the inescapability of a value-laden starting point.[36]

According to Protestant ethicist Stanley Hauerwas, narrative ethics is first of all about achieving what one considers an accurate vision the world.[37] The experience of the ethical life, then, indicates that values, virtues, and norms are more fully understood in terms of their place within a story. They cannot be mere isolated components of a rational argument made in the abstract. The narrative itself, then, is a hermeneutical tool of epistemic authority. Particular human situations and the ethical resources employed to tackle them tend to be considered as embedded in a wider arc, a larger paradigm of meaning. The way in which agents make associations between ideas or activities and the way they determine what is ethically significant about a certain situation are in large part guided by this narrative experience. For this reason, one might prefer to consider the ethical agent as living out a way of life rather than making discrete or disconnected decisions. Ethics as reasoned activity is about living out or continuing a story. Community belonging and participation in community practice are the primary means by which one internalizes the meaning of the grounding narrative.[38]

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[35] Ibid., 216. In a similar vein, Ricœur would claim that the seminal ethical question is not "What should I do?" but "How would I like to lead my life?" See *Oneself as Another*, trans. Kathleen Blamey (Chicago: University of Chicago Press, 1992), 170. This emphasizes the role that agents have in choosing their narrative community. My own view is that the rational will is unavoidably informed by the hermeneutics of narrative communities, but this does not preclude the agent's capacity to evaluate and even reject a community. In other words, agency is contingent but not fated.

[36] MacIntyre, *After Virtue*, 220.

[37] Stanley Hauerwas, *The Peaceable Kingdom: A Primer in Christian Ethics* (Notre Dame: University of Notre Dame Press, 1983), 29. Gustafson articulates something similar in claiming that theology is a way of construing the world by relating all things to God. Gustafson is more comfortable than Hauerwas with articulating principles as foundations for ethics, but he too sees value in the narrative approach for the internalizing of community tradition and strongly emphasizes contextualizing relationships. See *Theology and Ethics*, vol. 1, *Ethics from a Theocentric Perspective* (Chicago: University of Chicago Press, 1981), 161 and 321.

[38] Although Eastern Orthodox Christianity, a third major division of the Christian religion, is not examined in this project occupied with Western Christian bioethics, it might be said to have the best grasp of the relation between ethics and community practice, including worship. See Stanley S. Harakas, "Eastern Orthodox Christian Ethics," in *The Westminster Dictionary of Christian Ethics*, ed. James F. Childress and John MacQuarrie (Philadelphia: Westminster Press, 1986), 166-77. Also see H. Tristram Engelhardt, Jr. and Ana Smith Iltis, "End-of-Life: The Traditional Christian View," *Lancet* 366, no. 9490 (2005): 1045-49, which describes Christian bioethical principles as the product of and intimately related to a teleological point of view.

Certainly narrative ethics—as opposed to narrative philosophy or theology—is concerned with evaluating situations and actions over merely describing their context. This kind of integrative evaluation will take up much of the thesis. But because so many of the tools Christian ethicists use for evaluating action are unique to this tradition and have been formed over the course of a specific history of experience with competing values, I am also concerned here with defending the idea that one's particular construal of the world is largely responsible for *how* one knows how to act well. This kind of narrative continuity exemplified in the Christian religion involves text and tradition lived out in community: the practices and mores present in and actions taken by the contemporary community are structured in reference to conventions and convictions developed over the course of many centuries. Hauerwas speaks directly to this throughout the body of a work shaped by an understanding of Christian ethics as deriving from a story that provides foundational metaphysics and scope for continuing tradition and ongoing action. His language is necessarily confessional, indicative of theodicy, and also references a sphere of value broadened beyond the human to include the eschatological: "The picture drawn by the New Testament about the world is cosmic rather than provincial and anthropocentric. It is a tale about the mortal combat between good and evil—that beyond us lie powers and principalities in the face of which we are powerless without God's intervention."[39] In Christian thought, personal narratives are thus part of a larger plot depicting God's creative and salvific acts and reaching its climax—but not its conclusion—in the coming of Jesus Christ. But this broad contextualization in a metanarrative does not negate the importance of narrative identity that, when shaped by the events and tone of the storyline, makes the actions of the ethical agent intelligible: "we are capable of agency, of having character, only to the extent that we are given the means to locate our lives within God's ongoing story."[40]

None of this is to say that the Christian is not universally concerned or that the Christian narrative is incapable of interacting with those outside this community; Hauerwas, for one, is well-known for his social ethics that encompass concern for

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[39] Stanley Hauerwas, "Why the Truth Demands Truthfulness: An Imperious Engagement with Hartt," *Journal of the American Academy of Religion* 52, no. 1 (1984): 144.
[40] Ibid., 63. Cf. Hauerwas, *The Peaceable Kingdom*, 27 and *Truthfulness and Tragedy: Further Investigations in Christian Ethics* (Notre Dame: University of Notre Dame Press, 1977), 77.

humanity at large.[41] Nor is it to argue that those questions usually taken up by the religions and in philosophy are the exclusive domain of Christianity. There are many different ways to construe the world, many different visions of it, and many different stories used to ground ethical theories and practices. What is important to understand, though, is that the ways in which answers to these common questions are understood, expressed, and justified in story and act have unique dimensions in the Christian context, as they do for any other context. For instance, the natural is not something arbitrarily valued on the basis of ahistoric propositions. Its worth is grounded in a story in which God and creation are related by ties of valuing. The more specific example provided by Hauerwas is of prenatal life: "Catholic convictions about abortion," he writes,

> have never been derived from abstract principles about the "right to life," but rather have been rational just to the extent that Catholic people were formed by practices that made them a community capable of welcoming children. What is "natural" about that is that it is the way we were created—which is a claim about "nature" that unavoidably requires acknowledgment that there is a creator.[42]

Certainly, there can be overlap in the outworking of ethics by two different traditions—often used to justify a concept of natural law. Sometimes these stem from common conditions, such as the experiences of illness and death. Yet there are always differences in the narratives that result from these experiences, and just as it remains important to acknowledge our common conditions, the corresponding hermeneutics remain critical foundations for ethics.

Because a major component of this thesis is clarifying a proper evaluation of human life and nature, it is helpful to consider the implications for this observed by Hauerwas in a narrative interpretation of the Christian tradition. Firstly, the individual's existence, along with the existence of the rest of creation, is a reality that is contingent on the acts of God's creation and preservation. The motif of contingency will be important in the exploration of the value of human life.[43] Contingency is nowhere felt more keenly than in the timeline of the individual's life bounded by birth and death. Such limits

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[41] See Stanley Hauerwas, *A Community of Character: Toward a Constructive Christian Social Ethic* (Notre Dame: University of Notre Dame Press, 1981).
[42] Hauerwas, "The Importance of Being Catholic: A Protestant View."
[43] Hauerwas, *The Peaceable Kingdom*, 25 and 28. Cf. Hans Jonas on the contingency, rather than the necessity, of all creation. "Jewish and Christian Elements in Philosophy: Their Share in the Emergence of the Modern Mind," in *Philosophical Essays: From Ancient Creed to Technological Man* (New Jersey: Prentice-Hall, 1974), 21-45.

indicate that a balanced view of the value of human life is called for, a view that takes into account the conflicted nature of life's restrictions: "The ambiguity found in the New Testament—where death is at once seen as an enemy yet accepted as a necessary and natural aspect of our lives—sets the boundaries for any general discussion of death."[44] This is a dual attitude toward death that will characterize Christian ethics of terminal care: at once death is to be both feared and accepted. Either of these approaches, if taken to the exclusion of the other, leads to a perversion of the value of human life. The unqualified acceptance of death opens the door to euthanasia and assisted suicide—killing without the apprehension of trespassing against the goodness of life. Similarly, an absolute fear of death or of allowing death to occur can encourage people toward the protraction of life as long as possible. This negates the idea that there is also something important to be found in life's ending, and forgets the larger span of the narrative arc. The proper attitude toward death might be characterized as one of appropriate respect for death and recognition that medicine is a tragic profession.

Second, the perception of the value of the human being is determined through the historical and communal context that makes up the circumstances of the narrative.[45] An agent's existence is conditioned by this situation. The character and moral perspective of the Christian are dependent on the features of these circumstances. Whether by birth or choice (or both), Christians are members of a particular group with a shared memory and outlook, one that persists as a source of guidance for its members. Individuals submit to the wisdom and fellowship of this community just as they contribute to it. But as a final note on this, not all changes in the narrative can be equated with deviations, and this extends not only to the individual within a narrative but to the larger community living out that narrative. Expressions like "tradition" and the "narrative unity of a life" do not imply static identity but continuity of identity even as identity undergoes modification.[46] Aquinas' integration of Aristotelian philosophy and Christian theology is a prime example of this. It is not the goal of the community and its members to avoid developing

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[44] Stanley Hauerwas, "The Ethics of Death: Letting Die or Putting to Death?" in *Vision and Virtue*, 177.
[45] Hauerwas, *The Peaceable Kingdom*, 28.
[46] Ricœur offers a fruitful discussion on this subject in terms of individual narrative identity as a way to resolve the tension between the *idem*- and *ipse*-identities (or sameness and selfhood). *Oneself as Another*, 115-68.

the story. They are, rather, to extend the story in ways that remain related to its origin and responsive to the external demands of the current situation.

1.2.2 The Ethical Aim

Certainly the idea of a *telos* or end of human life (and even life in general) is indicated in the trajectory of the narrative arc and in the continual realization of purpose and goodness. *Telos* is no mere "happy ending." Such an idea would be difficult to defend in light of the destiny—decay and death—of every human life. The mistake of many evaluations of teleology is in interpreting *eudaimonia* (happiness or flourishing) as a possession or *telos* as a final state of affairs. *Telos* is not *finis*. Hauerwas identifies *telos* with narrative itself, saying, "the good is not so much a clearly defined 'end' as it is a sense of the journey on which [a] community finds itself."[47] Likewise, MacIntyre understands Christian teleology as recognizing that "in this life we are always *in via*."[48] Aristotle, too, defines *telos* in terms of continued activity, and to better outline the significance of teleology for this ethical methodology I naturally turn to him. I also turn to Paul Ricœur, whose philosophical approach to narrative ethics is understandably less confessional than Hauerwas' and more focused on individual identity. But his account of the human *qua* ethical agent is not incompatible with the Christian worldview already described. For instance, Ricœur gives credence to the notion that one understands the good not merely due to individual moral intuition but largely in terms of the religious and philosophical traditions of which one is a part.[49] Whereas Hauerwas supplies the character of the story for Christian bioethics, Ricœur aids in situating the aims and norms of the agent on the narrative journey in relation to one another.

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[47] Hauerwas, *The Peaceable Kingdom*, 119. However, there is a certain tension between the concepts of journey and *telos* as Aristotle would have it. The significance of contemplation (enjoying study) and even friendship (enjoying the friend) for Aristotle indicates that there is also a sense of "arrival" fundamental to *telos*. At the same time, this arrival does not negate the importance of ongoing activity. Hauerwas goes on to say that a particular community's conversation "is not *about* some good still to be realized, but the conversation *is* the good insofar as it is through the conversation that the community keeps faithful to the narrative." Certainly Christianity's eschatological perspective and the supernatural end that I discuss below also speak to this sense of arrival-in-activity.

[48] Alasdair MacIntyre, "Can Medicine Dispense with a Theological Perspective on Human Nature?" in *The Roots of Ethics: Science, Religion, and Values*, ed. Daniel Callahan and H. Tristram Engelhardt, Jr. (New York: Plenum Press, 1981), 133. It is also important to note that Aristotle understands pursuit of the human *telos* not in terms of the historical progress of humanity but in terms of individual human development. See MacIntyre, *After Virtue*, 159.

[49] Paul Ricœur, *The Just*, trans. David Pellauer (Chicago: University of Chicago Press, 2000), 56.

I have indicated that principles and norms are not the starting point of ethics, but they do have a vital place in moral deliberation. In Ricœur's analysis of action, the narrative perspective opens one up to the reality that there is a place in the ethical life for both the good pursued (the teleological aspect) and the imposition of obligation (the deontological aspect).[50] He distinguishes the terms "ethics" and "morals" by using the former to refer to the pursuit of what is understood to be the "good life"—the *ethos* or characteristic perspective on life—and the latter in terms of the norms that both spring from and govern this pursuit. These are expressed in three movements of subordination and complementarity. First of all, the ethical aim has a primary place over the moral norm. Second, the ethical aim on its own can founder in the practical situation without being shaped by prescriptions that prepare it for interaction with reality. So the aim "passes through the sieve of the norm."[51] Finally, moral norms, which are not independently derived, do not take precedence in times of moral quandary. If on occasion one arrives at an impasse of the nature of the ethical pursuit and the demands that typically delineate how it is best pursued, the latter must bow to the former. I will treat each of these three movements in sequence.

Outlining the good life requires a review of its conception in the Aristotelian tradition as well as reference to some major Thomistic adaptations. The good life entails the excellent pursuit of the complete good or ultimate end, the *telos* of human life.[52] This being the case, all action, including life plans and practices, is ordered by and converges on this end. The *telos* is not independently determined by ethical agents but is proper to their nature—supplied by virtue of the kind of beings they are. Likewise, the particular function or chief characteristic (*ergon*) of humanity is not up for deliberation.[53] The imposition of end and function, rather than their election by the individual, is one of the ways in which Aristotelian ethics is distinguished from utilitarianism, which aims to maximize pleasures or preferences. Aristotle subtly identifies the *telos* with *eudaimonia*, (happiness or flourishing) in order to reinforce its finality and self-sufficiency. Desired for its own sake, there is no good beyond *eudaimonia* nor could it be improved upon

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[50] Ricœur, *Oneself as Another*, 170.
[51] Ibid.
[52] Aristotle, *Nicomachean Ethics*, 1.2.1094a18-23 and 1.7.1097a15-1098a20.
[53] Ibid., 3.3.1112b12. Also See Ricœur, *Oneself as Another*, 177-78.

through the addition of any other good.[54] Consider, as Jonas does, that happiness or flourishing is a desire of all people.[55] No one is obligated to pursue flourishing in life, but it is a desire that is common to everyone and so not pursued arbitrarily; its establishment in human nature means that people presume that it is justified as the human end. Aristotle understands *eudaimonia* to be realized in continued excellence in particularly human activities—those that are most distinctive of humanity as a species—and so flourishing is not a passive state.[56] For Aristotle and others, the most distinctive quality about humanity is the capacity for virtuous, rational deliberation.[57]

Similar observations are made of the Christian understanding of the human end. Aristotelian metaphysics, the basis for Thomistic natural law theory, asserts that people are naturally oriented toward their natural good. But in addition to the natural end prescribed by a natural condition, Christians understand the spiritual nature of humanity as leading to a spiritual end, union with the supreme good—God.[58] Consider Augustine's well known aphorism: "Thou hast made us for thyself, and our hearts are restless until they find their rest in thee."[59] Aquinas calls the fulfillment of the transcendent end the *beatitudo perfecta* or the vision of God.[60] Strictly speaking, then, it should not be thought of as an end in addition to the natural end but as a perfection of that end. Not all Christian thinkers look upon Aristotle and Aquinas as authoritative sources, but it is fair to say that they do tend to view human fulfillment as oriented toward this dual end.[61] Even higher than human reason is the capacity to engage in the special relationship initiated by God, a relationship that also governs one's conduct with others, oneself, and the natural world. Aquinas claims that all humans have a *natural* aptitude for knowing and loving God[62]

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[54] Aristotle, *Nicomachean Ethics*, 1.7.1097a25-30 and 10.4.1174b21-3.
[55] Jonas, *The Imperative of Responsibility*, 75.
[56] Aristotle, *Nicomachean Ethics*, 10.6.1176b2 and 1.7.1098a3-15. Cf. Aquinas' distinction between actions performed by an individual and truly human acts in *Summa Theologica*, I-II, q.1 a.1. I deal with this distinction in the second chapter.
[57] Aristotle, *Nicomachean Ethics*, 1.7.1097b22-1098a20.
[58] This is Aquinas' major innovation on Aristotelian ethics. Aquinas, *Summa Theologica*, I-II, q.5, a.3.
[59] Augustine, *Confessions*, 2nd ed., ed. Michael P. Foley, trans. F. J. Sheed (Indianapolis: Hackett, 2006), I.1. Here "rest" should not be taken to indicate a conclusion to action but rather fulfillment in continuing relationship with God.
[60] Aquinas, *Summa Theologica*, I-II q.4 a.5. Unlike human efforts to pursue the good life, the supremely good end is not subject to "luck."
[61] I reserve a more thorough examination of human ends for the chapter to follow.
[62] Thomas Aquinas, *Summa Theologica*, I, q.93 a.4.

and, certainly, Christian ethics is centred on this relationship, whether the aptitude for it is considered natural or not. I too make it my reference point in discussing value relations.

Although humans have an innate potential for flourishing, actualizing this potential does require some strategy on the part of the agent. Aristotle offers a picture of who people are and who they might become—indeed, who they are *meant* to become—by taking advantage of the resources proper to human nature. As the human end is active and not passive, this strategy and these resources will involve certain kinds of activities performed in certain ways. To clarify this, Aristotle occupies himself with a comparative analysis of the types of activities available and how they lead to the ultimate end or the highest good. The first kind, *poiesis* or movement, refers to productive activities, or those whose end is external to their work.[63] The value of these activities is not unrelated to the individual's ultimate end, but the benefit is not found in the acting out but in the product that results. Hence this kind of activity is transitive or ultimately incomplete in itself. Complete activity, or *praxis*, on the other hand, refers to actions whose activity is intimately related to the end. This means that the end of *praxis* is *eupraxia* (good practice) in which the good activity and the good end together constitute the goodness achieved.[64] The end is not a possession so much as it is immanent in the very acting out (*energeia* or actualization).[65] To distinguish, the carpenter's task is accomplished with the completion of the table or house being built, but the act of seeing is at every stage complete.[66]

The distinction between *poiesis* and *praxis* is an important one for understanding human activity in terms of ends and means or, more properly, ends and the things leading up to them. Although *praxis* has its end in itself and achieves a real good, it does not on its own constitute the ultimate end. In view of *eudaimonia*, even perfect activities will be classified as means, though also ends in themselves.[67] When activities are both ends in

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[63] Aristotle, *Nicomachean Ethics*, 10.4.1174a19-24; cf. 1.1.1094a3-4.
[64] See Gaëlle Fiasse, "Aristotle's *Phronesis*: A True Grasp of Ends as Well as Means?" *Review of Metaphysics* 55, no. 2 (2001): 332.
[65] Aristotle, *Nicomachean Ethics*, 10.4.1174a14-15.
[66] Certain actions can span these two categories. Alfred Guy interprets child rearing as having an extrinsic aim (the good and happy adult) and an intrinsic aim (a labour of love undergone for its own sake). See "The Role of Aristotle's *Praxis* Today," *Journal of Value Inquiry* 25, no. 3 (1991): 287-89.
[67] It is confusing that something could be an end in itself but not the ultimate end. This is clarified by Gaëlle Fiasse, who recognizes in Aristotle an "overlap of ends and means." Perceiving this overlap requires recognizing "the different perspectives in which things can be regarded as ends." See "Aristotle's *Phronesis*," 324.

themselves and means to the final end, they share in the character or nature of the final end and are partly constitutive of that end. It is because of this fact, and not as an independently justified activity, that an action is worth choosing for its own sake, and not for any external good, such as pleasure, that results from it. But this requires some explanation. When something is a component or ingredient of flourishing, it is intrinsically valuable, and not (only) instrumentally valuable. However, this is not the same thing as equating any genuine good with the ultimate good. Even intrinsic goods lack self-sufficiency when they are not the final end; that is, on their own they do not constitute the good life but are contingent on a vision of the ultimate good.[68] What is important to recognize here is that particular values are understood as such according to a theory of value, or an interpretation of the nature of goodness. This, in turn, is determined in reference to what the *telos* is understood to be. Even though not all intrinsically good activities wholly constitute the complete good, their intrinsic value is made apparent in the context of a life aimed at a particular construal of flourishing. This idea of goodness being interpreted through contextual relation has been affirmed by others. Sulmasy observes, "One might be tempted to say that flourishing is intrinsically good, but the goodness of flourishing is always dependent on the kind of thing that is said to be flourishing, and thus that state of affairs is not, strictly speaking, intrinsically valuable."[69] Similarly, in discussing how humans are like God, Aquinas contends that they are so not because they have the ability to know and love (typically taken to be praiseworthy actions on their own) but because they know and love *God*.[70] Aquinas perceives valuable things as related in kind to the highest good. When he claims that "God wills His own goodness as an end, and all things else as means thereto," this statement is best read in light of what follows directly after:

> The good of a part is ordained to the end of the good of the whole, as the imperfect to the perfect. But things become objects of the divine will according as

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[68] Aristotle, *Nicomachean Ethics*, 1.7.1097b15-22.
[69] Daniel P. Sulmasy, "Dignity and the Human as a Natural Kind," in *Health and Human Flourishing: Religion, Medicine, and Moral Anthropology*, ed. Carol Taylor and Robert Dell'Oro (Washington, D.C.: Georgetown University Press, 2006), 75.
[70] Aquinas, *Summa Theologica*, I, q.93 a.8; see him also on God as the standard of justice, in *Summa Theologica*, I-II, q.21 a.4.

> they stand in the order of goodness. It follows that the good of the universe is the reason why God wills every good of any part of the universe.[71]

The frame of reference for intrinsic value will be something to keep at the forefront in the following chapter as the constitutive goods of the human (both body and soul) are discussed. On the other hand, circumstance might mean that a good activity excellently practiced does not necessarily end up contributing to the ultimate end at which it aims. But this does not rob it of its intrinsic goodness. Skill and efficiency, though important to the ethical life to a certain extent, do not amount to the good life. At the same time, to say something is good (whether intrinsically or instrumentally) would be nonsensical apart from the theory of value in which value is determined with respect to the ultimate end. The importance of this recognition is that it distances Aristotle from utilitarianism, which is also by some accounts teleological but wholly subordinates means to ends.

Evidently, Aristotle is concerned with *praxis* more so than *poiesis* since the former is aligned with the particular excellences—virtues (*aretē*)—of humanity. Virtue is a necessary component of the good life because, although humans are endowed with particular natural capacities or powers, the actualization and perfection of these require that agents properly cultivate their inclinations into stable dispositions. The good harpist, for example, is not one who merely plays the harp, or who even enjoys playing, but the one who also does so skilfully on a consistent basis.[72] The cultivation of virtues includes both theoretical deliberation and perfection through their exercise in concrete situations. With regard to the first, understanding the content of virtue is best done by referring to narrative context. What it means to be engaged in the virtue of justice, for instance, is intelligible in relation to a history of actions taken to represent just conduct, since fitting actions are not determined in the abstract but with respect to context. But understanding virtue also requires nurturing a disposition, a matter of habituation and experience, something I will return to later in the discussion of practical wisdom.

Virtue is certainly a familiar concept in Christian ethics as Aquinas incorporates it in his Christian rehabilitation of Aristotelianism. In addition to Aristotle's intellectual and moral virtues, Aquinas' understanding of the good life as culminating in relationship with

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[71] Thomas Aquinas, *Summa Contra Gentiles*, I, trans. Joseph Rickaby (London: Burns and Oates, 1905), q.86 §2.

[72] Aristotle, *Nicomachean Ethics*, 1.7.1098a8-15. Enjoyment of virtue, of course, is also important for Aristotle.

God requires the inclusion of the theological virtues of faith, hope, and love. These are virtues infused by God and not perfected through human achievement.[73] I will not engage in an analysis of these here, but they do indicate the complementary but distinct nature of the spiritual direction of human life.

Among the Aristotelian virtues, there is one that coordinates the application of excellence in practical scenarios. Only the individual agent having prudence (*phronēsis*), also called practical wisdom, will be able to judge rightly what is valuable in itself, order all goods according to the highest good, and determine what is most fitting for the human *telos* in light of particular circumstances.[74] Practical wisdom oversees both complete and incomplete activities in this way. An examination of prudence will come later, but this much sets the tone for the additional Ricœurian steps to follow in this methodology: the activity of practical wisdom is not equivalent to a consequentialist means-end deliberation. In seeking means that in some way contribute to an end, the agent always begins with the premise of the good end of human flourishing. An appropriate bioethical example illustrating a consequentialist violation of the good end is euthanasia: if the physician's goal is to help the patient become healthy insofar as this can be done reasonably, it is out of character with this goal to kill the patient, even if the patient is suffering. Euthanasia instead indicates another intention, perhaps to be merciful in the face of suffering or to reallocate scarce health care resources that can be applied to other patients with a greater hope of recovery. Either intention violates the goal of the health of the patient by usurping it with an incomplete interpretation of the goal, whether mercy or the common good, that is nonetheless falsely perceived to be authentic. The one who acts with practical wisdom, however, will know when and how skilful means are applicable, and when even virtue is insufficient for reaching the fixed end. In making the most of the natural virtue of the human being, Aristotelian ethics is not a theory that pretends human excellence is capable of resolving the tragic situation. The aim of action may be infinite, but the possibilities for action are not. Likewise, the Christian narrative perspective accepts the conditional and limited nature of humanity and affirms human moral action as worthy and important but, at the same time, not something that guarantees satisfaction.

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[73] Aquinas, *Summa Theologica*, I-II, q.55 a.4.
[74] Aristotle, *Nicomachean Ethics*, 6.7.1141b10-23.

1.2.3 The Sieve of the Moral Norm

I have promised an ethical approach that also includes norms, and certainly the consideration of norms is significant for a project addressing a conceptual moral device that deems certain instances of treatment morally obligatory. The orientation of this section is directed toward two assertions: first, that the evaluation of action through moral norms is necessary to ethics, and, second, that it is nonetheless insufficient for ethics. Deliberation about what is right, as Aquinas observes, requires both a worthy end and means ordained to realize this worth.[75] Once one recognizes the final end and the kinds of dispositions and activities humans cultivate in order to pursue it with skill, one can begin to express the limits of the ethical vision in rules and norms that contribute to the effort. So, the place for deontology is secondary but essential. An evaluation of action is required in order for the ethical aim to remain authentically interpreted over the course of historical action; the ambiguities that inevitably come in seeking to pursue the ultimate end in the concrete situation demand that the aim of the agent pass the test of the moral norms that arise out of that aim.

How are moral norms to be considered in relation to virtue? As humans match fitting actions to a situation by way of virtue, and as the circumstances of situations are complex, it is Aristotle's conviction that no series of rules, however involved, would be adequate to express the virtuous response to every case.[76] Of course, the same might be said of medicine; medical practitioners learn techniques associated with certain conditions, but it is a common complaint that there are no "textbook" cases.[77] Instead, reason and the virtuous one (who acts rationally) are each identified as the standard of judgement, so it might be anticipated that two virtuous people would approach a single problem in the same way.[78] At the same time, Aristotle does admit to certain rules of thumb that stand. For example, some kinds or categories of feeling and action are always wrong, regardless of the circumstances.[79] According to the nature of human flourishing, it

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[75] Aquinas, *Summa Theologica*, I-II, q.57 a.5.
[76] See Aristotle, *Nicomachean Ethics*, 5.10.1137b12-16 and 6.7.1141b15-17.
[77] Ibid., 2.2.1104a5-10.
[78] Ibid., 2.6.1107a1-3, 3.4.1113a33-34, and 9.4.1166a13-14. Of course, this is a difficult point to defend. Despite sharing a common narrative starting point, Christian denominations diverge at various points and Christian ethicists regularly come to differing conclusions on practical matters, not the least of which is the bioethical problem prompting this inquiry.
[79] Ibid., 2.6.1107a10-18.

will never be possible to feel spite excellently, although one might take some kind of pleasure in it; nor will it be possible to commit murder well, although one might do so with expediency and undetected.[80] On the other hand, which instances of killing are considered to belong to the category of murder, for instance, will be determined in large part by reference to a theory of value, and so it is incorrect to assume that certain emotions or actions can be considered wrong or evil in isolation from such a theory.

More significant than Aristotle's acceptance of particular rules is the fact that he integrates a sort of test of universalization into his theory: the doctrine of the golden mean (*mesotēs*). This is the idea that virtues of character exist along a continuum as the midpoint between the vices of excess and deficiency.[81] This shows at least a *prima facie* acceptance of normative formalism, even if putting it to good use is more complicated than simply following rules. Aristotle points out that it is not always easy to define this midpoint in the practical situation, giving the example of mistaking docility for the virtue of mildness, or irascibility for manliness. He argues that the golden mean is used properly by those with experience who have learned to perceive the good in the concrete situation.[82] Even so, if Aristotle admits of a universal standard for action there is an opening point for normative prescription in eudaimonic or teleological ethics.

The factor that is often used to distinguish deontological ethics from teleological, virtue-based ethics is that in the latter any prescriptions for action receive their validity by conforming to an idea of the virtuous life. On the other hand, Ricœur eschews an interpretation of Kantian deontology as being an attempt to invent morality from the ground up rather than an attempt to interpret the moral life as it does in fact exist.[83] He sees an antecedent recognition of the good life in Kant's concept of the good will, which is considered at the very start of the Kantian argument as the only good not contingent on empirical facts.[84] Even virtues, Kant says, cannot be called unconditionally good because, divorced from their aim and apart from the good will, they can be made to serve bad ends.

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[80] Of course, the moral analysis of both of these activities includes consideration not only for the agent but also the one on the receiving end of the action or sentiment. Ricœur shows great concern with giving consideration or respect to the other person. See *Oneself as Another*, esp. 180-202.
[81] Ibid., 204 and Aristotle, *Nicomachean Ethics*, 2.6.1107a1-3.
[82] Aristotle, *Nicomachean Ethics*, 2.9.1109b12-18.
[83] Ricœur, *Oneself as Another*, 205 and 262-63.
[84] Immanuel Kant, *Grounding for the Metaphysics of Morals*, 3rd ed., trans. James W. Ellington (Indianapolis: Hackett, 1993), 7.

The good will, Ricœur says, is the Kantian counterpart to rational desire for the good: whereas the Aristotelian desires to act well based on a recognized aim (the optative mode), the Kantian wills to do what is right based on a recognition of the law (the imperative mode).[85] The two share the understanding that particular inclinations contrary to reason have no place in determining appropriate action.

Appeals to formalism and duty are often made in response to the reality of evil and the ease with which people are led away from what is right, all the while justifying their action in reference to the good end. Ricœur agrees that having an affirmative foundation in ethics—a foundation that establishes the positive good to seek—does not negate the importance of identifying offences against this good. According to his theory of action, the threat of violence (not violence itself) is inseparable from action because of the social context: the act of one agent will have some effect on the capacity of another to act, good or bad, intended or not.[86] And the vulnerability of eudaimonic ethics is that ethical skill will degenerate into utilitarian efficiency to the detriment not only of other individuals, but also of the pursuit of the aim itself. These dangers make it crucial that one's agency be constrained by certain prohibitions that make operative at the moral level what can only be "sensed" at the ethical level.[87] The strength of the deontological move, or the formalization of the ethical aim, is in its starting point: the attempt to address the moral complexity of particular situations in light of a clear and substantive vision of the good life. As Ricœur says, "the norm puts the wish to live well to the test."[88]

So Ricœur's contention is that normative prescription is to be valued for its ability to discriminate between right and wrong, thereby translating the ethical aim into action, and not in setting up ahistorical proceduralism. He places the break between the self-contained theories of teleology and deontology at the point where the test of universalization takes the place of the agent's teleological orientation, or where obligation is determined in isolation. Here there is a discrete formal inquiry in an abstract moment made by an autonomous agent apart from reference to the aim understood through tradition or story, and there appears to be nothing of the historical character of

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[85] Ricœur, *Oneself as Another*, 206-07.
[86] Ibid., 218ff.
[87] Ibid., 227.
[88] Ibid., 204.

Aristotelian ethics, nothing of the "sense" of the good. The deontological mistake is to misconstrue the gap between the aim and its actualization as a failure of the teleological orientation. In response to this, it reduces the formal component of ethics—the test or "sieve" of action—to empty proceduralism, at the same time inflating the status of this component. This impression has been heightened by the modern rejection of Aristotelian metaphysics and natural teleology, or the separation of the "is" and the "ought." The marriage of formalism and contractualism, prompted by discomfort with a eudaimonic vision not subject to scientific proof, entails the divorce of the good from the right. If modern liberalism, in league with science, insists that there is no set goal for humanity, no definitive task to be carried out, then rules are adopted not as means to this end, but as procedures for moderating multiple subjective pursuits. Ethics becomes concerned with nothing more than social contract, keeping the peace, and creating space for the dialogue that must persist between conflicting groups in order to achieve a "common good."[89] This perspective recommends that the process determinative of which rules contribute to such an effort—here Ricœur makes an example of the Rawlsian "veil of ignorance"—be ahistorical if it is to be objective.[90] Here the narrative hermeneutics that gives meaning to real experiences and interprets the complexity of life is left behind for a proceduralism that, in contrast, represents a foundational and fictional social contract, thereby simplifying the original situation.[91] The veil of ignorance abstracts individuals and groups from reality, seeing the solution to utilitarian use of others or to inadvertent evil in an impartial distribution of relevant goods in society.

The deceptions of this fiction include the insistence that it is the normative itself that allows one to define the good, rather than the reverse, and the corresponding claim that a contract can assume the place of the rational, personal good will in the deliberation.[92] The authenticity of a good will that comes in working in rational autonomy (though not in isolation) is reduced when the agent takes on the role of the objective, contracted individual.[93] Such vulnerabilities have been observed in secular medical ethics.

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[89] Cf. MacIntyre, *After Virtue*, 119.
[90] John Rawls, *A Theory of Justice* (Cambridge: Harvard University Press, 1971); cf. Paul Ricœur, "Is a Purely Procedural Theory of Justice Possible?" in *The Just*, 36-57.
[91] Ricœur, *Oneself as Another*, 228-29.
[92] Ibid., 238.
[93] Ibid., 229.

Consider those particular mechanisms that arise from formalistic moves such as informed consent and advance directives. I find nothing objectionable in patients determining and expressing their wishes concerning medical treatment when this is done with regard to their particular moral positions. However, from a legal standpoint the significance of consent is as a procedural benchmark, the formal completion of which can be easily established. Even though attempts can be made to explain diagnosis and potential courses of therapy to the patient, no formal benchmark provides the tools needed to facilitate genuine understanding on the part of the patient.[94] Heightened through the rise of the consumer model of the physician-patient relationship, mutual consent becomes the only significant moral standard in healthcare, often distancing the attending medical practitioners from responsibility for patient decisions.[95] Removed from the patient's internal dialectic of a particular vision of health as aim and available treatments as means, the context that provides substantive content to consent is lost. Observing this, it is questionable that formalism alone has the power to keep medicine grounded in morality, and yet awareness of the moralities in play is required in order to prevent confusion between the parties and to promote mutual understanding.

According to the narrative and teleological perspective in which one's story influences how one will tend to act, no deontological sieve on its own will be an adequate resource for action. It is evident that even Rawls must affirm some "considered convictions" about values and virtues, such as justice, as arising prior to and apart from an original, ahistorical position.[96] In fact, Ricœur maintains, projects like Rawls' amount to rationalizations of convictions about the good life that occur even before they are tested out against the theory. Rules and procedures for rule making at least implicitly receive

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[94] It is, however, apparent that secular bioethics also struggles against this difficulty. Consider the following passage from the Canadian Interagency Secretariat on Research Ethics: "The ethical recruitment of participants in human research goes beyond an evaluation of autonomy, which often seems to focus primarily on whether an adult person has signed a consent form. It is a more complex consideration of whether the recruitment of participants has been carried out on a basis that is ethically legitimate and methodologically justified. It should be a process that respects and reflects, wherever possible, the values and preferences of the individual participants and, where necessary, engages the groups that may be affected by the research." In Interagency Advisory Panel on Research Ethics, *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans*, 2nd ed. (draft) (Ottawa: 2008), 4.

[95] I do not mean to say that practitioners do not care about or communicate with their patients; rather, I observe that the health care system is not set up in a way that promotes discussions of value relating to health care decisions.

[96] Rawls, *A Theory of Justice*, 19-20; cf. Ricœur, *Oneself as Another*, 237.

content from some ethical aim. The troubles of a founding fiction are patent in light of finite humanity; one cannot truly abstract oneself from the practical situation. Interpreting the nature of a relevant good requires some reference point. These truths are quite evident in the OEMD, which is always grounded in a particular interpretation of the value of the human being made evident in createdness; it is through this lens that the available courses of action are considered and evaluated. The flexibility of this conceptual tool in determining what is beneficial and what is burdensome in a situation is not the product of moral relativism. It is a response to the reality of the moral perception found in Christian bioethics that life should be protected, and not attacked, but also not sustained in ways that are overly burdensome or lacking in benefit.

If the basic rightness or wrongness of action is evaluated in consultation with the particular details of the way an action is being performed, and not exclusively in reference to an abstract universal norm or principle, this evaluation proceeds from the agent's own perspective influenced by narrative context. It is impossible to deny that certain prohibitions, such as that against murder, span cultures, and their ubiquity might lead one to consider the actions they proscribe to be objectively wrong. At the same time, in prohibiting murder, each tradition first distinguishes some instances of killing from others in accordance with the ethical trajectory of life and how these instances are perceived to respond to it, whether negatively or positively. Only then are some considered illicit. Hauerwas insists that the rules set out in the Decalogue of the Hebrew Bible are only intelligible in reference to the surrounding context of the covenant relationship between God and Israel.[97] This is not to say that an evaluative label of murder, for instance, is meaningless apart from this context, but rather that there have been particular occasions of killing that have led to this tradition's development of the concept of murder—what counts as murder—and its own particular reasons for banning the action. These reasons are formulated not necessarily in reference to some superseding concept of the common good or premised on self-interest, as in contemporary secular ethics. The Israelites are not asked first of all to be a rule-abiding people or a successful example of social cooperation, but a people engaged in life with God; the commands laid out for this people indicate the boundaries for action that arise naturally from a more

[97] Hauerwas, *The Peaceable Kingdom*, 23-24.

substantive notion of who God is in relationship to them. The danger is that, in codifying the law, the law itself comes to stand for morality. As MacIntyre points out, "When teleology, whether Aristotelian or Christian, is abandoned, there is always a tendency to substitute for it some version of Stoicism. The virtues are now not to be practiced for the sake of some good other, or more, than the practice of the virtues itself."[98] I have said that human virtues are only intrinsically valuable because they take on the character of the final good or, rather, because the one exercising them conforms to this character. When virtue is performed entirely for the sake of conforming to a mean, when rules are followed for the sake of obedience, or when principles are upheld in abstraction from their underlying value commitments, the final good is either misrepresented or forgotten.

Ethics, to paraphrase Hauerwas, does not begin with abstract questions such as "Should I or should I not steal to feed my family?" but with an existing vision of the good life that informs the way one considers the moral status of a particular action.[99] Hauerwas calls attention to the fact that there is a history that accounts for why a particular action is described as something to be wary of, something that tends to go against the good. The essence of such a description cannot fully be captured in a summary prohibition or moral categorization abstracted from this context. This does not necessarily deny the need for a *prima facie* prohibition on such actions in Christian ethics; nor does it limit the prohibition to a mere cautionary measure. It does, however, affirm that in understanding how to act well in a situation in which one is tempted to steal, one will necessarily read this norm in light of the tradition that formed it and that shapes the interpretation of the circumstances that bring it into focus. It also allows for the idea that, for the most part, the conditions that make such judgements normative in light of the good are not universal or unchanging. Whereas the good remains constant in nature, no evil is ever really self-sufficiently evil but understood to be so based on an understanding of the good.

The failing of formalism, then, is in its inability to provide substance to the moral life and in the tyranny that results when it is taken as self-justifying. Rules on their own are capable of directing the agent to avoid evil and imposing certain basic obligations, but they cannot establish *how* to pursue the good. This is affirmed by the Catholic distinction

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[98] MacIntyre, *After Virtue*, 233.
[99] Hauerwas, *The Peaceable Kingdom*, 21.

in obligation that exists between prohibitive laws, which are forever and in every situation binding, and affirmative laws, which stand without requiring the agent to carry out the law at every moment.[100] The nature of moral reality means that it is much easier for lawmakers to anticipate how to aid people in avoiding bad behaviour than how to direct them in doing something positive. Universalizable principles are important because they commit the agent to a faithful pursuit of the ethical aim, one shared in common with a community of people who should be enabled to do the same. But what is required to found this community and to enact positive good is an antecedent orientation toward that good and, as I will go on to show, a respect for changing circumstances. In light of this, my own ethical approach considers rules as tests of validity for the ethical aim. The ethical aim itself determines their form, but they in turn strain out the illusions that can arise in continued interpretations of it. Norms are not justified on their own apart from the vision of the good life.

1.2.4 Recourse to the Ethical Aim

If ethics is prior to morality, that is, if moral norms are derived from the ethical aim and only then assist in deliberation, then avoiding an "epistemological crisis" requires a third move of ethics. This balances the limits and possibilities of ethical action and also keeps the ethical aim at the forefront of dilemmas and moral confusion.

Practical wisdom restores the focus on character development that a strictly procedural notion of morality would eschew.[101] I have said that this kind of wisdom makes one capable of judging what is valuable in itself apart from subjective preferences,[102] ordering goods in relation to the highest good, and determining what is the fitting action in a particular situation. Consequently, practical wisdom enables the agent to identify when a certain rule should be engaged, but it also perceives when rules cannot restore the right to a situation or do not respond adequately to the goods at stake.

Moral dilemmas can be heightened by the apodictic status given to norms. For this reason, people generally avoid a strict adherence to a rule when such obedience would not appear virtuous because it either goes directly against another norm or contravenes the

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[100] Victor Cathrein, "Law," in *The Catholic Encyclopedia*, vol. 9 (New York: Robert Appleton Company, 1910), 56.
[101] On character see Aquinas, *Summa Theologica*, I-II, q.57 a.4.
[102] On prudence belonging to the dominion of knowledge rather than that of appetites see ibid., II-II, q.47 a.1.

vision of the good life set out from the start. In response to this, the school of utilitarianism has risen to prominence alongside social contract theory. The mistake of this school is in attempting to resolve moral discomfort by substituting for both aim and norms the objective of maximizing pleasures and preferences (or minimizing miseries and harms) that need not be virtuous or coherent. Of course, in tragic situations that offer no good options for action this strategy is fruitless. But even in situations that are not necessarily tragic, moral clarity requires one to bring the moral norm into dialogue with the ethical aim, determining which values conflict and why they do so. According to Ricœur's ethical theory, if in this discourse these two movements finally arrive at incompatible conclusions, it is the ethical aim that takes primacy. Any qualifications of what are considered conventional moral norms are derived from this process and endeavour to restore the assertions of value coming from the founding narrative.

This being the case, the conviction of my ethical theory is an optimistic one: human moral agency is innovative and generally capable of matching fitting action with the opportunities and challenges that arise in particular situations. The theory is also one that, with Ricœur, champions the role of Aristotelian prudence or practical wisdom in being sensitive to the complexity of circumstance and values deliberation not only as response to particular quandaries but also as character development and preparation for future responses.[103] (This does not contradict my earlier assertion that ethical strategies are sometimes necessarily dissatisfying in the face of tragedy.) This third movement, then, is not a capitulation to situationism or a denial of moral obligation as a significant movement. Against the notion that a determination of the fitting is not a consequentialist means-end judgement, Aristotle indicates:

> For the principles of things achievable in action are their goal, but if someone is corrupted because of pleasure or pain, no appropriate principle can appear to him, and it cannot appear that this is the right goal and cause of all his choice and action; for vice corrupts the principle. And so prudence must be a state grasping the truth, involving reason, and concerned with action about human goods.[104]

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[103] Cf. Hauerwas, *Vision and Virtue*, 49. Also see Aristotle, *Nicomachean Ethics*, 6.12.1143b28-33 on how prudence makes people good.
[104] Aristotle, *Nicomachean Ethics*, 6.5.1140b17-22; cf. 6.12.1144a31-1144b2.

Alone, the kind of capacity that makes one skilled at determining the best means to the end in sight Aristotle calls "cleverness."[105] This in itself is not adequate as a virtue, but it is indeed an ingredient of prudence. Aquinas also refers to cleverness in his discussion of "false," "true," and "perfect" prudence. False prudence includes cleverness, but its falsity is indicated by an end that is evil, although the agent might incorrectly perceive it as good.[106] In this way, euthanasists might be very "good" at their job, although, as I have said already, this kind of good is not properly a moral good—not even an instrumental one. For those who understand the nature of goodness as Aquinas does, this kind of skill is evil because it offends the nature of the good. True prudence, on the other hand, understands what kinds of ends really are good and acts toward them using skilful means, such as administering pain relief in an expert and proportionate way.[107] However, not all forms of true prudence are perfect. The prudent administration of pain relief is not a final end, though it might constitute a good action. Perfect practical wisdom takes into account the whole of human life; it judges the final end rightly and aims actions toward it. Again, there is here a reinforcement of the understanding that for something to have intrinsic value, it requires having a shared character with the final good.

In contrast with cleverness, practical wisdom is certainly not inspired by a desire to get around a moral law that articulates an authentic interpretation of the ethical aim for the situation. It indicates good will on the part of the agent to deliberate over a perceived conflict between the aim and the norms that typically represent it. Ricœur expresses this as the distinction between the "sense" of virtue and the rules of virtue.[108] Christians consider it the distinction between the spirit of the law and the letter of the law. In those cases in which love of the good and respect for the right conflict, prudence assists agents in establishing what the ethics of their narrative context indicates. The example Ricœur provides of prudence in action is an Aristotelian one. In his paragraph on equity (*epieikēs*, sometimes translated as decency or even goodness), Aristotle outlines the conceptual problem: justice and equity are not unrelated but, if they are taken to be so, they can

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[105] Ibid., 6.12.1144a25-37.
[106] Aquinas, *Summa Theologica*, II-II, q.47 a.13.
[107] Ibid., I-II, q.57 a.4.
[108] See Ricœur, *Oneself as Another*, 227-39 and Aquinas, *Summa Theologica*, I-II, q.100 a.8.

appear to come into conflict.[109] For instance, in the realm of distributive justice, to be equitable is often not the same thing as promoting exact numeric equality—that kind of legal justice that began with "an eye for an eye" and admits of universalization. Equity aims at restoring an equal *relationship* by distributing shares in amounts that are different but proportionate to the respective needs of the parties. The fact that equity does not conform to the arithmetic equality of portions does not make it unjust. For the ethical agent, equity surfaces in those circumstances for which a strict equality of shares is inadequate to realizing the good in the situation—when it does not conform to the intended scope of justice, or the sense of justice Aristotle thinks is common to human nature. When one recognizes that this strategy does not achieve equality between individuals because of a prior inequality existing between them, equity recognizes the deficiency in the rule and attempts to compensate for it.[110] The accidental circumstances of the situation do not make the rule of numeric equality forever invalid, although it is recognized that equity is closer to the aim of the virtuous one.[111] So, it is not devotion to justice that is in error, but devotion to absolute rules of justice: "Then it is correct to rectify the deficiency; this is what the legislator would have said himself if he had been present there, and what he would have prescribed, had he known, in his legislation."[112] Truly, then, rules tend to apply, all other things being equal, but the inequalities of a situation prompt the ethical agent to adapt rules—not the ethical aim—to the situation.

Another example Ricœur provides, one that pertains to bioethics, is the idea of truth telling. This illustration also reveals what Ricœur means by arguing that practical wisdom aims to satisfy the ethical aim and, if it is necessary to break a rule, to break the rule to the smallest degree necessary.[113] The clinical relationship between medical practitioner and patient presents some ambiguities for carrying out the norm of truth telling when the practitioner believes the patient is imminently dying. Certainly telling the truth is the kind of behaviour accepted as valid by most ethicists, and Kant is famous

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[109] Aristotle, *Nicomachean Ethics*, 5.10.1137a32-1138a3.
[110] Ibid., 5.3.1131a30-33 and Ricœur, *Oneself as Another*, 201-02 and 262.
[111] Aristotle, *Nicomachean Ethics*, 5.10.1137b10; cf. Aquinas, *Summa Theologica*, II-II, q.120 a.1.
[112] Aristotle, *Nicomachean Ethics*, 5.10.1137b22-24.
[113] Ricœur, *Oneself as Another*, 269.

for considering it a perfect duty.[114] Compounding this are the effects of medicine's chequered past when it comes to disclosure. The paternalistic attitude of physicians in previous days has been restrained by the principle of respect for patient autonomy,[115] which, when interpreted in a balanced way to allow patients interest in and responsibility for their own health, has merit. To be sure, one should not be denied access to one's own medical diagnosis and prognosis. On the other hand, the kinds of truths that practitioners are sometimes called upon to speak are not easy ones to hear. As Ricœur says, the additional factor to consider here is the capacity of the dying patient to receive the truth.[116] Moreover, patient autonomy does not necessarily require the patient to bear the burden of ultimate responsibility in decision making. It would seem that telling the truth indiscriminately, perhaps without sensitivity to the personality and predispositions of the patient, would violate the bioethical principle of beneficence, which is also an indication that such an act does not fulfill the intention behind truth telling, but only conforms to a literal fulfillment of the rule. Opposing this option, and perhaps appearing to uphold beneficence, would be the withholding of the truth for fear that the patient might suffer too greatly with this news. To this end, exceptions to the disclosure directive have been observed in Canadian law.[117] But although the eradication of suffering is a mandate in contemporary secular bioethics, religious narratives tend not to be so prohibitive. Christian concepts of the human being are insightful enough to see that a degree of meaning and value can be found in certain experiences people find painful. So, however important the eradication of unwanted or excess suffering remains, this stands alongside the conviction that beneficence is not always to be strictly equated with the prevention or removal of suffering. (This is why the OEMD omits *unreasonable* or *disproportionate* burden, not burden *per se*.) As it is part of the nature of human beings to be vulnerable and even to suffer, Ricœur points out that suffering does not always contradict happiness or *eudaimonia*. It would seem that establishing a rule about lying to terminal patients is an inadequate response as well; in conformity with the idea that necessary transgressions

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[114] Kant, "On a Supposed Right to Lie Because of Philanthropic Concerns," in *Grounding for the Metaphysics of Morals*, 63-68.
[115] See Tom L. Beauchamp, "The 'Four Principles' Approach," in *Principles of Health Care Ethics*, ed. Raanan Gillon (New York: John Wiley & Sons, 1994), 3-12.
[116] Ricœur, *Oneself as Another*, 269.
[117] *Hopp v. Lepp*, [1980] 2 S.C.R. 192; and *Reibl v. Hughes*, [1980] 2 S.C.R. 895.

should transgress the law as little as possible, Ricœur affirms, "Never can practical wisdom consent to transforming into a rule the exception to the rule."[118]

But the complexity of the moral situation does not admit of only two possibilities for action. The dangers associated with truth telling might be alleviated given the right conditions; it is sometimes possible to nurture a relationship with patients such that they feel they have a safe environment in which to receive this news. If this is not possible, and the practitioner and the patient's family sense that the truth of the medical prognosis would be overly burdensome for the patient, then one might take Jewish bioethicist Benjamin Freedman's line of reasoning and say that truth is something that should always be offered to, but not imposed on, patients.[119] In considering the moral validity of patient responses to the truth of their medical conditions I am not dealing, strictly speaking, with a relativistic analysis. The concern of the physician in this case is not with avoiding an awkward scene, nor is action motivated by any other reason that would betray some preoccupation with something aside from the authentic ends of medicine. The question to ask, then, when one considers the validity of a rule is, "What is obeying this rule supposed to accomplish?" The truth is valuable, but this is because in a typical situation it promotes trust between people and frees up individuals to act intelligently based on an accurate understanding of their circumstances. When the value of truth telling would not be achieved in a particular instance of telling the truth (and here that value might even be threatened by the act), one falls into empty formalism again. Devotion to exposing the literal truth, rather than to the good life made possible by truth, becomes the justification for the action. But the morally relevant factor at stake, threatening a divide between aim and norm, is the patient's inability to cope with the news. The practitioner will only know the best way to proceed given both the particulars of the situation—the patient's level of coping—and the trajectory of ethical action—a "good" death. This approach, then, is something like the casuistry adopted by the manualists, but it takes into account a scope for action that is not limited to articulating what is obligatory and what is forbidden. Having access to the ethical aim and keeping it at the forefront at all times, practical

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[118] Ricœur, *Oneself as Another*, 269.

[119] Benjamin Freedman, "Offering the Truth: One Ethical Approach to the Uninformed Cancer Patient," *Archives of Internal Medicine* 153, no. 5 (1993): 572-76. It is important, then, for medical practitioners to gain an understanding of a patient's capacity to receive such truth prior to the point in time at which they have bad news about the patient's diagnosis or prognosis.

wisdom allows one to see actions that extend to the excellence in virtue that is inspired by the good and not only limited by prohibitions.

With this in mind, Ricœur outlines three features that define prudence.[120] The first is loyalty to a foundational idea that can be expressed as a narrative identity, or the tradition of moral stories of which one is a part.[121] The defining factor here is that, whatever the means called for in particular circumstances, the means always express the character of the ethical aim. This requires that the consistency of typical practices and activities with ethical foundations be continually evaluated. Second, prudence, in keeping with Aristotle, also pursues the golden mean. Ricœur is careful to distinguish this mean from compromise, citing the idea that when it comes to what is best, the mean represents an extreme.[122] Since the mean actually refers to what is most appropriate in the situation, the virtuous response avoids both deficiency—as in skirting the truth and thereby avoiding authentic relationship—and excess—telling the truth in a manner that upsets the patient to the extent of precluding a peaceful conclusion to life.

Aristotle sets out the golden mean as characteristic of the strategy of virtuous activity rather than delineating a list of rules for action because he understands that matching a virtue to a situation is an "adaptive strategy."[123] As indicated by the famous Aristotelian practical syllogism, prudence takes two factors into consideration: the major and minor premises. The former relates to the considered universal good end (*eudaimonia* and the virtues necessary for reaching it) and the latter to the perception of the particular or accidental features of a situation.[124] Prudence is able to reach a conclusion on the syllogism first by avoiding error in formulating the two premises, and then by determining how to actualize virtue according to them both. This necessarily requires remaining faithful to the content of the major premise and being effective in responding to the peculiarity of the minor premise. So, both perceiving the golden mean and being virtuous entail a certain amount of adaptation without fundamental reorientation. It will be of particular importance to remember this in the later discussion of Hans Jonas and his

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[120] Ricœur, *Oneself as Another*, 273.
[121] In particular, Ricœur speaks of this as loyalty to the principle of respect for persons, which adheres with the character of his own narrative ethics concerned with solicitude of persons.
[122] Cf. Aristotle, *Nicomachean Ethics*, 2.6.1107a6-7.
[123] This term is adopted from Nick Haslam, "Prudence: Aristotelian Perspectives on Practical Wisdom," *Journal for the Theory of Social Behaviour* 21, no. 2 (1991): 153.
[124] Aristotle, *Nicomachean Ethics*, 6.11.1143a 33-1143b10.

perception of an age of pervasive technology, at which point it will be argued that a significant change has taken place in the context for ethical action. The narrative has remained constant in its trajectory, but the latest chapter of the story has introduced circumstances that undermine the typical efforts of Christian ethicists to pursue the human *telos*. An ethical response to this change calls for a certain adaptation of the rules that have so far served to organize the pursuit of value. What is required first, of course, is an accurate assessment of the ethical aim and foundational commitments that derive from it, including an understanding of human nature and value.

The third feature of prudence, according to Ricœur, is the avoidance of arbitrariness by taking account of opinions espoused by other virtuous people. Practical wisdom, then, is not a solitary effort. Indeed, the importance of community tradition and narrative approach is seen in the need for counsel. Certainly, there is nothing near a unanimous affirmation of the morally ordinary status of ANH in cases of PVS, as mandated by the Catholic magisterium and echoed by certain Protestant voices. There appears to be a deep lack of consideration of community perspectives in the moral conclusion. It is for this reason that my ethical examination will continue to consider the insights of the Aristotelian-Thomistic voice in Catholic theology and those of scriptural theology in Protestant ethics. Further, as indicated earlier, my descriptive work will bear in mind those insights of the larger Christian bioethical tradition, along with ones stemming from other areas of applied ethics that might be recessive or absent in Christian bioethics and yet that recognize additional features of the problem in view. When Christian ethics applied to medicine does not take into account the broader narrative with its concomitant foundational considerations—considerations that arise in the area of environmental ethics, for example—or when it refuses to recognize changes in the context of action—such as those Jonas observes with the influence of modern technology—what results, in my judgment, is a conclusion that is not reflective of its own story. With this in mind, my task in the following chapter will be to outline the foundational features of Christian anthropology—some emphasized in bioethics and others often neglected—that deserve further reflection in light of the problems posed to medicine in this age of pervasive technology.

Chapter 2
Anthropology in Christian Bioethics: Approaching a Proper Valuation of Human Nature and Human Ends

Theological anthropology is the study of the human being as created by and related to God. Acting well and developing virtuous practices such as medicine depend on what is first understood about being human. The purpose of this chapter is to provide such an account that is, in the first place, directed to factors particularly salient to this bioethical project and, in the second place, responsive to the varieties of consideration pertaining to anthropology that are influential in Catholic medical moral theology and Protestant bioethics. I confine this effort to examinations of human ontology, including the nature of and relationship between the body and soul; human value, including varieties of human dignity; and human ends, both natural and spiritual. In short, I aim to ground the following assertions of Christian anthropology as preparatory steps for subsequent analyses of the role of medical technology and the ends of medicine in Christian bioethics. According to Christian anthropology, human nature is the same for all living human beings. That is, all humans are made up of a formative element, the soul, and a receptive and participatory element, the body. Likewise, human dignity, or God's declaration of the special value of human beings, is intrinsic to and present in each individual. Furthermore, humans are not ahistoric but act to achieve the ends proper to them. Realizing such ends requires the integrated functioning of the body and the soul. However, the working relationship between them can sometimes be unavoidably impeded by the ill health of the body.

In choosing to concentrate on these particular assertions I do not intend to alter Christian tradition in any fundamental way. Rather, this work entails a re-emphasis of certain elements in this tradition that the current technological situation leads ethicists to play down or deny altogether. With this in mind, the aim here is not to capitulate to a technological imperative but to sustain Christian anthropology against those influences of technology that would promote inappropriate visions of the human being, human living, and human dying. Articulating anthropology is both a consistent and an ongoing enterprise. Its vitality is the result of its being shaped through the progressive narrative of life in which new situations and complications arise. Christian anthropology, then, is

significant not as a static doctrine but as a dynamic expression of the human. Although foundational anthropological principles, such as intrinsic human dignity, continue to stand, they are amended over time in ways that do not overturn them but rather refine and sharpen their articulation. In concurrence with the discussion of practical wisdom in the previous chapter, encountering novel circumstances that seem out of line with the ethical aim leads the virtuous agent not to redirect that aim, but to make it more precise in its direction. This is one reason why experience through time is so important for the ethical agent. Additionally, anthropology becomes more precise and robust in its articulation as it responds to those other ways of perceiving the human being, including scientific ways, and provides rejoinders to the conflicting accounts that surface from time to time.

It has been said, however, that it is easier to recognize evil than it is to express the good. Ricœur points out that justice is a difficult concept to define in the abstract, yet every child knows when something is not fair.[1] I take this as applicable to other aspects of knowing what is normative for human life. It is often easier to recognize something unfitting for the human—sometimes mediated to the consciousness through the "yuk factor"[2]—than it is to offer a positive portrayal of what is fitting. Indeed, conveying the latter in a detailed and precise way is sometimes only possible after considering potential deviations from what is fitting. The anthropological account presented in this chapter is made in anticipation of some of the challenges that modern medical technology poses to it, especially the introduction of the PVS as a medical possibility.

My effort is a limited one. Many important aspects of a theological anthropology, including soteriology, for instance, will, for the most part, be set aside. An account of the nature of human power and human responsibility will be bracketed and returned to when technology is later addressed. Other descriptive work, including outlining specific human capacities (those unique to humans and those shared with other living creatures) will be restricted to basic considerations of autonomic functions, consciousness, reason, and relationship, things vital for discussions of human actualization.

The problematic that this chapter centres on is particularly critical for Christian bioethics today: there is tension between the value of the human being as good in himself

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[1] Ricœur, *The Just*, x.
[2] This term is discussed in Mary Midgley, "Biotechnology and the Yuk Factor," in *The Essential Mary Midgley*, ed. David Midgley (New York: Routledge, 2005): 269-80.

or herself, on the one hand, and the importance of an individual's pursuit of certain ends, on the other. In examining this tension I am compelled to affirm not only the intrinsic human value that obtains regardless of medical condition, but also—and this is the more neglected affirmation—the intimate link between human ontology and a calling toward particularly human activities. The possibility for apparent conflict between human value and human ends is raised by new technological capacities for sustaining life. The conflict is especially evident when life-preserving acts done out of respect for the intrinsic dignity of a patient do nothing to counter a patient's powerlessness to engage in particularly human activities or those beyond the physiological level.

A requisite understanding here is that the expression "particularly human activities" does not distinguish, for instance, those that indicate genius from those that indicate mediocrity. Rather, it is used to point to activities that directly comprise properly human ends, often depicted relationally.[3] This is to say that an individual cannot finally be comprehended in a strictly discrete or isolated way because to do so unduly impoverishes the Christian concept of the human. Instead, individuals are identified in terms of their being situated and related beings. As bioethics, in its focus on human health, can sometimes inappropriately narrow its reflection on the human being by abstracting the individual from the community, the following discussion will call attention to the importance of relationship for Christian bioethics in particular. There is, certainly, value in the properly ordered relationship internal to the human being, the one that exists between the body and soul. But there are greater goods, I argue, to be found in properly ordered relationships between people. Furthermore, in the context of Christian ethics, at the core of the human being is the relationship between humans and God.

One implication of this chapter is that the Christian reasons for withdrawing treatment from a PVS patient must originate in a conception of the human being that is significantly different from that held by many in the contemporary secular bioethical context, the kind of context that increasingly grants legitimacy to euthanasia and assisted suicide. It is confusion at the level of anthropology that allows the Christian bioethicist's line of reasoning to coincide with that of the secular bioethicist. In order to explicate the distinctiveness of the anthropology that provides Christian bioethics with its coherence, I

[3] "Human acts" is a Thomistic notion and is further outlined below.

reference biblical texts that are often quoted in anthropological investigations, although I do not pretend expertise in scriptural exegesis. Also, I consult Catholic sources of authority, including those that represent magisterial positions and those that are unofficial or disseminated by independent Catholic theologians. Finally, I refer to statements by Protestant denominations and theologians at various levels of authority.

2.1 Human Ontology

> The ontological problem at hand is defining, as Jonas puts it, a
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> concept of the *human being* that informs us what the human *Good* is, what human beings should be, what we are all about, and what is advantageous for us—which at the same time involves what we must *not* be, what diminishes and distorts us…. The dangers are new, but the Good is old.[4]

Appreciating the continuity between human nature and activity requires a foray into the makeup of the human being that arouses and enables human ends. A significant part of this discussion is centred on the constitutive elements of the human—the body and soul in unity. Although the articulations and opinions of Christian theological anthropology that have surfaced differ widely, leading to various interpretations of dualism and nondualism, It is critical today to hold the following features together: the goodness of human bodily life (and, concomitantly, of all natural life), the distinctiveness of the human soul in the natural world, and the unity of the human being produced by the relation of soul and body as form and matter. I address these not to present an entirely static interpretation of the human but to identify what is enduring about human nature.

Some word of explanation must first be given with regard to why the expression of human capacities or traits is not more foundational than the unity of human body and human soul in identifying a being as human. This explanation is given with respect to the view of beings as having intrinsic or natural teleology. I have already pointed out that, for Aristotle, the ultimate end of a being is given in its nature. The Aristotelian-Thomistic perspective holds that human ends contribute to the shape of the narrative of human life and are found within the metanarrative of the relationship between God and creation. Going deeper into the relationship between nature and end, Aristotle makes the

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[4] Hans Jonas, *Mortality and Morality: A Search for the Good after Auschwitz*, ed. Lawrence Vogel (Evanston: Northwestern University Press, 1996), 104. Emphases in original.

distinction between actuality (*energeia*) and potency or capacity (*dynamis*).[5] Actualization and potential relate to what is real and what is possible for a being, respectively. Aristotle prioritizes the former over the latter, claiming actuality as the beginning and end of potency. Actualization is both foundation and fulfillment (*entelecheia*). Faculties are only recognized as such based on a prior understanding of what *is*. As he puts it, "it is not that animals see in order that they may have sight but they have sight so that they may see."[6] What one will be able to do depends fundamentally on the kind of being one is, whether a human being, which is a seeing being, or an Olm salamander, which is not a seeing being. In the Catholic tradition, this establishes the ground for natural (as opposed to moral) good and evil.[7]

Faculties, in turn, are oriented in their expression toward the actualization or flourishing of the being to which they belong, so the kind of acts and flourishing that result are particular to the kind of being one is.[8] Put differently, the soul is the act of the body and the body expresses the soul's act. Aristotle puts this in terms of there being various kinds of souls, forms, or life principles, which are different for different classifications of beings according to what constitutes them primarily or essentially.[9] In brief, human beings, having a rational soul, are most fully themselves when acting rationally.[10] (More specifically, the human has a tripartite soul bearing the rational level or part.) Built into human nature is the capacity for both theoretical and practical wisdom.[11] The rational soul makes one capable, among other things, of sophisticated deliberation and the willed ordering of complex desires. A nonhuman animal, having a sensitive soul, is not capable of these things—certainly not to the same extent—but what is essential to it is that it can react to sensory experience. The plant, having only a nutritive soul, is limited to internal regulation of its system and the powers of nourishment, growth, and reproduction. These sets of primary capacities indeed represent

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[5] Aristotle, *Metaphysics*, trans. W. D. Ross (Australia: University of Adelaide, 2007), 9.8.1050a1-17.
[6] Ibid., 9.8.1050a10-11.
[7] Natural evil, for instance, pertains to an accidental inability to actualize a potential that naturally belongs to one. Human blindness would be a natural evil. As I indicate below, although natural evils are nonmoral evils, Christians generally consider people to have a moral obligation to reduce such evils as far as is reasonably possible.
[8] Cf. Aquinas, *Summa Theologica*, I, q.76 a.3.
[9] Aristotle, *De Anima*, trans. R. D. Hicks (New York: Prometheus Books, 1991), 2.2.413a-2.3.415a.
[10] Aristotle, *Nicomachean Ethics*, 10.7.1178a1-8. Cf. *De Anima*, 2.3.414b18.
[11] Aristotle, *Metaphysics*, 1.1.980a21 and *Nicomachean Ethics*, 6.8.1143a35-b5.

a *chain* of being. For instance, Aristotle considers vegetative or nutritive functioning the most common capacity of the soul. It is in virtue of this that something has life.[12] So, the rational soul does not exclude the sensitive and nutritive capacities or parts but is largely predicated on them and able to use them in ways beyond those of an animal or plant.[13] Of course, Aristotle does consider human beings capable of a kind of activity whose operation transcends the nutritive and sensory faculties. But although he makes room for the "agent intellect,"[14] which takes knowledge as intelligible in abstraction from matter, engaging in this activity is something that is only possible for the human who first achieves nutritive actualization. This being the case, human actualization is, to some degree, contingent on the capacities shared with other forms of life.

Recovery of the tripartite soul—that is, the human soul bearing nutritive, sensitive, and rational parts—is one way of reinforcing the relationship humans have with the rest of the natural world as it complements the idea of the goodness of all creation. However, despite Aquinas' engagement of it, the tripartite soul is somewhat neglected by contemporary Christian theologians and virtually absent in Protestant discourse, which tends to consider the soul not as the act or life principle of any living body but as a substance that is both unique to humans as a species and in some way responsible for the individuation of human beings.[15] Actually, there is no observable consistency in how the soul is regarded by Protestants, despite attempts to base anthropology on biblical terminology. The identity of the soul is often further confused by various renderings of its relationship to (or its identity with) a "spirit" that is also given with or to human nature.[16] Those Protestant theologians who argue for the spirit as a constitutive element in addition

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[12] Aristotle, *De Anima***,** 2.4.415a24-25.
[13] Cf. Aquinas, *Summa Theologica*, I, q.76 a.3.
[14] Aristotle, *De Anima*, 3.5.
[15] This may be more a credit to Descartes' mechanical view of nature than to Christian scriptures or theology. See René Descartes, "Discourse on Method; Letter to Henry More, 5 February 1649," in *Animal Rights and Human Obligations,* 2nd ed., ed. Tom Regan and Peter Singer (Engelwood Cliffs: Prentice Hall, 1989), 13-19. For a rare example of Protestant consideration of the tripartite soul, see Advisory Council on Church and Society of the Presbyterian Church, *The Covenant of Life and the Caring Community, and Covenant and Creation: Theological Reflections on Contraception and Abortion* (New York: Office of the General Assembly, 1983), 40. For an extended philosophical recovery of the tripartite soul see Hans Jonas, *The Phenomenon of Life: Toward a Philosophical Biology* (Evanston: Northwestern University Press, 1966).
[16]Trichotomism, or the contemporaneous existence of the body, soul, and spirit in the individual, was rejected at the Fourth Council of Constantinople in 869-70. See Karl Barth, who refutes this kind of anthropology, in *Church Dogmatics*, III:2, ed. G. W. Bromily and T. F. Torrance (London: T & T Clark International, 2004), 355-56.

to the soul and body often appeal to certain Pauline texts.[17] Generally, however, theological anthropology is an underdeveloped area of Protestant theology.[18] It is not a concern of this thesis to deliberate about the relationship of soul to spirit. But, undoubtedly, the lack of a shared anthropological foundation adds to the disorder of Protestant responses to PVS, a bioethical problem that, in turn, points to the need for an explanation of human nature that is basically coherent. The view of the soul as tripartite, though not embraced by all Christian theologians, has the advantage of avoiding any strict humanity/natural world dichotomy. It aligns with the biblical creation story, which indicates that human beings, however distinct, are embedded in relationship with other life forms by the creative acts of God.

Identifying the capacities of souls indicates relationships between species, and it also distinguishes categories or classifications of species. What others write off as speciesism Christians call perceiving the distinctiveness of particular "natural kinds," a term that Sulmasy defines as "a category of entities, all the members of which, by virtue of being brought under the extension of the kind, can be *necessarily* known to be that sort of thing."[19] Although it might well be impossible to provide an unassailable argument for the concept of natural kinds, Sulmasy defends the essentialist notion by attacking its alternative, a "completely undifferentiated" reality: "It seems bizarre to suggest that there really are no actual kinds of things in the world independent of human classification—no such things, *de re*, as stars, slugs, or human beings."[20] In the Christian perspective, categories of natural kinds are determined by something beyond human powers. This something other is, of course, God, who is considered pure act. That is, God already fully actualizes God's form. There is nothing merely potential about God.[21] This is important to highlight since it must be understood that human actualization, as I use the term, will

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[17] See especially 1 Thessalonians 5:23.
[18] See, for instance, Jeffrey H. Boyd's interesting study of this lack amongst Evangelical theologians in particular. "The Soul as Seen through Evangelical Eyes, Part II: On the Use of the Term 'Soul,'" *Journal of Psychology and Theology* 23, no. 3 (1995): 161-70.
[19] Sulmasy, "Dignity and the Human as a Natural Kind," 76.
[20] Daniel P. Sulmasy, "Dignity and Bioethics: History, Theory, and Selected Applications," in *Human Dignity and Bioethics: Essays Commissioned by the President's Council on Bioethics*, ed. President's Council on Bioethics (Washington, D.C., President's Council on Bioethics: 2008), 477. Against the charge of speciesism, Sulmasy notes that if there were other natural kinds also exhibiting properly human characteristics, such as angels or an alien species, they too would have intrinsic dignity.
[21] Aquinas, *Summa Theologica*, I, q.77 a.1.

not entail full or complete actualization. Only God can be fully actualized, although humans ought to strive toward actualization. Furthermore, as prior to creation, God is the prime mover on which everything else depends, and so every potentiality comes from a preceding actuality, reaffirming actuality as prior to potentiality or capacity.[22]

Aquinas follows Aristotle in insisting that identifying a particular being as a certain kind of being is not done primarily with reference to its *demonstrated* faculties: "in the angel to understand is not the same as to exist, nor is any operation in him, nor in any other created thing, the same as his existence. Hence the angel's essence is not his power of intelligence: nor is the essence of any creature its power of operation."[23] Christian ethicists generally refuse to ascertain human identity based on the faculties individuals express because, although there certainly are species-typical capacities, these can sometimes be restricted by "luck," or factors that are accidental rather than essential. A lack of education, for example, can prevent intellectual or ethical actualization. A lack of health can thwart actualization at the physiological level or the level of the living being. In admitting this, it should not be assumed that ill health always impedes actualization, be it intellectual, ethical, aesthetic, or otherwise. Aristotle has great respect for the ability of human beings to overcome unlucky obstacles through their cultivated virtues.[24] However, he also allows that such obstacles can make it difficult or, in the most extreme cases, even impossible to flourish.[25] So, Aquinas observes, "what has a soul is not always actual with respect to its vital operations."[26] This being said, the only way a being can lose its nature is if it is transformed into something entirely different.[27] So, whether individuals demonstrate reason or not, and even if their accidental situation leaves them with no *possibility* for expressing reason, they are by virtue of their natural kind human beings with rational souls.

Christian ethics contends that human nature, and not merely certain instances of that nature, deserves to be honoured. It is, therefore, important to stand in solidarity with the vulnerable. Not only this, but it is incumbent on those who are able to do whatever is

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[22] Aristotle, *Metaphysics*, 9.8.1050a 23-29; Aquinas, *Summa Theologica*, I, q.2 a.3 and q.3 a.4.
[23] Aquinas, *Summa Theologica*, I, q.54 a.3.
[24] Aristotle, *Nicomachean Ethics*, 1.9.
[25] Ibid., 1.8.1099b33-35 and 7.12.1153b17-19.
[26] Aquinas, *Summa Theologica*, I, q.77 a.1.
[27] Daniel P. Sulmasy, "Death, Dignity, and the Theory of Value," *Ethical Perspectives* 9, nos. 2-3 (2002): 113.

reasonably in their power to improve the circumstances, or the quality of life, of the vulnerable such that the latter might be put in a better position for self-actualization.[28] Later (see 5.1) I will argue that this duty is the proper moral foundation for the practice of medicine, an effort that can be made illegitimate if it attempts instead to improve upon human nature itself. That is to say, the role of medicine has no mandate to alter the given form and function of the human being. It is charged, rather, with facilitating flourishing at the physiological level and relieving the suffering that comes with a lack of physiological flourishing. This is done not merely for the sake of an excellent physique but ultimately so that patients might be better enabled to pursue particularly human activities.[29] This limits medicine at the frontiers of innovation and experimentation by curtailing transhumanist projects. It also limits medicine in its daily practice, restricting it to cases that allow it to bring comfort to the vulnerable or bridge the gap that ill health creates between the act of the body, the soul, and its expression through the body.

However, if pursued philosophically, the stance on the protection of the vulnerable becomes axiomatic. A philosophical explication is not wrong or unhelpful, but the ethical position can be more thoroughly justified in the Christian context. Such a justification comes in terms of a history of community relations and the moral ethos that arises from it. Many human communities have learned that there is a unique bond that can arise among members of the human species, regardless of how the capacities of these members differ in their demonstration.[30] For the Christian community, the recognition of the uniqueness of human relationships begins with the second biblical creation story in which Adam, the sole human, is in the presence of God and surrounded by the other created animals. Yet he finds himself to be alone. God declares that this is "not good" and is compelled to create a second human, Eve.[31] The bond unique to humans continues to be affirmed in contemporary experience. For instance, even those with a friend or relative in a PVS who recognize the appropriateness of allowing the patient's death have difficulty letting go of their loved one. Much of this difficulty stems from the fact that the

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[28] See Sulmasy on "inflorescent dignity" in "Dignity and Bioethics: History, Theory, and Selected Applications," 483-84. On quality of life see Louis Janssens, "Ontic Evil and Moral Evil," *Louvain Studies* 4 (1972), esp. 149-50.

[29] The role of medicine as pertaining directly to the physical wellbeing of patients and as indirectly related to the wellbeing of patients in a broader sense will be addressed in greater detail in chapter five.

[30] Aristotle's affirmation of this is found in *Nicomachean Ethics*, 8.1.1144a20-23.

[31] Genesis 2:18-23.

two have been in relationship with each other. The relationship is no longer a mutually active one in any practical sense, but some kind of recognition of the patient as friend, spouse, parent, or child remains. One might also attribute this recognition as one reason why it is difficult even to let go of those who are newly deceased.

More specific to the Christian context, a history of particular struggles and forms of oppression provides another reason for affirming some value in vulnerability. Whereas there is no obligation in Christianity to suffer ill health, suffering has often been recognized as effecting atonement. That is to say, suffering in itself is not good, nor should it be encouraged for its own sake.[32] But suffering for the sake of something can be excellent. This idea, which began with the writings of Second Isaiah, was embodied in the hardships faced by the Jewish people and demonstrated later on in the crucifixion of Jesus Christ. Pope John Paul II has explained this by showing that suffering makes an individual susceptible not only to pain and misery but also to power, namely a power of salvation that is not human but Divine.[33] In his Letter to the Romans, Paul also wrote of suffering as a moral experience important for building character, and this is a meaning particularly emphasized in Protestantism.[34] This history leads Christian bioethicists to affirm inclusivity of those who are physiologically vulnerable in their humanity, also recognizing the potential for value in their experiences of suffering. What all this entails, moreover, is that the "common good," though not insignificant, will not customarily be pursued at the expense of the weakest.

As a postscript to this, and in anticipation of the discussion of value (see 2.2), let me note that in speaking of the human being I prefer language that indicates membership in a "natural kind" to the more commonly used "person." "Person" is not a foreign or new term to Christian ethics,[35] and Christian and other religious bioethicists often attempt to

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[32] Pius XII, "The Morality of Pain Prevention," *Catholic Mind* 55 (May-June 1957): 260-78.
[33] See John Paul II, *Salvifici Doloris*, (February 11, 1984), esp. §23, http://www.vatican.va/holy_father/john_paul_ii/apost_letters/documents/hf_jp-ii_apl_11021984_salvifici-doloris_en.html.
[34] Romans 5:3. Cf. David H. Smith, "Suffering, Medicine, and Christian Theology," in *On Moral Medicine: Theological Perspectives in Medical Ethics*, 1st ed., ed. Stephen E. Lammers and Allen Verhey (Grand Rapids: William B. Eerdmans, 1987), 255-61.
[35] Most notably, there is Aquinas, who affirms Boethius' definition of person as an individual substance with a rational nature. *Summa Theologica*, I, q.29 a.1.

assert personhood as a direct equivalent of humanness or the human natural kind.[36] Despite this, the term is not well suited to discourse engaging a secular culture that largely denies intrinsic nature. The difficulty with introducing this term in addition to "human being" is that it allows others to construct too wide a gap between the human categories of physiological life and personhood. Often these categories are differentiated in secular bioethical literature with an eye toward making evaluative distinctions between human beings. The patient who is biologically alive but not biographically alive is not identified as a person, and thus not respected in the same way as other patients. I do think the distinctions between nutritive, sensory, and rational life are important ones for medicine, but not for the purpose of determining if a patient has intrinsic value. Instead, they are distinctions that surface in the consideration of the role medicine will play in a particular patient's situation. Refraining from the language of personhood and confining my terms of identification to human being, human natural kind, or simply human, I offer at this point that any living human remains fully human and retains intrinsic dignity. That notwithstanding, having a kind of nature and value in common does not entail that every patient will require the same kind of care and treatment.[37]

2.1.1 The Constitutive Parts of the Human Being

It is important to make some concrete assertions about the human body and soul because it is often observed that Christian bioethicists become divided on the question of treating the permanently vegetative at the level of the interpretation of the constituent parts of the human and their respective values. The question hinges on the matter of anthropological dualism, the definitions of which will be surveyed throughout this section. Those who contest treatment withdrawal often identify themselves as forceful opponents of anthropological dualism and the corresponding implication that the human

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[36] For example, William E. May, "What is a Human Person and Who Counts as a Human Person? A Crucial Question for Bioethics," http://www.christendom-awake.org/pages/may/humanperson.htm. There is also, of course, Ramsey's *The Patient as Person*.

[37] For another disfavourable analysis of personhood, one not unrelated to my own, see Stanley Hauerwas, "Must a Patient Be a Person to Be a Patient? Or, My Uncle Charlie is Not Much of a Person, But He is Still My Uncle Charlie," in *Truthfulness and Tragedy*, 127-31. Hauerwas considers the term to be a regulatory notion motivated by a desire to dissociate moral commitments from the particular socio-historical narratives that give rise to them, making them intelligible to a broader audience. His observation is that, by not relying on a foundation of value as stable as one supplied in these narratives, and by viewing others first as strangers rather than as friends, personhood can be manipulated to the respective advantages of both sides of the euthanasia debate.

being can be dissociated from the body. Alternatively, some who advocate treatment withdrawal contend that the body plays little part in contributing to the human "essence." This has been argued by certain Evangelical ethicists occupied with the language of personhood. Robert Rakestraw insists that "what is essential about humanness…is irreversibly gone" from the PVS patient, who "is a body of organs and systems, artificially sustained, without the personal human spirit that once enabled this body-soul unity to represent God on earth."[38] Likewise, Peter Alan Emmett asserts that a patient who no longer has a functioning cerebral cortex might be physiologically sustainable but is actually "theologically dead."[39] Both Rakestraw and Emmett use the language of the human "spirit" and "image of God" found within the human being to indicate the critical component of a patient's personhood, a dualism that enables them to distinguish between biological death and the death of the person.[40] In order to appreciate the anthropological conflict, a brief sketch of dualism and nondualism in Christian thought is indicated. Although this outline is not concerned with the finer distinctions of the positions identified or always attentive to the influence of more contemporary philosophical articulations, such as Cartesian dualism, it does serve to depict the background of the bioethical debate that follows.

Gnostic metaphysical dualism has long been considered heretical in the Christian tradition. However, anthropological dualism has, at times, been accepted because Christianity's philosophical roots are not limited to Aristotle but extend back to his teacher, Plato. The Platonic idea of human nature takes the body (or *hyle*) and soul (or *psyche*) as ontologically different entities. Put simply, Platonic idealism makes form real (though incorporeal) and matter illusory (though phenomenal). Plato favoured the soul as the essential and eternal part of the human being; it was thought to pre-exist the body and survive the body's death. The body contributed to the soul as its vehicle, but because of the body's limitations, it was considered a prison or tomb for the soul.[41] The most influential Christian theological adaptation of this anthropology came in the fourth

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[38] Rakestraw, "The Persistent Vegetative State and the Withdrawal of Nutrition and Hydration," 402.
[39] Emmett, "The Image of God and the Ending of Life," 59. Rakestraw echoes this in ibid.
[40] Theirs is not the only or most accurate rendering of the image of God. I examine this terminology in 2.2.1.
[41] Plato, "Phaedo," trans. G. M. A. Grube, in *Plato: Complete Works*, ed. John M. Cooper (Indianapolis: Hackett, 1997), 62b and 67d.

century with Augustine, who, though eschewing the notions that the soul pre-existed the body and that the body had no part in goodness, accepted the soul as the more essential part of the human being. The body was to be used by the soul for the latter's own purposes. The soul, then, was "a special substance, endowed with reason, adapted to rule the body."[42] Anthropological dualism continued to influence Christian thought into the Middle Ages. With the Protestant Reformation it was translated outside Catholicism, notably through Calvin.[43] A misinterpretation of the Pauline idea of the corruption of the "flesh" would contribute to the popular Protestant notion that material reality itself is essentially corrupt and inevitably distorts the discernment of the good.[44]

In the thirteenth century, a different interpretation of the relationship of body to soul arose alongside this dualism. Aquinas attempted to synthesize Augustine's Platonism and the Aristotelian interpretation of hylomorphism, or the fundamental unity of matter and form.[45] Aristotle affirmed that in living creatures form is the soul and matter is the body, but his understanding of form differed from Plato's. Though not pre-existent, the form of the body was considered its animating and organizing principle, or what gives it life, nature, and purpose.[46] In this view, then, form determines how matter is actualized, or form "informs" matter. Matter, though unable to actualize itself, is capable of allowing form expression in the world. Thus, the human being is not comprised of two opposing substances yoked together. Rather, the human is a relationship of two metaphysical principles working together to comprise one substance. This view affirms that actuality and potentiality are intimately interrelated and belong together; theirs is not an accidental but an essential relationship. According to Aristotle, "there is no need to inquire whether

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[42] See Augustine, "The Greatness of the Soul," in *The Greatness of the Soul, The Teacher*, trans. Joseph M. Colleran (New York: Newman Press, 1978), chapter 13. To be fair, Augustine's dualism was not as radical as it is popularly characterized. For instance, on human bodies he wrote, "they are not an ornament, or employed as an external aid; rather, they belong to the very nature of man." *The City of God against the Pagans*, ed. R. W. Dyson (Cambridge: Cambridge University Press, 1998), I.13; cf. XIX.3.

[43] See John Calvin, *Institutes of the Christian Religion*, trans. Henry Beveridge (Grand Rapids: William B. Eerdmans, 1989), I.15.6. Not all Protestants, however, are dualist. Two important and recent examples of Protestant nondualism are found in Karl Barth and Oliver O'Donovan. See Barth, *Church Dogmatics*, III:2, §46; and O'Donovan, "Keeping Body and Soul Together," in *On Moral Medicine: Theological Perspectives in Medical Ethics*, 2nd ed., ed. Stephen E. Lammers, and Allan Verhey (Grand Rapids: William B. Eerdmans, 1998), 223-38.

[44] Romans 8:1-13. Also see Lisa E. Dahill, "Spirituality," in *The Encyclopedia of Christianity*, vol. 5, ed. Erwin Fahlbusch (Grand Rapids: William B. Eerdmans, 2008), 159.

[45] Aquinas, *Summa Theologica*, I, qq.75-83.

[46] Aristotle, *De Anima*, 2.1.412a.

soul and body are one, any more than whether the wax and the imprint are one."[47] One way of looking at this, as I have mentioned already, is to consider how dependent the operations of the soul are on the body for their very expression.[48] For example, humans have visual and auditory access to the world because of their eyes and ears—integral components that are formed in such a way to allow seeing and hearing.

None of this, however, precludes a hierarchical relationship between soul and body, since actuality is prior to potentiality. According to Aquinas' Christianized hylomorphism, the soul is immortal. In this way, it transcends the physical body.[49] But, of course, the Thomistic view does not wholly concede to Platonism. Separated from the body in death, the soul cannot constitute the whole human being. This nuanced hierarchy suits the biblical depiction of the resurrection of Jesus Christ, a central event in the Christian story that is significant not only for its soteriological implications—redemption for all people—but also for its metaphysical ones: the human body—albeit a perfected, imperishable body—participates in redemption and has eternal life with God. Only the general resurrection of the dead is a complete response to the "fall" of humanity, at which point death is introduced as the consequence of human disobedience against God.

Evidently, however, there is some ambiguity in the terms "dualism" and "nondualism" as alternatives for Christian anthropology. The term "dualist" is typically used to describe those who not only believe that two things comprise the human but who also place them in opposition, viewing one as much more authentically or essentially human than the other. But since radical dualism and monism are not the only two alternatives at work here, anyone who considers there to be two distinct components of the human being, whatever their relationship and status, is, technically speaking, a dualist. Aquinas was indeed dualist, though not a substance dualist. But, as he considered body and soul in terms of their belonging together—the Catholic interpretation of this is that the human being is of a single nature[50]—rather than in terms of their unnatural or accidental union, he and his followers are usually considered nondualist. What is more,

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[47] Ibid., 2.1.412b; cf. 412a.
[48] See Aquinas, *Summa Theologica*, I, q.75 aa.3-4; and Benedict Ashley, *Theologies of the Body: Humanist and Christian* (Braintree: Pope John Center, 1985), 157-58.
[49] Aquinas, "Questions on the Soul," trans. James H. Robb, in *The Collected Works of St. Thomas Aquinas* (Charlottesville: InteLex, 2002), q. 14.
[50] United States Conference of Catholic Bishops, *United States Catholic Catechism for Adults* (Washington, D.C.: USCC Publishing Services, 2006), §365.

others who are identified as dualists can have a softer dualism than first appears. Beyond Augustine, there is John Wesley who, having in one place affirmed that only the "spiritual" part of the person is truly the person,[51] elsewhere admits some ambivalence about radical dualism:

> But what am *I*? Unquestionably I am something distinct from my body. It seems evident that my body is not necessarily included therein. For when my body dies, I shall not die: I shall exist as really as I did before….Indeed at present this body is so intimately connected with the soul that I seem to consist of both. In my present state of existence, I undoubtedly consist both of soul and body: And so I shall again, after the resurrection, to all eternity.[52]

Orthodox Christian ethicist H. Tristram Engelhardt, Jr. is considered both a prominent dualist and an opponent of those who favour treatment for the PVS patient.[53] Even Engelhardt, though, seems to avoid the absolute opposition of body and soul and the instrumentalization of the body. He considers the mind and body as "distinct inseparables," explaining, "they are categories distinguishable in thought, though mundane mind is as such inseparable from its embodiment."[54] Engelhardt avoids the extremes of saying that the soul-body or mind-body relationship is either one of radical difference, thus denying the unified character of the phenomenological experience of the self, or one of radical similitude, which ignores the common desire to transcend human limitations. By nature, human beings not only act but also suffer (both in the sense of enduring anguish and in the sense of being acted upon). What seems to be shared by all kinds of dualists, then, is that the *conceptual* difference that can be articulated between body and soul is respected. Further, their unified functioning is held as necessary to the identity of any living human being.

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[51] John Wesley, "What is Man?" Sermon 103 in *Sermons on Several Occasions* (London: Epworth Press, 1946), §5.

[52] Wesley, "What is Man?" Sermon 109 in *Sermons on Several Occasions*, §10. One may even point to René Descartes, *Meditations on First Philosophy*, ed. Stanley Tweyman (London: Routledge, 1993), VI: "Nature also teaches me by these sensations of pain, hunger, thirst, etc., that I am not only lodged in my body as a pilot in a vessel, but that I am very closely united to it, and so to speak so intermingled with it that I seem to compose with it one whole." The difference for Descartes, of course, is that this phenomenological unity appears accidental.

[53] See, for instance, Brice de Malherbe, *Le respect de la vie humaine dans une éthique de communion: Une alternative à la bioéthique à partir de l'attention aux personnes en état végétatif chronique* (France: Parole et Silence, 2006), esp. chapter 3.

[54] H. Tristram Engelhardt, Jr., *Mind-Body: A Categorial Relation* (The Hague: Martinus Nijhoff, 1973), 62.

2.1.2 Duality

It is apparent that the philosophical roots of theological anthropology have been allowed to span quite a large ground. There is evidence that the members of the early church, coming from both Jewish and Greek cultural backgrounds, held diverse metaphysical ideas that were then integrated with the resurrection, a key component of their message.[55] Compounding this is the neglect on the parts of eighteenth and nineteenth century Protestant theologians of any sustained focus on the connection between human anthropology and the resurrection of the body. At this time, Friedrich Schleiermacher and others were particularly occupied with harmonizing Christian theology with science and eschewed the supernatural.[56] Indeed, many biblical scholars and theologians tend to agree with Karl Barth: "We shall search the Old and New Testaments in vain for a true anthropology and therefore for a theory of the relation between soul and body. The biblical texts regard and describe man in the full exercise of his intercourse with God."[57] What might be called anthropological "indetermination" in the Christian story comes, then, from the fact that the biblical texts are not concerned with precise, analytical, and philosophical argumentation about the human being *in se*. Instead, they seek to portray the relationship of humanity and God beginning with creation, continuing with redemption, and climaxing in resurrection.[58]

It is clear, then, that there is no comprehensive account of the particular relationship between the human body and soul that will satisfy all Christians. It is also clear that various renderings are compatible with the biblical portrayal of humans in relationship to God. If this is so, why is what would seem to some to be an arcane debate important for responding to the role of the OEMD in light of PVS? The answer lies in the dangerous conclusion that, by some accounts, is held in common by secular proponents of radical substance dualism and reductive materialism, the legacies of Cartesian and Hobbesian philosophies, respectively. Whether the soul or mind merely interacts with the

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[55] See Joel B. Green, "'Bodies—that is, Human Lives': A Re-examination of Human Nature in the Bible," in *Whatever Happened to the Soul? Scientific and Theological Portraits of Human Nature*, ed. Warren S. Brown, Nancey Murphy, and H. Newton Malony (Minneapolis: Fortress Press, 1998), 149-73.
[56] See O'Donovan, "Keeping Body and Soul Together," 229. O'Donovan also observes anti-resurrectionist tendencies in figures as diverse as Anselm and J. S. Bach.
[57] Barth, *Church Dogmatics*, III:2, 433.
[58] For one account of how this story is determinative for Christian anthropology see Allen Verhey, "The Body and the Bible: Life in the Flesh According to the Spirit," in *Embodiment, Morality, and Medicine*, ed. Lisa Sowle Cahill and Margaret A. Farley (Dordrecht: Kluwer, 1995), 3-22.

body in an accidental way (radical dualism), or whether human beings are merely their bodies and nothing else (materialism), those human individuals whose bodies or brains fail to serve them well become disenfranchised and are labelled "nonpersons." Either because physical life constitutes the whole of human life or because physical life is only of instrumental significance to soulful or spiritual existence, its poor quality makes it not worth sustaining. Such a judgement goes against the value Christians have come to place on those who are vulnerable and their refusal to abandon the weakest among them—body and soul. It also justifies euthanasia and assisted suicide.

If this judgement were a danger limited to secular anthropological accounts the debate would indeed be irrelevant to the conversation internal to the Christian community. However, I have already spoken to the possibility in Evangelical bioethics of dismissing the dignity of PVS patients or their share in human nature. Further, an examination of texts written by certain Catholic moral theologians yields inconsistency on this score. Many who oppose treatment for PVS patients insist they are not radically dualist. But they do, on occasion, carelessly identify the body as something only used by, and apparently not integrated with, the soul. Thus, when the rational soul is not demonstrably actualized in the body, as in the case of PVS, these moralists are free to claim that the body's value is negligible. For instance, David Thomasma has been content to call life a value that is conditional on the realization of higher values.[59] Benedict Ashley has observed that the value of life diminishes along with its diminished capacity to sustain human activity.[60] Kevin O'Rourke, a notable opponent of the magisterial position, has claimed: "Mere physiological existence is not a value if no potential for mental-creative function exists."[61] Such statements are problematic for the Catholic magisterium, which recognizes a connection between the devaluation of physical life and the "culture of death." The denigration of the patient in a PVS, according to the magisterium, begins with the normative tone sometimes taken in using the descriptive

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[59] David C. Thomasma, "The Range of Euthanasia," *Bulletin of the American College of Surgeons* 73, no. 8 (1988), 10.
[60] Benedict M. Ashley, "Dominion or Stewardship: Theological Reflections," in *Birth, Suffering, and Death: Catholic Perspectives at the Edges of Life*, ed. Kevin W. Wildes, Francesc Abel, and John C. Harvey (Dordrecht: Kluwer, 1992), 97.
[61] Kevin D. O'Rourke and Dennis Brodeur, *Medical Ethics: Common Ground for Understanding* (St. Louis: U. S. Catholic Health Association, 1986), 213. More recently O'Rourke has been careful to deny radical dualism. See, for instance, his "Father O'Rourke Responds."

word "vegetative" or the more disparaging "vegetable."[62] Clearly, there is a need to make and hold to firm anthropological statements in order to render a stable ethical judgement.

Taking into account the anthropological indetermination of Christian scripture and theological tradition, what is called for is not so much a philosophical debate on the nature of the body and soul as an articulation of anthropology that illuminates the view derived over the course of the Christian story, a view that reflects tension in the human identity. There does appear to be a persistent articulation in the Christian tradition of the relationship between the constituent parts of the human as one that is integral but also hierarchical. This view carries with it implications for bioethical discussions. It is a balanced interpretation of the unity of the human being, one that views the physical as more than merely instrumental, and one that is not dismissive of the diversity of human experience in terms of the interplay of freedom and finitude. It manifests as a functional (if not substantial) holism in which the parts of an individual remain conceptually distinct.[63] Whatever their ontological reality, human individuals must be subject to conceptual analysis in terms of their soul (or organizing principle) and their body (that which is subject to the organizing principle). At the same time, both parts must be seen as valuable and inseparable when it comes to human flourishing.

Another way of putting this is that the human represents a duality, but does not admit of dualism. The term "duality" was emphasized earlier on in the twentieth century by John Wright Buckham, who commended it as language that avoids "the sense of disruption and hostility implied in the ending 'ism.'"[64] Duality does not disparage the body as evil, merely instrumentally valuable, or fundamentally opposed to the immaterial. It does, however, allow for the body's subordination to the formal element of human life. By this account, the constituent parts of the human—whether conceived of as body and

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[62] John Paul II, "Life-Sustaining Treatments and Vegetative State," (2004), §3. The term "vegetative" is not originally meant in a derogatory manner but, in Aristotelian fashion, refers to the idea that only the nutritive functions of the lower part of the human soul, or the patient's autonomic functions, are expressed. According to Aristotle, anything that is nourished shares in this part. See *De Anima*, 2.4.415b27-28 and 416b9-11. Also see *Nicomachean Ethics*, 1.13.1102b2-4. Despite the papal insight, the descriptive relevance of this term and its widespread use lead me to favour it over the Australian alternative "post-coma unresponsiveness." See National Health and Research Council of Australia, "Post-Coma Unresponsiveness (Vegetative State): A Clinical Framework for Diagnosis," (2004), http://www.nhmrc.gov.au/publications/synopses/_files/hpr23.pdf.

[63] For one example of this approach see J. P. Moreland and Scott B. Rae, *Body & Soul: Human Nature & the Crisis in Ethics* (Downers Grove: InterVarsity Press, 2000).

[64] John Wright Buckham, "Dualism or Duality?" *Harvard Theological Review* 6, no. 2 (1913): 156.

soul, body and mind, the receptive and the formative, or potency and act—remain distinct but complementary in both nature and value. The natural body is affirmed as capable of expressing the immortal soul—which, as the life principle, is the act of the body—and of participating in human actualization. But of itself it does not actualize nor constitute what is immortal in humans. That is what, in Buckham's view, authentic Christian expressions of anthropology really attempt to convey. They are not radically dualist and they ought not totally dismiss the material. That this basic position can be amenable to those who argue on either side of the PVS treatment debate becomes evident in bringing to bear certain statements of major players in the game. James Walter and Thomas Shannon, two Catholics who have been vocal in their arguments for the legitimacy of allowing ANH to be withheld from PVS patients, have been careful to affirm that "physical life is indeed a value that is not conditioned on any property or characteristic of the person."[65] Likewise, Meilaender, a Protestant representative of those who favour treatment, explicitly identifies a concept of human duality as his preferred alternative to what he observes to be a near monistic spiritualism evident in Christian church culture. He affirms the interplay of freedom and finitude in the human experience.[66] In fact, duality has been an emphasis in Protestant bioethics from its inception. Paul Ramsey is well known for defining the human as "a sacredness in bodily life" and "an embodied soul or ensouled body."[67] Similarly, Pope John Paul II has written that the person is "a soul which expresses itself in a body and a body informed by an immortal spirit."[68] This, then, is the basic common anthropological ground in Christian bioethics, which is only sometimes threatened by unorthodox spiritualism in popular Christianity and isolated instances of careless phrasing on the part of some scholars. It admits that the Christian narrative is peopled with characters who are fundamentally embodied and who also have a transcendent freedom. In general, "life *is* life of the body, and while it is this it is more than this."[69]

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[65] James J. Walter and Thomas Shannon, "The PVS Patient and the Forgoing/Withdrawing of Medical Nutrition and Hydration," in *Artificial Nutrition and Hydration and the Permanently Unconscious Patient*, ed. Hamel and Walter, 155.
[66] Meilaender, *Bioethics: A Primer for Christians*, 4.
[67] Ramsey, *The Patient as Person*, 2nd ed., xlvi.
[68] John Paul II, *Veritatis Splendor*, (August 6, 1993), §50, http://www.vatican.va/holy_father/john_paul_ii/encyclicals/documents/hf_jp-ii_enc_06081993_veritatis-splendor_en.html#$2J.
[69] Barth, *Church Dogmatics*, III:2, 352-53. Emphasis added.

2.2 Human Value

Since this discussion of anthropology is concerned with ethics, it is necessary to explore the notions of value that ground practical action concerning human life. Here I engage the concept of human dignity in terms of its relational meaning. The primary assertion is that the human individual is intrinsically valuable, but this value is created and thus also limited. This work will serve to ground an interpretation of the respective values of the body and soul, contributing to an understanding of how the latter interrelate.

2.2.1 The Dignity of the Human Natural Kind

The kind of value that is particular to human beings is often called "dignity," denoting that which is worthy of some special kind of respect. But what exactly is being attempted in bioethical discourse in the use of this word? Dignity has received increased attention over the past decades in the secular and religious spheres, having been used both to oppose and champion acts such as euthanasia and assisted suicide. A recent document from the Congregation for the Doctrine of the Faith, *Dignitas Personae*, indicates that human dignity is present in every human being and "must be at the center of ethical reflection on biomedical research."[70] Although much has been written on the subject,[71] certainly disputes about human dignity are too easily reduced to the polarities of sanctity and quality of life. But the dominant—not entrenched or undisputed—conception of dignity in Western secular culture is that of intrinsic dignity as a foundation for human rights. To this end, what is often employed to greater and lesser degrees is the Kantian interpretation: all persons are intrinsically dignified based on their rational nature or the fact that they exist as ends in themselves.[72] This interpretation avoids the instrumentalization of the human being and respects all equally. But one of its problems is that it builds no foundation for the intrinsic value of those beings without a rational nature. Perhaps because of this, as contemporary bioethics has developed, respect for individual human beings has been exchanged for respect for a "person's" rational autonomy, a transformation made acute in what is arguably the most formative work of

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[70] Congregation for the Doctrine of the Faith, "Instruction *Dignitas Personae* on Certain Bioethical Questions," (September 8, 2008), §1, http://ncronline.org/mainpage/specialdocuments/Dignitas_Personae_Inglese.pdf.
[71] For example, see President's Council on Bioethics, *Human Dignity and Bioethics*.
[72] Kant, *Grounding for the Metaphysics of Morals*, 38ff.

secular bioethics, *Principles of Biomedical Ethics*.[73] In the face of PVS, anencephaly, and dementia, a defence on the basis of the dignity of the autonomous can appear to fall flat. What about those human beings who are not and can never be demonstrably rational? Do they lack dignity? Do they deserve respect—or even protection, as Beauchamp and Childress are more inclined to say? This focus on the expression of reason as determinative for the demarcation of the limits of the community of moral agents results in the tendency to dissociate the rational will from the remainder of an individual's historical character and relationships.[74] The version of intrinsic human dignity dominant in secular bioethics today largely disregards the freedom-finitude relationship in human nature and the notion that the rational and ethical capacities of humanity are in many ways dependent on the nutritive and sensory capacities for actualization.

Christian moral theologians and ethicists have a way around this problem, one that is to be expected: being a rational creature is not fundamentally about demonstrating reason but about membership in a species that bears the rational soul. So, the worth of human beings, at least in Thomistic Christian bioethics, follows from their being identified by their essential nature. Natural kinds, in turn, have intrinsic value because of the fact that they are of value *to* God, the centre of value. However, the particular ethical status of the human natural kind is somewhat problematic because of its uncertain origins in Christian theology. Human dignity as a term is found nowhere in Christian scriptures and was only introduced in the fifth century by Pope Leo I. He interpreted human dignity as being evident in the creation of all humans in the image of God (*imago Dei*), a biblically derived notion.[75] At one place in the biblical text, God is said to demand a reckoning for the spilling of human blood on the basis that people are made in the image of God.[76] Thus, the image of God has often been used as shorthand for or a signifier of intrinsic dignity in humans. In Catholic language, this is the good of the person or the

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[73] Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics* (New York: Oxford University Press, 1979), esp. 58-60. For a thorough analysis of how "respect for persons" became "respect for autonomy" see M. Therese Lysaught, "Respect: Or, How Respect for Persons Became Respect for Autonomy," *Journal of Medicine and Philosophy* 29, no. 6 (2004): 665-80.
[74] See Stanley Hauerwas, *Suffering Presence: Theological Reflections on Medicine, the Mentally Handicapped, and the Church* (Notre Dame: University of Notre Dame Press, 1986), 127.
[75] Leo the Great, "Sermon XXVII," in *Tractatus Septem et Nonaginta* (Turnhout, 1973), cap. VI, col. 220. Cited in Carlos Ruiz Miguel, "Human Dignity: History of an Idea," in *Jahrbuch des öffentlichen Rechts der Gegenwart*, Neue Folge, ed. J. C. B. Mohr (Tübingen, 2002), 284. Cf. Genesis 1:26-27.
[76] Genesis 9:6.

recognition that the human being is "the only creature on earth whom God willed for its own sake."[77] However, it is well known that the Bible makes scant reference to this image and offers little in the way of its substantive content.[78] This being the case, there is no general agreement amongst theologians and biblical scholars on what exactly the *imago Dei* constitutes. Nevertheless, there are interpretive trends. In the Greek tradition, theoretical wisdom is the activity most akin to the gods.[79] Likewise, there is a Christian convention of relating the *imago Dei* to human reason, the "meeting point" of humanity and the Divine. Augustine, for example, reinforced the emphasis on reason as definitive for human nature by relating the three faculties of the rational soul (memory, intellect, and will) to the doctrine of the Trinity.[80] Aquinas, too, likened the *imago Dei* to the rational nature constitutive of humanity, observing that the human being is in the image of God "inasmuch as he too is the principle of his actions, as having free-will and control of his actions."[81]

At the same time, another trend in Christian theology, one particularly emergent in Christian environmental ethics, interprets the *imago Dei* as a task, rather than an inherent element of human nature or a possession. Based on the idea that there is close proximity in the biblical creation story between the reference made to the image of God and the charge given to humans to "fill the earth and subdue it,"[82] this school of thought argues that the image of God is to be identified in the activity of reflecting God and, in particular, ordering the world as God orders it.[83]

Further, tension has been indicated in some biblical scholarship that distinguishes between the "image" (*tselem* or the Latin *imago*) of God and the "likeness" (*demuth* or the Latin *similitudo*) people can have to God.[84] Both terms are mentioned in the biblical text and each is taken to represent a different aspect of the human being. The former is

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[77] John Paul II, *Veritatis Splendor*, (1993), §13; and his "Letter to Families," (February 2, 1994), §9, http://www.vatican.va/holy_father/john_paul_ii/letters/documents/hf_jp-ii_let_02021994_families_en.html.
[78] Other texts in which the *imago Dei* is mentioned include but are not limited to Genesis 5:1-3; 1 Corinthians 11:7; Colossians 1:15; and James 3:9.
[79] Aristotle, *Nicomachean Ethics*, 10.9.1179a25-30.
[80] Augustine, *The Trinity*, trans. Edmund Hill (New York: New City Press, 1991), XIV.4 and 8.
[81] Aquinas, *Summa Theologica*, I-II, Prologue; also see I, q.3 a.1 ad.2.
[82] Genesis 1:26-28.
[83] For example, see Douglas John Hall, *Imaging God: Dominion as Stewardship*, (Eugene: Wipf & Stock, 2004).
[84] Genesis 1:26. Irenaeus of Lyons first made this of theological importance. See *Against the Heresies*, trans. Dominic J. Unger and John J. Dillon (New York: Paulist Press, 1992), 5.6.1; 5.16.2.

understood as the essential aspect of human nature, that which is unchanging, and the latter represents that which people can change or lose by virtue of their conformity to God's own character.[85] Although many biblical scholars and theologians now contend that there is no significant textual or theological difference between these two words,[86] the longstanding attempts to differentiate human nature and human activity indicate that friction reverberates between how human ontology and human flourishing are perceived. It seems that there is a need to articulate human dignity in terms of nature and history, or potentiality and actuality, together. That human beings have a given nature and that this entails a possible actualization is demonstrated in the Catholic Catechism: "Created in the image of the one God and equally endowed with rational souls, all men have the same nature and the same origin. Redeemed by the sacrifice of Christ, all are called to participate in the same divine beatitude: all therefore enjoy an equal dignity."[87] Broad acceptance of this tension is also found in the work of the Canadian Council of Churches on theological anthropology, which interprets "our true humanity as both *bestowed and acquired*, gift and attainment."[88]

In the current bioethical discussion, the tension is problematized by the incapacity for flourishing that can sometimes follow from accidental circumstances, namely one's medical condition. Two things are at stake in this discussion: the equal status of all human beings and the concept of human flourishing as important for human identity. However, dignity as an attainment is not often considered in Christian bioethics or medical moral philosophy for fear that the lives of those patients whose ill health impedes the achievement of human excellence will be viewed as having lesser worth than the lives of the healthy. Instead, the emphasis naturally falls on the inalienability of human dignity. Even so, a carefully preserved tension between inalienable dignity and engagement in

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[85] G. C. Berkouwer, *Man: The Image of God*, trans. Dirk W. Jellema (Grand Rapids: William B. Eerdmans, 1962), 43. Augustine was influential in promoting this division. See his "Unfinished Literal Commentary of Genesis," in *On Genesis*, vol. 13, *Works of St. Augustine*, ed. John E. Rotelle, trans. Edmund Hill (New York: New City Press, 2002), §57.

[86] In fact, the distinction remains prevalent only in Orthodoxy. See Berkouwer, *Man: The Image of God*; and Faith and Order Commission of the World Council of Churches, *Christian Perspectives on Theological Anthropology: A Faith and Order Study Document*, Faith and Order Paper No. 199 (Geneva: World Council of Churches, 2005), §86.

[87] United States Conference of Catholic Bishops, *United States Catholic Catechism*, §1934.

[88] Commission on Faith and Witness of the Canadian Council of Churches, *Becoming Human: Theological Anthropology in an Age of Engineering Life. Christian Reflections for Further Discussion* (Toronto: Canadian Council of Churches, 2005), 3. Emphasis in original.

particularly human activities does surface sometimes. Catholic medical moralist Luke Gormally writes, "the image [of God] consists in the first instance in our intellectual nature, in virtue of which we are endowed with the *dynamic capacity* to develop the abilities necessary to knowledge and love of God."[89]

But even if this order is maintained, how is attainment of excellence to be accorded significance for understanding human dignity in a way that does not compromise the value of those who, through no fault of their own, are unable to express the powers of their humanity? Is there a way of reconciling potentiality and actuality that does not frustrate the Christian ethic of protecting the vulnerable?

2.2.2 Varieties of Human Dignity

What is required is to uphold the dignity of all human beings, regardless of the accidental deviations that come with extreme ill health and, at the same time, to recognize the significance of actualization for human life. In order to express the relationship between these two, I introduce a typology of varieties of human dignity present in Christian reflections on the human being. The first variety is ontological human dignity, also called intrinsic or inalienable human dignity—that which belongs to all humans by virtue of their identification as members of the human natural kind. This might be considered the proper good *of* the individual. The second type is actualized human dignity—that which is realized by those human beings who flourish by acting toward their natural end. This flourishing or actualization can happen at several levels. There is, for instance, the physiological level or the level of the living being. But human flourishing also pertains to other activities: the intellectual, ethical, aesthetic, and so on. For instance, ethical actualization is, in the Aristotelian tradition, critical for the human being in the sense that the moral virtues provide direction to all other human endeavours and accomplishments. Actualization, then, indicates what is good *for* the individual. It can

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[89] Luke Gormally, "Human Dignity: The Christian View and the Secularist View," paper presented at the Seventh Assembly of the Pontifical Academy for Life, (March 1-4, 2001), http://www.academiavita.org/template.jsp?sez=Pubblicazioni&pag=testo/cultvita/gormally/gormally&lang=english. Emphasis in original. Another example is found in Sulmasy, "Dignity and Bioethics: History, Theory, and Selected Applications." Also see the distinction between "creation" and "recreation" in C. Ben Mitchell et al., *Biotechnology and the Human Good* (Washington, D.C.: Georgetown University Press, 2007), 68-76; and Francis George on "dignity" versus "fulfillment" in "The Need for Bioethical Vision," in *Cutting-Edge Bioethics: A Christian Exploration of Technologies and Trends*, ed. John F. Kilner, C. Christopher Hook, and Diann B. Uustal (Grand Rapids: William B. Eerdmans, 2002), 97-98.

be compromised at the ethical level through choice, by disorienting one's will. It can also be impeded accidentally, through limitations imposed by a lack of goods. There is a third variety of dignity, that is, transcendent or ultimate dignity. This is understood as completed through the general resurrection and the *beatitudo perfecta*. It does not negate the importance of the dignity available in the natural world; instead, it completes the meaning already found therein.[90] It is important to be aware that the three types are not to be taken as alternatives in the Christian rendering of human dignity but as constitutive dimensions that together entail a complete account of the dignity proper to the human being. They reveal the integral relationship of nature and history or potentiality and actuality in the human being, and also the definitive relatedness of the human being to God.

In addition, they reveal a fundamental relationship between the faculties of the human soul. I have, however, observed that there is a tendency in Christian thought toward identifying human nature with its most distinctive capacity, reason or the "rational soul." Also, there is the transition from "respect for persons" to "respect for autonomy" in contemporary secular bioethics. In earlier times, the major threat to human reason was viewed to be a disordered will, or failure to actualize at the ethical level. So, this was the focus in deliberations on the dignity of an individual.[91] But it is clear that underscoring reason has become problematic for bioethics, first, because this discipline is directly concerned with failed actualization at the physiological level, and second, because the philosophical underpinnings of secular Western culture ensure that demonstrated capacities will have an effect on the evaluation of the worth of the human being. In an age of anthropological dualism and radical materialism, extreme ill health is taken not only to threaten individual human flourishing, but also to destabilize the ontological basis of the individual's dignity (if such a notion is even taken seriously). For many people, including the severely disabled, the rational will is demonstrated to an insufficiently "human" degree, if at all. To reiterate, invoking the centrality of the rational will in this context readily reduces the significance of human actualization to respect for autonomy in the abstract and provides no impetus for protecting those who are not autonomous—the most

[90] I return to this kind of dignity in 2.3.3.
[91] See, for instance, Aquinas' discussion of the person who is a menace to society in *Summa Theologica*, II-II, q.64 a.2.

vulnerable in society—as human beings. Thus, it is unclear that merely invoking the *imago Dei* or the "right to life" accorded by basic human dignity are strategies sufficient for responding to the moral ethos of secular bioethics—one that creeps into the religious discourse as well.

According to Hauerwas, the most fundamental problem with focusing on reason as the *imago Dei* or the defining characteristic of humanity is that reason in abstraction is allowed to digress into a technical instrument used for the purpose of securing survival.[92] At best, this results in the utilitarian calculation of maximizing goods or pleasures for the greatest number. But surely this is not how the forerunners of Christian bioethics have viewed reason. What is forgotten is that, even though reason is certainly distinctive for humanity, an account of the human being is reduced if it focuses on reason in isolation. Correcting the emphasis on reason requires contextualizing it, as Aquinas does, in relation to the larger vocation or complete actualization of the human being. Earlier (see 1.2.4) I noted the difference for Aristotle and Aquinas between prudence and cleverness, the latter being a form of intellectual activity abstracted from a noble goal or final end. So, whereas activity in accord with reason is Aristotle's *ergon* (the human task), it is never empty of substantive content—the "excellence" that virtue adds to any human activity. Likewise, Aquinas commends reason not as a capacity oriented toward purely calculative or self-centred concerns, but rather as an expression of the potential for a special kind of relationship with God. Reason, without a rightly-ordered *desire* for the good end, is not particularly excellent at all.[93] As capacities are ordered toward an end, human nature will not be best articulated through the delineation of particular attributes but in terms of overall vocation. With this in mind, Hauerwas prefers to see reason as "that which lays bare and scores our roles and relationships befitting our nature (agency) as social creatures."[94]

With the abstraction of human reason, it is understandable that Christian bioethicists have tended to assert a commonly held intrinsic dignity at the expense of

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[92] Hauerwas, *Truthfulness and Tragedy*, 63.
[93] For more on the important role of the passions see Hauerwas, *A Community of Character*, 123ff. Cf. Aquinas, *Summa Theologica*, I-II, q.59 a.2, and generally qq.22-48.
[94] Hauerwas, *Truthfulness and Tragedy*, 58. On page 162 he observes: "To try to substitute 'impersonal criteria' for what should be the moral agency of such decisions is already to sacrifice more of our humanity than we can stand."

entertaining the validity of the relationship between the dignity of human nature and actualization at the physical level. As indicated, the strategy in Christian bioethics has been to consider membership in the human natural kind the only significant matter for determining whether someone "deserves" medical treatment. However, in ignoring the vocational aspect of dignity Christian bioethics risks inconsistency with the larger narrative, which indicates Christian impressions about the whole of human life. The *imago Dei* and human dignity cannot be taken to refer simply to a created reality given once for all since the Christian narrative does not end with creation. In fact, considering human dignity in terms of vocation or actualization embraces the whole of human life: as much one's emotional, familial ties as one's formal associations; as much the daily drudgery of life as its singular moments of achievement; as much the maintenance of the physical body as the improvement of the intellect or professional or artistic endeavours. All these things contribute to or exemplify excellent human relationships with God, oneself, and others. Each points to the need to reinvigorate the notion of human actualization in bioethics, though not for the purpose of denying protection to those whose possibilities for actualization are compromised, or to maximize scarce medical resources. An account of human actualization or flourishing is important for determining the proper task of medicine. The ends of medicine will be founded on the twofold anthropological assertion that all humans are intrinsically valuable regardless of medical condition, but there is something of disvalue about the situation of an individual unable to flourish because of ill health. All humans are dignified, but not all are fulfilled. Sometimes this is the fault of impeded physical actualization. This being the case, the recognition of human dignity will be articulated in different ways for different people. According to the explanation of equity already given, caring for some patients will mean that the level of medical intervention will need to be increased beyond what is typical for the healthy patient in order to successfully compensate for ill health. However, for others, it will mean that medical intervention will be limited to making them comfortable because medicine cannot compensate for the barrier ill health has raised against physiological and other varieties of actualization.

Although aware of this distinction, some Christian bioethicists have argued that the notion of human actualization is important for understanding human dignity, but that

it ultimately needs to be subordinated to the ontological dimension of dignity in order that patients not be devalued when their functioning is compromised.[95] This is a real concern. However, to say that the one must be completely subordinated to the other is an oversimplified way of handling the distinction. It should be said, rather, that in considerations of value, or whether certain patients are worthy of the moral consideration generally given to human beings, it is ontological dignity that takes precedence. But, at the same time, patients' particular functional capacities do represent factors in the situation that will influence the deliberative process of determining how they should be treated (or not treated). Such a decision cannot be based only on intrinsic dignity in abstraction from how various conditions affect the functioning of the body and higher kinds of actualization. So, although it is wrong to act out of disrespect for the dignity of anyone, it is impossible to remove basic dignity from anyone, as dignity is intrinsic. At the same time, it is not always possible for medicine to play a part in facilitating a patient's actualized dignity. Sometimes medical means can do nothing to improve a patient's physiological condition to the point at which such a pursuit will be possible.

2.2.3 Contingent Dignity

Enumerating the various dimensions of human dignity is important. Nonetheless, relating human nature to a vocation and appreciating the basis for the *limited* task of medicine requires that one go deeper into other elements constitutive of the Christian narrative, namely, the situatedness and contingency of human dignity. Theologically, the *imago Dei* belongs to human nature by virtue of its creation. But this also means that the source of human nature and dignity is not in the human but in God. What is indicated by the very language of being made in the image *of God* is that the human being, in Christian perspective, is only perceptible in light of the Divine.[96] This idea establishes that human value is not absolute but limited, relative to God's infinite value. There is no contradiction in holding this together with the notion of intrinsic value. Having ontological and moral status does not preclude contingent existence.

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[95] For one example, see Gregory Glazov, "Biblical Anthropology and Medical Ethics," in *Issues for a Catholic Bioethic: Proceedings of the International Conference to Celebrate the Twentieth Anniversary of the Foundation of The Linacre Centre, 28-31 July 1997*, ed. Luke Gormally (The Linacre Centre: London, 1999), 107.

[96] Cf. Paul VI, *Gaudium et Spes*, (1965), §24.

The Christian view is that human value is dependent on God's prior activity. As soon as Christian bioethicists go beyond the surface rhetoric of having a "right to life" and look to the story that provides this with content and direction, they find that the whole of human existence is premised on the understanding that God has freely created out of love.[97] Although the contingency of human life and value tends to be underemphasized in bioethics, it has a thoroughly grounded position in Christian theology. Dietrich Bonhoeffer points out that any right to life is not "primarily something that man can sue for his own interest, but…something that is guaranteed by God Himself."[98] This right can be asserted only in response to the powers of other people over life, not in response to God's power over life. Likewise, Barth insists, "man exists as he is grounded, constituted and maintained by God."[99] This is not, he stresses, a single act willed once for all. God's involvement with human life and dignity does not end with creation. Instead, humanity is portrayed in the Christian story as continually willed by God. This does not imply that God is obliged to do so, and so the *imago Dei* is not a cause for pride so much as humility. Humanity's existence is forever "gratuitous."[100]

If this is the case, human life itself—the integrated functioning of body and soul—is not the ultimate end. Instead, humans find their end in what God has provided for them. Meilaender affirms this in defining humans as "a particular kind of being made (unlike the beasts) for communion with God (on whom human life is utterly dependent)."[101] This utter dependency or contingency is indicative of what some have called a position of radical monotheism that avoids idolatry by subjecting all relative values to the absolute value of God: "It is the confidence that whatever is, is good, because it exists as one thing among the many which all have their origin and their being, in the One—the principle of being which is also the principle of value."[102]

However recessive the notion of the finite value of human life is in Christian bioethical discourse, it is not altogether denied. Ramsey, for instance, has advocated the

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[97] Aquinas, *Summa Theologica*, I, q.20 a.2.
[98] Dietrich Bonhoeffer, *Ethics*, ed. Eberhardt Bethge (New York: Macmillan, 1955), 151.
[99] Barth, *Church Dogmatics*, III:2, 346 and passim.
[100] Stanley Hauerwas, *Wilderness Wanderings: Probing Twentieth-Century Theology and Philosophy* (Boulder: Westview Press, 1997), 201.
[101] Gilbert Meilaender, "Human Dignity: Exploring and Explicating the Council's Vision," in *Human Dignity and Bioethics*, ed. President's Council on Bioethics, 259.
[102] H. Richard Niebuhr, *Radical Monotheism and Western Culture* (New York: Harper & Row: 1960), 32.

idea of "alien humanity dignity," or an understanding of human life that emphasizes its givenness and contingency.[103] Ramsey adopts this term from Lutheran theologian Helmut Thielicke.[104] Although I do not defend all the implications Thielicke extends from this notion,[105] I am sympathetic with Ramsey's use of the term insofar as it emphasizes the idea that God, and not a certain human capacity, is the origin of human value. The use of the term "alien" is not meant to deny the dignity of the human being. Rather, it observes that this dignity is found equally amongst all human beings and continually supplied by God's ongoing creative and redemptive activity: "A man's dignity is an overflow from God's dealings with him, and not primarily an anticipation of anything he will ever be by himself alone."[106] What is helpful about this interpretation is that it removes the emphasis further from the expression of reason as the justification for valuation of the human and secures human dignity first of all in God's own value and God's movements of valuation. Moreover, it does this without denying the importance of an individual's flourishing: the rational capacity is not beside the point, but it is not the starting place of ontological dignity so much as it is a way to respond to God's movement of coming into relationship with humanity. What surfaces, then, is an embedding of the human being in a relationship and a story. Attempts to characterize the human rely on what Aquinas would call God's prior actuality and what other theologians call God's creative, sustaining, and redemptive activity. It is a narrative that engages the interplay between what is at the same time intrinsic and contingent human dignity.[107]

If this interplay is taken to be authentic, the foundation is laid for a practice of medicine that is inspired by the duty to protect actualized dignity, and limited by the knowledge that actualized dignity—moreover, human life itself—is not an infinite value. Moreover, medicine will understand itself not as supplying humanity with its final end

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[103] See Paul Ramsey, "The Morality of Abortion," in *Moral Problems: A Collection of Philosophical Essays*, ed. James Rachels (New York: Harper & Row, 1971), 5-27.
[104] See Helmut Thielicke, *Foundations*, vol. 1, *Theological Ethics*, ed. William H. Lazareth (Philadelphia: Fortress Press, 1966).
[105] In a move reminiscent of Aquinas and influenced by his Lutheran heritage, Thielicke depicts the *imago Dei* as separated from humanity through the fall and restored in the activity of Jesus Christ. This, I think, is something not necessary to the seminal idea of alien dignity as contingent dignity.
[106] Ramsey, "The Morality of Abortion," 11.
[107] Karen Lebacqz offers a more thorough rapprochement of these two ideas in "Alien Dignity: The Legacy of Helmut Thielicke for Bioethics," in *On Moral Medicine*, 2nd ed., 184-92.

but as merely providing a service that is sometimes requisite for particular humans in pursuing their ends.

2.3 Human Ends

Human dignity is found naturally in all humans but is actualized in the achievement of human ends. Having affirmed this holistic account of human dignity what remains is to answer the questions that straddle human nature and human value. What are those ends given in human nature? Further, how do the body and soul relate to achieve them? If human dignity is more than ontological dignity, if it also includes a teleological notion of flourishing or actualized human dignity, the kind of flourishing proper to humanity must be appreciated.

Individual actualization, despite being proper to the individual, is not purely self-referential. Rather, it is accomplished by way of a response to something outside oneself. In his philosophical biology, Jonas illustrates that this is the case even at the level of the organism. He observes that "needful freedom" is pervasive in nature and demonstrated most cogently through metabolism or an organism's exchange of matter with its surroundings: "The power to use the world, this unique prerogative of life, has its precise reverse in the necessity of having to use it. For the organism, to exist, in fact, *is* to use and keep using 'something else'—therefore to need it."[108] For Aristotle, too, living life humanly entails the achievement of a good that belongs to oneself but requires looking to what is outside the self. The different faculties of the soul are dependent on external objects for their actualization. This is demonstrated in a literal way through the example of vision, which refers both to a capacity and to the object of the capacity. The potential of the eye to see is only actualized through the external colour made visible in act.[109] But, ultimately, actualization is a concern for Aristotle at the level of the final end or the most characteristic activity of humanity.

Looking at humanity and the ends proper to it in this relational perspective requires that the goods pertaining to the body and the soul are asserted in their value but also examined in terms of how they relate to the final end. This requires a more detailed

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[108] Jonas, *Philosophical Essays*, 196. Cf. his "Is God a Mathematician? The Meaning of Metabolism," in *The Phenomenon of Life*, 64-98. A further account of this is offered in chapter four.
[109] Aristotle, *De Anima*, 3.2.426a14; and *Nicomachean Ethics*, 10.4.1174b15-16. Also see Fiasse, "Aristotle's *Phronesis*," 327.

account of the tripartite soul in its various faculties, how it is properly unified with the body to achieve natural ends, and how all of this is to be finally ordered toward the *beatitudo perfecta*.

2.3.1 Intermediate Ends

Early on in the *Nicomachean Ethics*, Aristotle indicates a tripartite division of goods.[110] First, there are external goods, such as nourishment and shelter. Second are the goods of the body, such as life and health. Finally, there are the goods of the soul, otherwise termed the human good. Although human actualization is the direct object of the activity of the soul, it should be recognized that all three kinds of goods together ground actualization. Thus, the ultimate object of each one is human flourishing or *eudaimonia*.[111] External and bodily goods are prerequisites for achieving the good of the soul in their role of providing the basic material resources necessary for engaging in human activities. They can also be consequences of reaching the human good, such as the pleasure that comes from flourishing. They can, moreover, be goods or ends in themselves, rather than merely instrumental goods, if, like the friend, they are constitutive elements of the ultimate good. This notwithstanding, it is the complete good pursued directly by the soul that causes us to desire the other goods.[112] Thus, they are parts of a comprehensive good, but not self-sufficient like the complete good or final end.

Following Aristotle's classification of the good that is most properly human in relation to those other goods that contribute to it, Aquinas is able to draw a value distinction between "acts of a man" (*actus hominis*), and properly "human acts" (*actus humanus*).[113] Both types are actualized by the soul in its different parts, but the latter type is more directly related to the human end because it indicates the acts that depend on the human being. That is, the category of "human acts" includes those that are voluntary, ordered by reason and will toward a perceived good, whether a true good or one that is merely apparent. Whereas one normally does not consciously control or will one's breathing or blinking, one does will the proper ordering of desire. Moreover, "human acts" are the kinds of acts that cannot be achieved by members of other species. "Acts of

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[110] Aristotle, *Nicomachean Ethics*, 1.8.1098b12.
[111] Ibid., 10.8.1178b34-35.
[112] Ibid., 1.1.1094a19-20.
[113] Aquinas, *Summa Theologica*, I-II, q.1 a.1.

a man," on the other hand, include those acts not ordered by the rational will. They are, rather, autonomic, inadvertent, or not deliberately chosen. Nonetheless, they can represent human physical actualization and also contribute to human flourishing by helping sustain the human being. Autonomic responses, such as breathing, blinking, and digesting, animated by the nutritive or vegetative part of the soul and enacted through the body, are indeed "constitutive elements" of human acts.[114] However, in not being subject to the rational will, nutritive capacities on their own cannot constitute human acts. At the same time, the rational soul of the living human being is not, on its own, the human being. People are not free-floating rational wills and, in the Aristotelian view, it would not be human to be so. From a Protestant perspective, Barth articulates something similar. He works from the context of the soul/body division prevalent in Protestantism but attempts to overcome radical dualism:

> We thus understand man as a rational being with regard not only to his soul but also to his body. For in virtue of his soul, his body also has a full participation in his rationality. It is ruled by the soul and serves the soul. Therefore it, too, is not non-rational but rational, in so far as it finds itself together with the soul in and under that meaningful order.[115]

In attempting to clarify the relationship of the excellent functioning of the "nonrational" parts of the human with that of the "rational," he shows that in the properly ordered human being the two cannot be seen only separately. If they are, one is liable to view an intermediate end's instrumentality in a way that detaches it from its intrinsic goodness.

These are important points to get straight in articulating the significance of the body and physiological functioning. They are especially critical for considering the much debated statement by Pope Pius XII about the need to subordinate intermediate ends, such as the attainment and maintenance of physiological life, health, and all temporal goods, to the spiritual end of humanity.[116] Elsewhere, the pope reaffirmed this, saying, "But there must be added to the subordination of the individual organs to the organism and its end the subordination of the organism itself to the spiritual end of the person."[117] Much confusion over such statements has resulted from neglecting to separate that which is purely instrumental from what which is both instrumental and good in itself, that is, the

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[114] Gormally, "Human Dignity: The Christian View and the Secularist View."
[115] Barth, *Church Dogmatics*, III:2, 419.
[116] Pius XII, "The Prolongation of Life," (1958), 395-96.
[117] Pius XII, "Tranquilizers and Christian Morals," in *The Pope Speaks* 5, nos. 8-9 (1958): 437.

true good that is yet not the self-sufficient good but an auxiliary good. Meilaender and others make the justified complaint that secular bioethics, in its mechanized description of the human being, is prone to a purely instrumental subordination of the body to the "person."[118] It is this description of the human being that makes concepts of "quality of life" and "sanctity of life" so radically polemicized. But this need not be countered by a radically opposite statement, that quality of life has no bearing whatsoever on self-actualization, or that life may never be allowed to end so long as one can prevent it. Rather, if the papal statement is read in light of the Aristotelian-Thomistic tradition from which it is derived, it is evident that the pure instrumentalization of the body is a danger that need not preoccupy Christian anthropology, as there is firm ground for regarding bodily life as a genuine good. As Walter puts it, bodily life, even in terms of its autonomic functioning, is "a *bonum onticum*, that is, a true and real value."[119] The intermediate ends of physical actualization have this status, despite being ordered beyond themselves.

This balanced position between two extremes has also been articulated in Protestant ethics, in which a body/soul distinction is more prevalent than a tripartite view of the soul. Bonhoeffer provides a thoughtful account of this, revealing how bodily resurrection plays a central role in appreciating the physiological as an intrinsic but not a self-sufficient good:

> The life of the body, like life in general, is both a means to an end and an end in itself. To regard the body exclusively as a means to an end is idealistic but not Christian; for a means is discarded as soon as the end is achieved. It is from this point of view that the body is conceived as the prison from which the immortal soul is released for ever by death. According to the Christian doctrine, the body possesses a higher dignity. Man is a bodily being, and remains so in eternity as well. Bodiliness and human life belong inseparably together. And thus the bodiliness which is willed by God to be the form of existence of man is entitled to be called an end in itself. This does not exclude the fact that the body at the same time continues to be subordinated to a higher purpose.[120]

There is a noticeable kinship between the latter part of this statement with that made by Pope Pius XII. Both attempt to show how incorrect it is to absolutize the goods of the

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[118] Gilbert Meilaender, *Body, Soul, and Bioethics* (Notre Dame: University of Notre Dame Press, 1995), 37.
[119] James J. Walter, "The Meaning and Validity of Quality of Life Judgments in Contemporary Roman Catholic Medical Ethics," in *Quality of Life: The New Medical Dilemma*, ed. James J. Walter and Thomas A. Shannon (New York: Paulist Press, 1990), 81.
[120] Bonhoeffer, *Ethics*, 156.

body or the nutritive and sensory capacities of the soul, and yet how important it is to value them in a way fitting to their nature.

In spite of this, not all interpreters of the Thomistic tradition have seen it this way. The dominant challenge to this nuanced view of the goods of the body is what is commonly called the new natural law theory promoted by Germain Grisez and other Catholic scholars.[121] The theory centres on "basic human goods," which, though not a term used by Aquinas, follows his understanding that there are certain intrinsic, nonmoral goods that provide people with basic reasons for action.[122] Despite naming some of them—including life, sexual reproduction, and society—Aquinas is not so exact in his listing as to say there are no other goods that could be included in his list. Rather, this group consists of those goods that are categorically ordered toward the human end because they share in its character. Thus to go against them could also indicate deviation away from the ultimate good. New natural law theorists agree that there are such self-evident, intrinsic goods, including bodily life. However, this group goes further in articulating the concept of basic human goods and the moral duties that pertain to them, desiring to provide a radical alternative to radically dualist views. New natural law theorists outline a kind of conceptual hierarchy of goods in terms of two categories: the substantive goods (such as life and health) are prerequisites for reaching the moral goods (such as self-integration and friendship). But the primary point of departure from Aquinas is in the assertion that the goods are finally incommensurable despite this categorical diversity.[123] Indeed, it is *because* of that very diversity, say the theorists, that basic goods are incommensurable. Evaluating physiological life against friendship would be like comparing apples and oranges: there is no standard of measurement common to them in

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[121] Germain Grisez, *Christian Moral Principles*, vol. 1, *The Way of the Lord Jesus* (Chicago: Franciscan Herald Press, 1983). Along with Grisez, the most notable new natural law theorists include John Finnis, Robert P. George, Joseph Boyle, and William E. May. The theory is an attempt to contribute to Pope John Paul II's personalism in ethics. Although there are proponents of the 2004 papal allocution who do not adhere to the new natural law theory, this school's thought serves as one possible justification of and support for what is only briefly stated in the allocution, namely that human bodily life is a fundamental good and that ANH provides a great benefit to the PVS patient simply in preserving life.

[122] Aquinas, *Summa Theologica*, I-II, q.94 a.2.

[123] Grisez, *Christian Moral Principles*, 124; and Joseph Boyle, "Free Choice, Incomparably Valuable Options, and Incommensurable Categories of Good," *American Journal of Jurisprudence* 47 (2002): 127. On this departure see Ralph McInerny, "Grisez and Thomism," in *The Revival of Natural Law: Philosophical, Theological and Ethical Responses to the Finnis-Grisez School*, ed. Nigel Biggar and Rufus Black (Aldershot: Ashgate, 2000), 53-72.

terms of valuation. All basic goods are ultimate reasons for acting; although each one's goodness is realized in a way particular to it, as no single good has more goodness than another.[124] So, whereas there can be moral reasons for the prescriptive ordering of the goods in practical cases, this ordering does not amount to an intrinsic hierarchy of the goods. Any attempt to classify one good as intrinsically higher or more basic than another is confused.

New natural law theorists accept that one will deliberate on a course of action from among a variety of morally acceptable options according to one's "coherent plan of life."[125] But they also make it incumbent to pay appropriate attention to all the basic goods. In saying this, new natural law theorists deny Aquinas' assertion that there is one final end for humanity that is absolutely fulfilling and to which all goods can be ordered: "In loving various human goods for their own sake, human persons remain upright insofar as they remain open to integral human fulfilment. This fulfilment is naturally only an ideal, not a determinate goal to which all the acts of a good life contribute."[126] It is impossible, in this view, to hold onto all the basic goods together. Moreover, the attractiveness of such an ideal rests on the prior goodness of the basic goods and is not in itself the ultimate reason for their pursuit. Thus, life does have a terminal conclusion but not a single purposive direction. The efforts of these theorists to hold basic goods together lead their opponents to dub them polyteleologists.[127]

This certainly does represent a robust attack on radical anthropological dualism because it makes bodily life a good whose goodness can be neither subject to the realization of higher goods nor compromised by poor physiological condition. To be clear, this is different from saying an individual ought never to be allowed to die. Grisez is explicit that one may refuse to be sustained by ANH in a situation in which financial resources are limited. It would be acceptable to make this choice in order to provide basic

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[124] Boyle, "Free Choice, Incomparably Valuable Options, and Incommensurable Categories of Good," 123-27.
[125] Germain Grisez, Joseph Boyle, and John Finnis, "Practical Principles, Moral Truth, and Ultimate Ends," *American Journal of Jurisprudence* 32 (1987): 140-41; and John Finnis, *Natural Law and Natural Rights* (Oxford: Oxford University Press, 2001), 103.
[126] Grisez, *Christian Moral Principles*, 809-10.
[127] Benedict Ashley, "What is the End of the Human Person? The Vision of God and Integral Human Fulfilment," in *Moral Truth and Moral Tradition: Essays in Honour of Peter Geach and Elizabeth Anscombe*, ed. Luke Gormally (Portland: Four Courts Press, 1994), 68-96.

necessities to "those likely to receive greater benefits from them."[128] Further, one may choose to let one's life expire, rather than be maintained by medical treatment as "one ages and other vocational responsibilities drop away."[129] And the burdens of treatment, including pain, are always valid considerations.[130] In each case, ANH may be removed if the treatment (and not the patient's life) is viewed as excessively burdensome or useless, in accordance with the OEMD. But apart from such exceptions, new natural law theorists insist on the preservation of the lives of PVS patients because they do not view the provision of ANH as imposing on such patients burdens that generally outweigh the benefits of the preservation of human life.[131]

In making this claim about the incommensurability of basic goods, the theory goes beyond what Aquinas is prepared to admit of these goods. On the one hand, new natural law theory elevates basic goods to "ultimate grounds for reasons for action."[132] Aquinas, on the other hand, follows the Aristotelian notion that there are different vantage points by which means and ends can be viewed. He sees these goods also as intermediate ends. In fact, they are the beginning of the consummate or complete good.[133] They are also auxiliary to the complete good. For attaining the complete good,

> there is requisite health of body; and all artificial necessaries of life are means to health. Another requisite is rest from the disturbing forces of passion: that is attained by means of the moral virtues and prudence. Likewise rest from exterior troubles, which is the whole aim of civil life and government. Thus, if we look at things rightly, we may see that all human occupations seem to be ministerial to the service of the contemplators of truth.[134]

From this position, Aquinas is able to argue that, although it is natural for everyone to value one's life, this value must be apportioned in due measure. One must "love these things not as placing his end therein, but as things to be used for the sake of his last end."[135] As Thomist scholar Benedict Ashley puts it, "some goods are ultimate in their

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[128] Germain Grisez, "Should Nutrition and Hydration Be Provided to Permanently Unconscious and Other Mentally Disabled Persons?" in *Artificial Nutrition and Hydration and the Permanently Unconscious Patient*, ed. Hamel and Walters, 169.
[129] Germain Grisez, "Bioethics and Christian Anthropology," *National Catholic Bioethics Quarterly* 1, no. 1 (2001): 38.
[130] Grisez, "Should Nutrition and Hydration Be Provided," 166 and 170.
[131] May et al., "Feeding and Hydrating the Permanently Unconscious and Other Vulnerable Persons," 211.
[132] Boyle, "Free Choice," 128.
[133] Aquinas, *Summa Theologica*, I-II, q.94 a.2 and q.1 a.6.
[134] Aquinas, *Summa Contra Gentiles*, III, q.37.
[135] Aquinas, *Summa Theologica*, II-II, q.126 a.1.

own order, yet means to some greater good. They are intermediate ends in a *hierarchy* of ends."[136] Although the fitting action usually consists in the pursuit of these goods, according to Aristotelian prudence, it does so only insofar as this pursuit is neither deficient nor excessive in aiming at the complete good. If two intrinsic goods are in irreducible conflict, there is no way to pursue the ultimate end or complete good without leaving one behind for the sake of the other. This does not entail directly going against an intrinsic good since the intention of the agent is not to disregard any value but to orient one's pursuit of the good in a way that corresponds to the demands of the practical situation.

The new natural law theory allows little room for prudence. It insists that certain sacrificial actions are immoral, whereas what really needs to be admitted is that moral tragedy is unavoidable. Moral tragedy, in which an agent must act to forfeit one legitimate good for the sake of another, higher good, is an indication of human limitation, not human immorality. The practical problem addressed by this thesis brings to light that extreme circumstances can arise in which physiological functioning no longer acts as a foundation for other levels of human actualization. In such cases, preserved physiological function, though still a good, contributes nothing to the only course left open to patient that is related to the ultimate good—the patient's death. This is not a commendation of suicide or euthanasia, since a moral distinction still obtains between attacking life and allowing life to expire. It is instead to admit that the ambiguity of death is found in its openness toward the spiritual human end. Certainly, the decision not to preserve life when it can possibly be preserved is always unsettling to some extent, even when "one ages and other vocational responsibilities drop away." But this is not necessarily because the decision is wrong or shows insufficient dedication to intrinsic goods. Clarity comes in holding two things together: there is a difference between directly going against an intrinsic good (disregarding its value) and allowing an intrinsic good to cease when to do otherwise would divert the teleological orientation. The Christian narrative insists that there are causes beyond life for which people should and do live. If God is to be viewed as the source of all value, it must be a primary presumption of Christian value theory that

[136] Ashley, "What is the End of the Human Person?" 79. Emphasis in original. Cf. Aquinas, *Summa Theologica*, I-II, q.1, a.6.

self-evident goods—even human life—are to be respected as constituent parts of the goodness God intends for human life. However, the same premise reveals that only God is of infinite value; these goods are not to be promoted at all costs.

In order to determine how far such promotion should go in particular cases, rules are enumerated that govern the proper pursuit of human ends. Quality of life becomes a valid consideration for questions of human flourishing. But this is not a movement of judgement of the worth of one patient's life against another's. It is always related to how well a patient's physiological state is ordered to the ultimate human end, and how much medicine can do to improve that ordering. After all, although the soul remains the act of the body, the body damaged beyond repair can prevent the expression of the soul.[137] Walter points out that quality of life judgements are better called judgements about the quality of the *relationship* between one's potential and one's efforts toward actualization.[138] If the relationship is severely and irreparably damaged due to ill health, the value judgement that is made pertains not to the patient's ontological value. It is, rather, about the status of the intermediate ends: "Whereas all physical life is of equal ontic worth and all personal life is of equal moral value, the quality of the relation between these lives and the pursuit of values is not equal."[139]

2.3.2 Natural Ends

What is the ultimate good of the soul toward which the goods of the body, along with external goods, are ordered? For Aristotle, such goods culminate in *eudaimonia*, otherwise put as virtuous or excellent rational activity. This is the complete good for humanity, its natural end, and it entails a good that includes but goes beyond the ordered functioning of the body. It is properly the end of the ethical being.

This does not mean, however, that the analysis is finished with intermediate ends. For these are prerequisites of *eudaimonia*. But bringing in intermediate ends, such as

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[137] Cf. Kevin D. O'Rourke, "Artificial Nutrition and Hydration and the Catholic Tradition," *Health Progress* 88, no. 3 (2007), http://www.chausa.org/Pub/MainNav/News/HP/Archive/2007/05MayJune/Articles/Features/hp0705i.htm.

[138] Walter, "The Meaning and Validity of Quality of Life Judgments," 81-82. Cf. Walter and Shannon, "The PVS Patient and the Forgoing/Withdrawing of Medical Nutrition and Hydration," 155.

[139] Walter, "The Meaning and Validity of Quality of Life Judgments," 84. Elsewhere, Walter distinguishes between axiological judgements of human value and normative judgements about treatment decisions. See Thomas A. Shannon and James J. Walter, "Assisted Nutrition and Hydration and the Catholic Tradition," *Theological Studies* 66, no. 3 (2005): 661.

ordered vegetative functioning, is a peculiarity in the analysis of the rational being brought about by changes in medical possibilities for human life. For, in addressing the natural ends of humanity that depend on human will and action, Aristotle is naturally quite cursory in his account of the role of nutritive functioning.[140] As Gaëlle Fiasse observes, when speaking about human anthropology from a biological perspective, Aristotle finds it appropriate to take into account all of the functions of the human being, nutritive, sensory, and rational.[141] However, in switching focus to the human being *qua* ethical being, the anthropological concentration shifts as well. The vegetative part of the soul becomes less significant to the consideration than those parts that are subject to reason, since the latter are the parts that pertain directly to virtue and the willed ordering of one's life. And so the significance he attaches to functioning at this level is limited to the role of luck in supplying or denying one of the bodily goods.[142] The assumption he can make is that a human being, sustained over the long term, has ordered vegetative functions that contribute to actualization at the sensory and rational levels. But with the medical possibility of permanent vegetation, it becomes appropriate to consider the place of autonomic functions for the one in such a condition. If utterly severed from the rational will or left thoroughly undirected in their functioning, autonomic functions do not facilitate other kinds of human actualization. It is in this restricted sense that Aristotle is able to make the claim that vegetative capacities have no share in human virtue.[143]

Insight into this suggestion is gained by referring to another discussion in the *Nicomachean Ethics*. Aristotle asks his readers to conceive of someone who is virtuous in character, but who falls asleep for the remainder of his life.[144] The sleeping one retains virtue but fails to put it into action. The result is that his existence is exposed to the worst of misfortunes but not to the possibility for flourishing. Aristotle's point is that inactive virtue is inadequate for the good life. But a parallel observation can be made: persistently vegetative patients, prevented from sensory and rational actualization, retain human identity, but can no longer pursue the larger vocation given with their nature. With ANH,

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[140] Aristotle, *Nicomachean Ethics*, 1.13.1102b1-1103a4.
[141] Gaëlle Fiasse, "Droit naturel, finalité, nature et esclavage chez Aristote," in *Le droit naturel. Relancer l'histoire?* ed. L-L Christians and others (Brussels: Bruylant, 2008), 133-54.
[142] Aristotle, *Nicomachean Ethics*, 7.13.1153b16-18.
[143] Ibid., 1.13.1102b13.
[144] Ibid., 1.5.1095b35-1096a2.

there is a new capacity of medicine to facilitate the expressions of the vegetative soul indefinitely. But in this case, such activity does not entail the expressions of the sensitive and rational soul. Thus, it also does not entail that an individual will be enabled to pursue the complete good or reach the final human end. In saying this, I do not relegate the vegetative part of human life to merely instrumental status or prevent its being called a genuine good. Rather, I mean to indicate the newfound possibility for tragedy in the medical capacity to maintain human life and the expressions of the nutritive soul that at the same time fails to make such expressions foundational for the higher ends of human life.

Having said this, I can move on to explore another prerequisite for *eudaimonia*. Consciousness is a faculty that is often underaddressed in studies of Aristotle, although he himself includes it among the parts of the human being subject to reason. Consciousness is a good not present at the nutritive level, and one that is available in different ways to strictly sensory beings and to rational beings. For instance, some sensitive beings are limited to the sense of touch.[145] Aristotle, however, does not use the word "consciousness" to describe this faculty but, instead, perception (*aisthēsis*). Perception, at base, is a matter of exercising the senses. It also includes being subject to appetites, nonrational desires, or passions aroused by external objects. Perception, however, shares in reason and contributes to ethical activity insofar as it "listens to reason as to a father."[146] The ethical life, then, is a matter of the proper interaction of these two parts. Thus, Aristotle indicates that perception takes on a different role in the human being: "For animals, life is defined by the capacity for perception, but for human beings, it is defined by the capacity for *perception or understanding*."[147] Barth explains this relationship as capable of being seen from the different perspectives possible in considering the body-soul unity. When looking at human beings as the soul of their *body*, the focus is on awareness. When looking at human beings as the *soul* of their body, rational thought is brought into focus.[148] All the same, both reason and consciousness or perception are less significant in themselves as they are in being parts of what enables people to live and act

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[145] Aristotle, *De Anima***,** 2.2.413b4-7.
[146] Aristotle, *Nicomachean Ethics*, 1.13.1103a4.
[147] Ibid., 9.9.1170a16-17. Emphasis added.
[148] Barth, *Church Dogmatics*, III:2, 400.

humanly. Unlike other creatures, humans are self-determining; they purposefully propel themselves to their own end, rather than being directed to it through instinct, say.[149] In isolation, reason will not move an individual toward action; what is required for such propulsion is desire. But desire at the sensory level, on its own, is untutored by wisdom and incapable of sustaining fitting or ethical activity over time. It must be joined with the rational in order to contribute to the ethical life. Reason and desire intertwined become deliberative desire, or the kind of desire that leads one to will the good and act toward this end.[150] In this way, human beings become, as Aquinas has it, the principles of their own actions[151] or, as Barth puts it, the subjects of their own decisions.[152] Thus, Aquinas indicates the significance of reason in terms of its ordering the will, providing an individual with the ability to recognize the authentic good and choose it over other perceived goods.[153] And the significance of the rational will is in the contribution it makes to the individual as a whole: "For the intellect understands, not for itself alone, but for all the powers; and the will wills not only for itself, but for all the powers too. Wherefore man, in so far as he is endowed with intellect and will, commands the act of the will for himself."[154]

In focusing on perception, especially in terms of its interaction with reason, Aristotle notes its two kinds of objects. The first and most definitive object of perception is the one external to the individual that actualizes the capacity. The task of the senses is to appreciate the outside environment, supplying information to the rational function as it attempts to determine how to engage the environment fittingly.[155] There is also, however, a reflexive function of consciousness. Whereas only God thinks in an exclusively reflexive way, according to Aristotle, humans are quite capable of perceiving themselves perceiving.[156] Being conscious or aware of one's own activity of perception is the same as

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[149] Aquinas, *Summa Theologica*, I-II, q.6 a.1.
[150] Aristotle, *Nicomachean Ethics*, 3.3.1113a4-13.
[151] Aquinas, *Summa Theologica*, I-II, Prologue.
[152] Barth, *Church Dogmatics*, III:2, 396-97.
[153] Aquinas, *Summa Theologica*, I, q.81 aa.2-3.
[154] Ibid., I-II, q.17 a.5 ad.2.
[155] Cf. Aristotle, *Metaphysics*, 4.5.1010b35.
[156] Aristotle, *De Anima*, 3.2; *Metaphysics*, 12.9.1074b35-36; and *Nicomachean Ethics*, 9.9.1170a30-35. It is unclear what Aristotle thinks of nonhuman animal perception on this score. In light of current studies on animal sentience it would be acceptable to assume that animals are capable of some reflexivity at various but rudimentary levels. Aquinas affirms animal sentience in *Summa Contra Gentiles*, II, q.82.

being conscious or aware of one's own being.[157] It is this conscious awareness that allows for subjectivity, "friendship" with oneself, and what Ricœur terms the narrative unity of life. That self-awareness has always been presumed in philosophical discourse on ethics and the rational will is clear. Ethical agency requires it. Without the perception that enables self-awareness one cannot obey a law, follow one's conscience, take responsibility for action, or nurture a virtuous character. Self-awareness is also assumed in religious discourse on friendship with God. Pope Pius XII speaks of the "self" as a "permanent character" manifested in both interior life and external action. It distinguishes one human being from another.[158] At the same time, he claims, this does not make the sleeping or permanently unconscious patient less than human. But because actualization requires efforts made toward "perfecting human nature" (in a spiritual, not medical, sense), consciousness is a requisite for reaching human ends, whether natural or spiritual.

The kinds of human activities Aristotle views as representative of the natural human end include ethical action in the practical sphere and contemplative action in the theoretical sphere *together*. Tension is often perceived in his description of the human being *qua* rational being, which can be mistaken for an isolated autonomy, and the human being *qua* political or social animal, which always seeks the good life with others. Alongside rational contemplation, Aristotle identifies friendship as a necessary and constitutive element of the proper end of humanity.[159] Ever the keen observer of human nature, he contends that individuals, having all other goods, will not finally be happy if they are alone.[160] His account of friendship reinforces that human beings cannot be actualized only by a movement inward. They must also be urged by and toward something external to them, the friend. Moreover, Aristotle's focus on friendship provides insight into his understanding of the nature and purpose of that distinctive human capacity, reason. Contemplation, or theoretical reason, is not something exercised only in isolation and apart from the practical life. It is also, as philosopher Robert Sokolowski calls it, a "distributed reason…shared among friends."[161] Lest it be thought that friendship

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[157] Aristotle also counts this as a pleasure in *Nicomachean Ethics*, 9.9.1170b1.
[158] Pius XII, "Applied Psychology," *The Pope Speaks* 5, nos. 8-9 (1958): 9.
[159] Aristotle, *Nicomachean Ethics*, 9.9.1169b10.
[160] Ibid., 8.1.1155a5 and 9.9.1169b18-20.
[161] Robert Sokolowski, "Friendship and Moral Action in Aristotle," *Journal of Value Inquiry* 35, no. 3 (2001): 368. Cf. Aristotle, *Nicomachean Ethics*, 10.7.1177a35-1177b1.

is an instrumental good only, or that the friend is desired merely for the sake of one's own self-improvement, Aristotle shows that the goods actualized in friendship are not only internal to friendship. Friendship does prepare the friends to reason and act excellently as individuals. Yet it also transcends the friends themselves in the results of their common projects.[162] Individual fulfilment is not a fulfillment accomplished in isolation and neither are its benefits appreciated in isolation.

The relationship between individuals in community is also an important component of the Christian understanding of the natural end of human beings: "The fullness of [the image of God] is expressed through life in human community."[163] This community is expressed primarily in the church and its practices, which are to exhibit love and mutual self-giving.[164] That the flourishing of the church itself, rather than simply that of its individual members, is a significant end in the Christian tradition is represented in various scriptural metaphors: Christians are branches on one vine or members of one body.[165] What results from this is what philosophers of medicine David Weisstub and David Thomasma have called an "ethic of covenantal reciprocity."[166] It is an ethic that upholds both justice and compassion for all not as axiomatic values but as values embedded in a story of God's loving action toward all of humanity.

A theoretical discussion of the dignity of the human being has been necessary to distinguish between human nature and vocation, and up to this point I have accepted "respect for dignity" as indicative of the kind of ethical action one's dignity elicits from another. Traditionally, Christian bioethics has used the term "respect" to indicate a "holy awe" that is experienced in the encounter with human life.[167] However, this concept on its own is perhaps not sufficient to convey the kinds of dispositions Christians are to have and the sorts of actions they are to demonstrate toward other human beings. The libertarian tendencies in modern Western culture encourage a reading of respect that bears the connotation of nonintervention. There is respect for the freedom of strangers in their

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[162] Aristotle, *Nicomachean Ethics*, 8.1.1155a15.
[163] Faith and Order Commission of the World Council of Churches, *Christian Perspectives on Theological Anthropology*, §45.
[164] Cf. Ashley, *Theologies of the Body*, 365.
[165] John 15:1-4 and Romans 12:4-5.
[166] David N. Weisstub and David C. Thomasma, "Human Dignity, Vulnerability, Personhood," in *Personhood and Health Care*, ed. David C. Thomasma, David N. Weisstub, and Christian Hervé (Dordrecht: Kluwer, 2001), 318.
[167] Paul Ramsey, *The Patient as Person,* 2nd ed., 106.

acting; other people must be allowed to take certain risks or make their own mistakes. There is respect for the religious and cultural peculiarities of strangers; other people must be allowed to live their private lives in manners that might be different from one's own. This is the kind of respect that conveys tolerance, even indifference, rather than admiration. What is missing in the use of this term is any sense of moral obligation or responsibility for active engagement with the other. Weisstub and Thomasma discern that what is often called showing respect is, in the Christian church, better described as *honouring* others.[168] Honour is a term they consider to be more reflective of the role Christians play in individuating their active responses to the unique situations and needs of other people. This is the honour that gives others their due in a particularized way. It is inspired by the admiration of their intrinsic dignity, though not necessarily for their character or deeds. It exceeds "respect for dignity" in the accuracy of its account of human nature: it perceives that human beings are as essentially fragile as they are capable or autonomous. As I have already indicated, this does not represent a weakness of character but a condition of finitude, one proper to human life. Alisa Carse puts this well: "our flourishing is in crucial ways *constituted* by vulnerability. Being open, receptive, flexible, and tender, being emotionally invested in relationships or committed to undertakings, being capable of nurturing and being nurtured, of loving and growing are necessary to realizing some of the most profound 'goods' of human life."[169] However, in recognizing human nature as such, a disposition of honour demands responsibility for others on the part of community members.[170] The Christian understanding of honouring people in their vulnerability requires that people have the moral courage to include the vulnerable in community life. Honouring another in this way entails understanding who the other is in a way that respect, a form of taking distance from the other, does not. Taking into account the identity and needs of the other better prepares one to build up the necessary factors, whether external goods or goods of the body, for a quality of life that enables the other's actualization at all levels. Another part of honouring others through

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[168] Weisstub and Thomasma, "Human Dignity, Vulnerability, Personhood," 328.
[169] Alisa L. Carse, "Vulnerability, Agency, and Human Flourishing," in *Health and Human Flourishing*, ed. Taylor and Dell'Oro, 35.
[170] It is important to observe that an ethic of responsibility is not limited to the Christian context. See, for example, Jonas, *The Imperative of Responsibility*. What I insist on here, rather, is that there is a particular context that grounds the Christian understanding of mutual obligation and responsibility.

intimate knowledge of them is to nurture the prudence required for recognizing when ameliorative efforts become futile. Such a balance values all individuals in their existence as beings who are made to actualize their capacities and who are restricted in their possibilities for doing so.

2.3.3 The Spiritual End

The idea that there can be a spiritual end to human life in addition to natural ends has antecedents in Aristotle. I have indicated the high value he assigned to the role of the intellectual virtues in daily life, but what remains to be observed is that Aristotle considered pure theoretical reason the highest activity. It was so high, in fact, that the philosopher thought that only one who had transcended human limitations and become like a god could exercise contemplation in isolation and for no further or conjoined end.[171] Whereas the gods were considered "wholly blessed," human life was blessed only insofar as it was able to "resemble" godlike theoretical reason.[172] There is in this portrayal of human life the interplay between finitude and freedom, but also a hope of release.

Aristotle's insistence that there was a transcendent end for humanity—indeed, a transcendent form of humanity dignity—was fulfilled in the work of Aquinas, who applied to this notion the *beatitudo perfecta*, or the blessed vision of God.[173] Aquinas is keen to describe this as a perfect contemplation of God, underscoring this activity as one effecting perfect union with God.[174] Certainly union with God is considered in Christianity something humans are capable of desiring and even obtaining to some degree. Aquinas affirms this by calling attention to the "inner life" or "spiritual life" of the human mind, which facilitates communication and fellowship between the individual and God.[175] Similarly, Barth has claimed, "man is capable of perceiving the God who meets him and reveals Himself to him."[176] But Aquinas adds something to this natural capacity: the virtues of faith, hope, and especially love (or charity), which are called

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[171] Aristotle, *Nicomachean Ethics*, 10.7.1177b27-28.
[172] Ibid., 10.8.1178b26-27.
[173] Aquinas, *Summa Theologica*, I, q.12 a.11.
[174] Ibid., I-II, q.3 a.7 and a.3.
[175] Cf. ibid., II-II, q.23 a.1 ad.1.
[176] Barth, *Church Dogmatics*, III:2, 399. It should be understood that this affirmation of human perception is not an instance of Barth condescending to natural theology. Rather, he insists that the capacity for perceiving the revelation of God—a capacity that is God-given—is necessary for existing in relationship with God. This relationship is, for Barth, what constitutes the *imago Dei*.

"theological" because they are not given with human nature but infused in the individual by God and have God as their object.[177] The human capacities for perception and reason, along with the infused theological virtues, allow people to pursue the spiritual end even though they are limited by the human condition. Meeting God, though, is never fully realized in this life because the senses cannot fully behold the ultimate good or beatitude. The mode of knowledge the embodied soul is capable of is not the mode required to perceive the "Divine essence." Human senses can perceive certain effects of God's power, but not that power itself.[178] However, Aquinas claims that after the general resurrection the vision of God will overflow into the senses and perfect their operation.[179] This must be so, he says, because an insensitive condition, such as sleep, "is not the ultimate act of life...[but] is described as half-life."[180] Perfection must include the kind of vigilance not subject to finitude and the kind of human functioning not subject to tragedy.

One point must be added to this account of the limited pursuit of the spiritual end. There are some who claim that the severely disabled are not capable of such a pursuit. New natural law theorist William May, for instance, argues that the inability of these individuals to make judgements and free choices radically impairs their spiritual activities.[181] According to the principles of his own theory, this does not separate the severely disabled from their humanity or goodness, nor does it mean they are less entitled to morally ordinary care. Although I agree that all living beings of the human natural kind have intrinsic value, once one looks into the Thomistic tradition I think it is clear that May goes too far in discounting the capacities of such individuals. A rational will is certainly necessary for the excellent pursuit of both natural and spiritual human ends, but it is *communication* between humanity and God that Aquinas points to as fundamentally constitutive of the human-Divine friendship.[182] In order to appreciate the difference, a lesson can be taken from human friendships. Friendships between the severely mentally disabled and the mentally abled are certainly not capable of the "excellence" of

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[177] Aquinas, *Summa Theologica*, I-II, q.65 a.3.
[178] Ibid., I, q.12 a.12.
[179] Ibid., I-II, q.3 a.3. Cf. III Suppl., q.82.
[180] Ibid., III Suppl., q.82 a.3.
[181] William E. May, "Caring for Persons in the 'Persistent Vegetative State,' and Pope John Paul II's March 20 2004 Address 'On Life-Sustaining Treatments and the Vegetative State,'" in *Artificial Nutrition and Hydration: The New Catholic Debate*, ed. Tollefsen, 66.
[182] Aquinas, *Summa Theologica*, II-II, q.23 a.1.

friendships between two parties who can each exercise a rational will. However, friendships of the former kind are not out of the question. Indeed, though moments of connection might be rare and even ambiguous in their appearance, they are possible. Added to this understanding of communication are the theological virtues, which are not called a matter of human excellence but, rather, the work of God. Although they supplement the properly ordered rational will, the loving actions of even the severely mentally disabled show that they are not dependent on the *excellent* functioning of reason. It is not apparent, then, that the kind of rational will exhibited by the abled is absolutely necessary to this kind of communication. What seems basically necessary for two-way communication and friendship is human perception, that is, consciousness. People with severe mental disabilities do have cerebral cortices functional to different degrees. But without a cerebral cortex that supports consciousness, the conditions for receiving and offering human communication are simply not present. O'Rourke makes a similar observation: "the soul needs proportionate matter—the functioning human body (specifically, the human brain)—in order for the organism to strive for its purpose in life."[183] But so long as the cerebral cortex is capable of basic function, that is, so long as the body remains healthy enough to allow the sensitive soul's expression, I fear it is dangerously presumptive to rule out the possibility of actualization through human perception. Thus, I am less comfortable than May with drawing so decisive a moral line between the severely disabled and those who can demonstrate a rational will.

Mental disability is one of the ways in which human life expresses its fragility and indicates one of the hopes for perfection found in eternity. However, the fact that temporal life entails limitation and eternal life entails transcendence does not mean there is a fundamental disconnect between the natural and spiritual ends of the human being or that the two categories of ends are in irreducible conflict. Whereas traditions of asceticism are present in various expressions of the Christian faith, Christians do not generally pursue spiritual goods at the expense of natural goods. As Thielicke has put it, the fact that the spiritual end of humanity is not fully realized in the course of human history "does not mean, of course, that it has nothing to do with our historical life. The new

[183] O'Rourke, "Artificial Nutrition and Hydration and the Catholic Tradition." Also see his "Father O'Rourke Responds," 16.

heaven and new earth that are not of this world are still goals of this world and also its critical limits. They are goals inasmuch as God's kingdom shows us what it is all about here and now."[184] The Christian believes that anticipation of the full actualization of the spiritual end affects one's character today, and practical and intellectual virtues have always been seen as complemented and perfected by theological virtues.[185] Hence the virtuous pursuit of natural goods, ordered by love, is consistent with the pursuit of spiritual goods. Both kinds of virtue can play a role in leading people toward their spiritual end. So, for instance, there is a genuine connection between the kinds of temporal friendship possible between people and the enduring friendship between humans and God. At the same time, if the pursuit of a natural or intermediate end conflicts with the pursuit of the spiritual end in a practical situation, it is the latter end that prevails. It is this idea that has been expressed by Pope Pius XII in claiming that life, health, and all temporal activities are to be subordinated to spiritual ends. It is also this idea that serves as the foundation for allowing patients to forego extraordinary means—those that are too burdensome or not beneficial—even at the risk of loss of life.

As is true of the Christian articulation of the natural human end, the idea of spiritual end as being one of union, relationship, or requiring reference outside the self obtains. "The ultimate and principal good of man is the enjoyment of God…and to this good man is ordered by charity."[186] The Catholic Catechism confirms this as the ultimate human end.[187] Other parts of the Christian tradition, too, concur in observing this end. For instance, the first question the Westminster Catechism asks is, "What is the chief end of man?" It answers, "to glorify God, and fully to enjoy him forever."[188] In line with Aristotle's notion that humans are fulfilled not through possessions or states but through activity, the enjoyment of God or the *beatitudo perfecta* cannot be understood simply as a passive receipt of the vision of God. Certainly, it is this vision—the essence of God—that is considered the ultimate desire of humanity; this end is legitimately described as

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[184] Helmut Thielicke, *Being Human…Becoming Human*: *An Essay in Christian Anthropology*, trans. Geoffrey W. Bromily (Garden City: Doubleday & Company, 1984), 366.
[185] Aquinas, *Summa Theologica*, I-II, q.65 a.3.
[186] Ibid., II-II, q.23 a.7.
[187] United States Conference of Catholic Bishops, *United States Catholic Catechism*, §356.
[188] General Assembly of the Presbyterian Church in the U. S., "Westminster Larger Catechism," in *The Confession of Faith of the Presbyterian Church in the United States* (Richmond: Board of Christian Education, 1965), Introduction, q.1.

external to the individual. Likewise, the *enjoyment* of God's essence in an active movement of love can also be described as this same end, a way of conveying it that explicitly involves the individual.[189] These two expressions of the end are in accord with the idea of self-fulfillment as entailing an outward movement of actualization, illustrated in the natural end of friendship. Hence Aquinas also calls the spiritual end friendship with God.[190] The Catholic Catechism affirms the human individual as being "called to share, by knowledge and love, in God's own life," further claiming, "it was for this end that he was created, and this is the fundamental reason for his dignity."[191] This concept of sharing has much in common with Aristotle's conception of the human as a political animal. But it also goes beyond natural sharing and points to a supplemental rationale for human activity. The ultimate human end is not to be realized in the self alone, apart from God. Put differently, "being human means being in relationship with God."[192] Having this in mind, Catholics and Protestants alike tend to look to Jesus Christ as the fulfillment of the *imago Dei* or "the point of reference for understanding what it is to be human."[193] Christ is understood as fully God and fully human, and although humans will never be constituted in such a way, what can be observed here is that Jesus Christ—not reason—is properly considered the "meeting point" between humanity and God. Once again, the relational activity of God comes prior to the fitting responses of human beings.

It has been argued here that human bodily life has intrinsic but not unlimited value. As an intermediate end, it is a genuine good but one that is not sufficient for human flourishing, as flourishing is understood in the Christian tradition. Even given the Aristotelian-Thomistic anthropology so central to the thinking of many Christian theologians and ethicists—especially Catholics—one should end up in a different place on the question of treating PVS patients than the Vatican and like-minded bioethicists do now. I will go on to insist that medicine must admit of exceptions in the effort to preserve life. Just as medicine must not be unduly influenced to consider the body as only of instrumental value—something to be discarded when the brain is not functioning

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[189] Aquinas, *Summa Theologica*, I-II, q.3 a.1.
[190] Ibid., II-II, q.23 a.1.
[191] United States Conference of Catholic Bishops, *United States Catholic Catechism*, §356.
[192] Commission on Faith and Witness of the Canadian Council of Churches, *Becoming Human*, 4.
[193] Faith and Order Commission of the World Council of Churches, *Christian Perspectives on Theological Anthropology*, §80.

properly—Christian ethics must not be counter-influenced to consider the body to be of infinite value—something to be preserved at all costs even when incapable of actualizing the sensitive and rational parts of the soul.

Challenging this balance are innovative human powers that open up novel possibilities for human action upon human patients. Certain new technologies have humanity as their direct object, and even the most conventional of these can change the course of human lives into something not in conformity with the Christian idea of what it means to live humanly. The PVS is a technologically dependent condition that defies the proper interaction of the body and soul. The patient in a PVS is not dead as the soul is still active, made evident to the observer at the nutritive or vegetative level. And the human soul is not divided but united; so the whole soul, nutritive, sensory, and rational levels together, remains present with the body. Nevertheless, there exists a physiological deficiency in the brain that prevents the expression of the sensory and rational soul through the body. This deficiency cannot be repaired by medical means. As I have indicated, it is unsatisfactory to label such patients "nonpersons" and thus unjustifiably devalue them or rob them of their identity as members of the human natural kind. But it is one thing to base one's ontic and moral evaluations of a patient on the patient's demonstrated capacities and another to tailor one's expressions of care and honour to those demonstrated capacities. Indeed, what is lacking in value is not the patient but, rather, any part medicine plays in protracting permanent vegetation. And so, in deciding whether to continue the means that sustain vegetation, the possibilities for action will continue to be brought up against a basic account of human anthropology—what the dignity of human nature demands and what the dignity of the human vocation delimits.

Chapter 3
The Ordinary-Extraordinary Means Distinction: Historical Survey and Contemporary Innovations

The previous chapter provided an account of the human being, which is always articulated in relation to God. It is now apparent that the value of human life merits the dedication of certain resources toward the preservation of that life. In practical terms, this will include the development and application of medical means. Also indicated by life's limited value is that there is no ethical justification for pursuing a limitless development and use of these means. In this chapter, the traditional representation of this limit, the OEMD, is described. Much consideration will be given to the origins and continued use of this distinction in Catholic moral theology. Understanding its use in the broadest possible context of Christian bioethics also requires that attention be paid to how it has been employed by prominent Protestant bioethicists.

The OEMD points to the necessity of allowing for the withholding or withdrawing of means of preserving life in certain instances. In point of fact, the OEMD, though normative, is not a rule that establishes an ethical outcome for a given eventuality. Rather, it is a conceptual tool, involving the weighing of benefits and burdens, which aids in making a prudential judgement. The formula in each case remains the same, but the outcomes are as diverse as the situations to which the OEMD is applied. In outlining the contours of the OEMD, several consistent and salient features can be specified. Among these, the distinction's contextual nature and its orientation toward the ultimate human good will be emphasized.

This chapter begins by accenting key historical developments in the construction of the OEMD. These are synthesized to establish the process of deliberation involved in the application of the OEMD. Following this, I offer an assessment of the Protestant usage of the tool since the time of the Catholic manualists. This has the effect of highlighting certain perceived difficulties with the OEMD, those that arise in a climate complicated by increased technological capacities and quality of life concerns. Finally, I outline a catalogue of major innovations responding to these threats. These innovations pertain, in particular, to how the OEMD is perceived in light of the new medical problem of the ability to stabilize and maintain vegetative human life by means of ANH. I argue

that each innovation, though formulated in reaction to contemporary medicine, actually represents a threat to the integrity of the OEMD.

3.1 History

A larger aim of this thesis is to render a clear statement of the role of medicine in assisting people in their efforts toward actualization and flourishing, however diversely pursued among differently abled individuals. How the ends of medicine relate to the ends of human life and the concept of human flourishing will be explicated in chapter five. Here I would like to suggest that the original proponents of the OEMD were indeed oriented toward human flourishing. That is to say, their concern was not only with the physiological condition of the patient but primarily with the patient as a human being oriented toward certain kinds of actualization. Despite the failure of the manualist tradition in general to put forth a substantive vision of what is noble, it will become apparent that the manualist formulation of the OEMD is in close keeping with the theological anthropology established in the previous chapter. In outlining the benefits and burdens relevant to a medical-moral judgement, the manualists continued to uphold the duty of life preservation as binding but imperfect, and this, it will be argued, was due to a concept of human goodness that did not end with human biological life. What makes the manualist efforts worthy of note is that these moralists undertook the challenge of limiting life preserving means during a time of expanding medical possibilities, a reality that could easily have led to a corresponding perceived expansion of moral obligation.

3.1.1 Manualist Development of the OEMD

In the fourth century, St. Basil the Great wrote:

> Whatever requires an undue amount of thought or trouble or involves a large expenditure of effort and causes our whole life to revolve, as it were, around solicitude for the flesh must be avoided by Christians….Therefore, whether we follow the precepts of the medical art or decline to have recourse to them…we should hold to our objective of pleasing God and see to it that the soul's benefit is assured, fulfilling thus the Apostle's precept: "Whether you eat or drink or whatsoever else you do, do all to the glory of God."[1]

In this excerpt we see that benefits and burdens alike concern St. Basil. The benefits provided by life preserving means are realized in the life with God. The burdens

[1] Basil the Great, "The Long Rules," q.55, 336-37.

discussed here do not represent mere physical impossibilities, since no one is held to do something physically impossible. Rather, undue amounts of thought, trouble, or effort represent *moral* impossibilities. Moral impossibility, as it is used in the Catholic moral tradition, exists when individuals are physically capable of fulfilling the law but find it extremely difficult to do so.[2] The difficulty may arise from objective circumstance, such as financial cost, or subjective perception, such as fear. Moral impossibility, then, indicates a legitimate exception to observing the law in a particular instance. Drawing on Ricœur's language, it might be said that allowing for moral impossibility prevents Christians from deviating from the ethical aim in their attempts to fulfill the moral law. Thus, one is to avoid those courses of therapy that take over one's life, or those that order life toward treatment rather than ordering treatment toward life. Pope Pius XII's statement that life, health, and all temporal activities are subordinated to spiritual ends is consonant with this.[3] This language of ordering treatment toward life is, of course, a rather imprecise way of speaking; sometimes even the most invasive and extensive treatments better enable a patient to pursue human ends. Imprecise, too, are other terms commonly associated with the OEMD, such as a "reasonable" or "proportionate" benefit. All the same, such terms are unavoidably connected to judgements about life preserving means: the OEMD is a tool that embraces the role of prudence. From Aquinas it is received that it is natural and good for one to value one's own life *in due measure*, or in a measure properly related to its final end.[4]

Thus, it has long been evident that a prudential limit must be placed on efforts to preserve human life. However, aside from this sentiment of St. Basil, there is little indication of anything approaching the OEMD until the sixteenth century.[5] With the development of modern medicine came an increase in options for preserving life, not all of which seemed appropriate in particular instances. In such a context, the basic concern

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[2] James T. Bretzke, *Consecrated Phrases: A Latin Theological Dictionary. Latin Expressions Commonly Found in Theological Writings*, 2nd ed. (Collegeville: Liturgical Press, 1998), 85.
[3] Pius XII, "The Prolongation of Life," (1958), 396.
[4] Aquinas, *Summa Theologica*, II-II, q.126 a.1. For more on the role of prudence in the OEMD see Daniel J. Daly, "Prudence and the Debate on Death and Dying," *Health Progress* 88, no. 5 (2007), http://www.chausa.org/Pub/MainNav/News/HP/Archive/2007/09Sept-Oct/Articles/Features/hp0709i.htm.
[5] Discussions of the licitness of fasting, however, continued between the third and sixteenth centuries; early development of the OEMD took place against the backdrop of this concern. See Julia Fleming, "When 'Meats are Like Medicines': Vitoria and Lessius on the Role of Food in the Duty to Preserve Life," *Theological Studies* 69, no. 1 (2008): 99-115.

of the manualists was to distinguish between illicit suicide and licit refusals of life preserving means. A major legacy of the OEMD has been protection against medical "aggression," a tendency that disregards the limited nature of the good of human life. Medical aggression can trespass the boundaries of what is (or should be) common medical practice as well as the limitations particular to individual patients.

Although the advancement of the OEMD, from the time of the manualists to the twentieth century, has been well documented by Daniel Cronin, it is beneficial to outline certain developments here.[6] This will establish that the manualists employed cogent interpretations of the categories of morally ordinary and extraordinary means over centuries of medical development, always with an eye toward the intrinsic but limited value of human beings. Reviewing the kinds of medical cases that confronted the manualists also reveals that the latter were persuaded of the possibility for objective moral evaluation in contextual, relative situations.

The first theologian credited with conceptualizing a distinction between morally ordinary (obligatory) and morally extraordinary (nonobligatory) means of preserving life was the Dominican Francisco de Vitoria (1480-1546). It must be said that Vitoria was not responsible for introducing the terms "morally ordinary" and "morally extraordinary." They were introduced later in the work of Dominic Bañez. But in Vitoria's only published works—the notes of his lectures that constitute the multivolume *Relectiones Theologiae*—one of his concerns was to distinguish the refusal of nonobligatory means of life preservation from suicide. As he said, "it is one thing not to protect life and it is another to destroy it."[7] In other words, it is one thing to allow the passing away of a good and another to seek to go against a good. The difference relies on a distinction in obligation in the manualist tradition that I have already briefly mentioned (see 1.2.3). This is the distinction made between prohibitive laws (*leges negativae*) and affirmative laws (*leges affirmativae*).[8] Affirmative laws indicate that some positive action (doing some good) is required. Prohibitive laws mandate a certain omission (of an evil). These

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[6] Daniel A. Cronin, "The Moral Law in Regard to the Ordinary and Extraordinary Means of Conserving Life," in *Conserving Human Life*, ed. Russell E. Smith (Braintree: Pope John Center, 1989), 3-145. Bishop Cronin's work was first published as a doctoral dissertation in 1958.

[7] Francisco de Vitoria, *Relectio de Temperantia*, in *Relectiones Theologiae*, n.9. Quoted in Cronin, "The Moral Law," 36. (Hereafter, manualist references also cited in Cronin's work will be accompanied by the following indication of the corresponding page number in "The Moral Law": Cxx.)

[8] Aquinas, *Summa Theologica*, II-II q.33 a.2 and I-II q.71 a.5 ad.3.

laws also differ in the kind of duty each imposes. Prohibitions, on the one hand, indicate a duty that is binding always and forever (*leges negativae obligant semper et pro semper*). Examples of prohibitions are the laws against murder and suicide. It is always illicit to destroy life in these ways; there are no exceptions. The duty imposed by affirmative laws, on the other hand, holds always but not forever (*leges affirmativae obligant semper, sed non pro semper*). That is, such laws "continue always to be laws but they do not oblige one at every moment to the performance of the action commanded, but only at a certain time and under certain conditions."[9] One example of this is the law to keep the Sabbath holy. The obligation to observe the Sabbath is fulfilled on the Sabbath, but this does not mean the law is abolished on other days. Moreover, an affirmative law need not be carried out when its fulfillment can only be accomplished by disproportionate measures or, in other words, when it imposes a moral impossibility. To paraphrase Paul Ramsey, the duty of affirmative laws never ceases; yet this duty, never ceasing, has no duty to do the impossible or useless.[10] So, the duty to preserve human life being affirmative, it is understood that it is not necessarily the case that life is to be preserved at all costs. Centuries after Vitoria, Pope Pius XII affirmed this in the statement to which I have already made reference (see Intro.2) but which bears repeating:

> Normally one is held to use only ordinary means—according to circumstances of persons, places, times, and culture—that is to say, means that do not involve any grave burden for oneself or another. A more strict obligation would be too burdensome for most men and would render the attainment of the higher, more important good too difficult. Life, health, all temporal activities are in fact subordinated to spiritual ends.[11]

Determining when the duty to preserve life need not be fulfilled is the task of the OEMD. Of course, the limitation on action does not entail that it is ever the case that human life is not a good. The physical or moral inability to carry out the duty does not invalidate the

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[9] Cathrein, "Law," 56.

[10] See Paul Ramsey, "The Nature of Medical Ethics," in *The Teaching of Medical Ethics*, ed. Robert M. Veatch, Willard Gaylin, and Councilman Morgan (Hastings-on-Hudson: Hastings Center Publications, 1973), 24. A similar expression of the duty is offered by Karl Barth in *Church Dogmatics* III:4, ed. G. W. Bromily and T. F. Torrance (London: T & T Clark International, 2004), 340-43.

[11] Pius XII, "The Prolongation of Life," (1958), 395-96. Bernard Keating makes an important observation about this statement, one that is often neglected by notable Catholic proponents in the PVS debate. It is an unduly strict moral obligation to preserve life, and not a particular extraordinary means in itself, that Pope Pius XII is pointing out as a hindrance to the attainment of spiritual ends. Bernard Keating, "L'alimentation et l'hydration artificielles des patients en état végétatif permanent: la discussion américaine et les interventions romaines récentes," *Laval théologique et philosophique* 64, no. 2 (2008): 506.

claim of the good protected by the duty. This is why directly killing and completely abandoning a patient are illicit.

It is of particular interest that many of the practical questions Vitoria treated in which the matter of moral impossibility arose pertained to the role of food in preserving life. In his day, the prescription of certain foods as remedial measures was quite common. Food was considered a potential medical treatment, though not an artificial one.[12] Vitoria identified food as a natural means of preserving life. Natural means were *per se* ordered to the flourishing of "animal" life, and thus *per se* obligatory.[13] The category of medical treatment, on the other hand—a category that could include both natural and artificial means—was not to be so identified. Even in the sixteenth century, Vitoria recognized that particular medical treatments could be expected to improve the health of an individual presenting a particular medical condition. Artificial medical means could be ordered toward human health when natural means proved insufficient for preserving life and maintaining health.[14] However, many of these were of dubious merit. On the matter of an obligation to employ artificial medical means, Vitoria's conclusion was appropriately relaxed. He saw the need to be cautious in instituting any absolute moral obligation to use medicine, claiming, "they are not to be condemned of mortal sin who have universally declared an abstinence from drugs…."[15] At the same time, he did not disparage the use of artificial means. If an instance of treatment was sure to offer improvement—in particular, a definite hope of recovery—he considered that particular application to be *per se* ordered toward health.[16] The physician was obliged to prescribe it and the patient was obliged to receive it. In this way, artificial means that offered a definite hope of success and benefit could be made supplements to the natural means. So, although Vitoria did not condemn those who abstained from all medicine, he also observed that such abstinence "is not laudable because God created medicine because of its need."[17] The *moral* differential that Vitoria presents between the natural and the artificial, then, is not one based on the origin

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[12] Specially prescribed diets for conditions such as high cholesterol indicate that food is still, in certain situations, used as a medical treatment.
[13] Vitoria, *Relectio de Temperantia*, n.1; C35. The precedent for identifying food as naturally ordered to human life is found in Aquinas, *Summa Theologica*, II-II, q.147 a.1 ad.2.
[14] Cronin, "The Moral Law," 80.
[15] Vitoria, *Relectio de Temperantia*, n.1; C35.
[16] Ibid.; C49.
[17] Ibid.

of each kind of means. It is grounded in the expected results. Cronin's historical excavation of the manualist development of the OEMD shows that, along with the absence of moral impossibility, a definite hope of success and benefit in terms of recovery is a common requirement of ordinary means.[18]

From this one might expect that eating and drinking, as means *per se* ordered toward health, represent an exceptionless obligation. But this is to forget that the directive to preserve life is an affirmative law that admits of exceptions in its acting out. In a time long before the invention of ANH, Vitoria argued that food is generally, but not always, obligatory. He understood hydration and nourishment to be necessary components of any effort to sustain life or recover from ill health. However, Vitoria demonstrated an understanding that some kinds of food, though beneficial, also presented burdens onerous enough to entail a certain impossibility. Common wisdom of the day taught that the meat from chickens, for example, was far more nourishing than eggs. Enjoying the former could even lengthen one's life up to twenty years.[19] However, meat was also expensive and out of reach for many. Vitoria's ethical prescription indicates that the moral obligation to nourish oneself (and thus to preserve life) is not necessarily expanded with the knowledge that the "most delicate and most expensive" foods do a better job of this.[20] Eating delicate foods might not be illicit, but neither would be subsisting on common foods, even if a physician prescribed better and even if one could afford better. In fact, in advising that people adhere to a common standard of food, Vitoria proposed an absolute limit or ceiling to moral obligation that held regardless of a patient's personal resources. He maintained that the command to preserve life did not impose an obligation even on the wealthy to visit the most expensive physicians or relocate to a region with a more amenable climate.[21] The burdens imposed by such means included great expense and

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[18] Cronin, "The Moral Law," 86.
[19] Francisco de Vitoria, *Commentarios a la Secunda Secudae de Santo Tomas*, II-II, q.147 a.1; C37.
[20] Vitoria, *Relectio de Temperantia*, n.12; C36.
[21] In addition to Vitoria, see these later manuals on the absolute limit: Noldin-Schmitt, *Summa Theologiae Moralis*, II, 307-08; C73. Jone-Adelman, *Moral Theology*, n.210; C76. Joseph V. Sullivan, *Catholic Teaching on the Morality of Euthanasia*, (Washington, D.C.: Catholic University of America Press, 1949), 64; C108. Some manualists made room for a *per accidens* obligation beyond the common expectation. Kelly included times when the preservation of life is necessary to one's salvation or required to ensure time for the Anointing of the Sick. See Gerald Kelly, "The Duty of Using Artificial Means of Preserving Life," *Theological Studies* 11, no. 2 (1950), 207. Lessius insisted that an important politician, one whose welfare was necessary for the common good, could be compelled to undergo torturous but life-saving surgery.

inconvenience. Other moralists also identified the burden of being absent from one's home as posing an overriding difficulty.[22]

Finally on the matter of food, it is important to note that Vitoria's pronouncements about the potential extraordinariness of eating did not only pertain to certain *kinds* of food. He also recognized certain *instances* of eating as presenting insufficient benefit or disproportionate burden. Although eating was usually ordinary, Vitoria made allowances for extreme circumstances:

> If the depression of spirit is so low and there is present such consternation in the appetitive power that only with the greatest of effort and as though by means of a certain torture, can the sick man take food, right away that is reckoned a certain impossibility, and therefore he is excused, at least from mortal sin, especially where there is little hope of life, or none at all.[23]

Another occasion when nourishment became extraordinary was treated by Juan de Lugo (1583-1660). He presented a hypothetical case of a man unjustly condemned to starvation. If a little food is smuggled into the prison cell, de Lugo asked, is the condemned morally obliged to eat it?[24] In the case that the prisoner knows he cannot obtain sufficient food on a regular basis, he is only extending his life for a short time. This kind of benefit is negligible and no obligation is present. Eating would only be morally required if he were able to obtain a regular supply of food that provided a reasonable certainty of preserving his life.

Like food, Vitoria recognized that even effective artificial means of preserving life were laden with potential burdens. Accordingly, the duty of employing artificial means, too, was limited to what was in common use. Such a standard avoided the extreme pain and onerous financial cost imposed by certain unusual or experimental treatments. On the latter burden, Vitoria asserted that "if a sick man could not have a drug except by giving over his whole means of subsistence, I do not think he would be bound

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Leonardus Lessius, *De Justitia et Jure*, Lib. II Cap. 9, dub. 14, n.96; C45. In disagreement, Thomas Tamburini pointed out that politicians are generally replaceable. *Explicatio Decalogi*, Lib. Vi, Cap. II, Sect. II, n.11; C60.

[22] See Claude LaCroix, *Theologia Moralis*, Vol. I, Lib. III, Pars I, Tract. IV, Cap. I, dub. I; C62. And Giovanni Vincenzo Partuzzi, *Ethica Christiana sive Theologia Moralis*, Tom. III, Tract. V, Pars V, Cap. X, Consect. sept.; C65.

[23] Vitoria, *Relectio de Temperantia*, n.1; C35.

[24] Juan de Lugo, *De justitia et jure*, Disp. 10, n.30. Cited in Kelly, "The Duty of Using Artificial Means," 208. Also see Aquinas, *Summa Theologica*, II-II, q.69 a.4, ad.2.

to do so."[25] This held even if the drug was *certain* to save one's life.[26] Of course, financial burden can only be measured properly in relation to the resources of the particular patient. The rich were not obliged to give up their fortunes because the ceiling of obligation was based on what was commonly affordable. But, what is more, no one was obliged to pay even what most others would consider a moderate sum if this put too great a strain on one's own meagre resources. Other burdens, too, were measured on a "sliding scale." Extreme abhorrence, which extends to both shame and fear, gave attention to the patient's psychological resources and personal situation. For example, Leonardus Lessius (1554-1623) argued that very modest women, especially virgins, were not bound to accept medical examination and treatment from a male physician, saying: "no one is held to accept a cure which he abhors no less than the disease itself or death."[27] In short, what these developments demonstrate is that measuring life preserving means against what was in common use was considered helpful for indicating the ceiling of moral obligation. However, no common standard could indicate a solid floor of obligation. The contextual factor meant that what was reasonable for most people could present an impossibility for others. The manualists recognized the imposition of an absolute floor of obligation as unfair to those who were more vulnerable to certain burdens. Instead, they proposed a norm of basic obligation that was relative to the contextual situation of the patient.[28] Always, it was the whole life of the patient—not just physical health—that was at the heart of the judgement.

In later centuries, the cautious attitude represented by Vitoria toward artificial means of preserving life eased in proportion to the increasing reliability of such means. A prominent example of this is the changing attitude toward anaesthesia. In the early days of its use, some manualists remained cautious about surgical operations. They doubted the efficacy of anaesthesia, decried even temporary loss of consciousness and reason, and allowed that an extreme abhorrence at the prospect of mutilation was generally felt. Such caution, however, would pass with increasing evidence in favour of the efficacy of

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[25] Vitoria, *Relectio de Temperantia*, n.9; C36.
[26] Francisco de Vitoria, *Relectio de Homicidio*, in *Relectiones Theologiae*, n.35; C37.
[27] Lessius, *De Justitia et Jure*, Lib. IV, Cap .3, dub. 8, n.60; C45. Some departed from this ruling, notably Patuzzi, who viewed this as a reckless distortion of modesty. Joannis Vincentii Patuzzi, *Ethica Christiana*, Tom. III, Tract. V, Pars V, Cap. X, Consect. sept.; C65-66. Nonetheless, intense abhorrence was viewed as a legitimate burden by most manualists.
[28] Kelly, "The Duty of Using Artificial Means," 206.

anaesthesia and the success of surgical techniques. For those who became convinced of the value of chloroform, "the whole moral aspect of surgical interventions had changed."[29] Whereas at one time major operations would have been considered *per se* extraordinary, one factor, their increasing reliability, changed the judgement. Thus, as medicine improves, so moral reasoning is subject to change. Routine operations today are presumed safe and impose no disproportionate burden of pain. The perspective on the temporary loss of consciousness has also changed. Despite this, no predetermined obligation to undergo even a life-saving operation is imposed on anyone, as moral impossibility cannot be ruled out prior to the consideration of the particular case.

The preceding discussion indicates that moral judgements about means of preserving life can be made at any point in a patient's history. They are even relevant to individuals who are not, technically speaking, patients. Indeed, many of the manualist discussions about preserving life attended to the details of an individual's lifestyle. Thomas Sanchez (1550-1610), for instance, elaborated on fasting. Reducing the number and portion size of one's meals, he says, is licit, so long as the intent of the agent is not to cut life short. And, generally speaking, engaging in the ascetic discipline of fasting "is not to intend to abbreviate life or kill one's self but it is only to use means directed by nature for sustenance and not to prolong life, to which no one is bound."[30] It is evident, then, that any obligations toward life preservation when one is close to death will bear the same reasonable quality as more typical and day-to-day obligations.

Even so, treatment decisions do take on particular exigency when death seems imminent. Some manualists demonstrated that these occasions produce additional factors for moral consideration. de Lugo raised the classic case of a man condemned to death by fire, a case similar to that of the man condemned to starve to death.[31] Here, the condemned man is about to be engulfed in flames when he catches sight of a bucket of water. If he is able to put the fire out and escape death, the water is indeed an ordinary means of preserving life. But what if the condemned is well aware that, although he may be successful in diminishing the fire temporarily, his executioners are bringing more wood to fuel the fire? Dousing the flames could extend his life by a matter of minutes or

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[29] Cronin, 70. Cf. Benoit Henri Merkelbach, *Summa Theologiae Moralis*, II, n.353; C74.
[30] Thomas Sanchez, *Consilia seu opuscula moralia*, Tom. II, Lib. V, Cap. 1, dub. 33; C43.
[31] de Lugo, *De justitia et jure*, Disp. 10, n.30; C53-54.

hours, perhaps, but it would not save it. Further, it would protract the experience of excruciating pain. In such a case, de Lugo judges the use of water extraordinary. Such brief conservation, he says, "is morally considered nothing at all."[32] This illustration distinguishes between those medical interventions that will prevent a patient's death and those that will only prolong the dying process, another prudential distinction. Cronin observes that de Lugo's example adds a qualification to the notion of benefit: any benefit to one's health must not only be of a particular quality but also of considerable duration.[33]

3.1.2 Synthesizing the Manualist Development

Toward the end of the manualist tradition, in the 1950s, physician Gerald Kelly attempted to synthesize the OEMD by defining the terms "ordinary" and "extraordinary."[34] Although Kelly's definitions are referred to by many Catholics employing the OEMD today, Cronin is more careful to take into account the whole of the manualist tradition and, thus, better able to identify its common features. He notes a significant shortcoming of Kelly's definitions: they fail to address nonartificial means of preserving life.[35]

In defining morally ordinary or obligatory means, Cronin notes that the manualists included means that 1) offer proportionate hope of a beneficial result in terms of quality and duration of recovery; 2) are commonly used; 3) are proportionate to one's social or financial position; 4) are not excessively difficult to obtain or use; and 5) are reasonably convenient.[36] Extraordinary or nonobligatory means, on the other hand, are unsuccessful in meeting one of these criteria. Thus, they can be summed up as those that fail to provide proportionate hope of benefit or those having a certain impossibility—physical or moral—associated with obtaining or applying them. Extraordinary means can carry with them the burdens of 1) excessive effort or difficulty; 2) extreme pain; 3) great

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[32] Ibid.
[33] Cronin, "The Moral Law," 54 and 88.
[34] Gerald Kelly, "The Duty to Preserve Life," *Theological Studies* 12, no. 4 (1951): 550. Also see his *Medico-Moral Problems* (St. Louis: The Catholic Hospital Association, 1958), 129. The definitions provided in these works correct Kelly's slightly earlier definitions, which had omitted the element of hope of benefit. See "The Duty of Using Artificial Means."
[35] Cronin, "The Moral Law," 112 and 83.
[36] Ibid., 85-98. Cronin himself labels the fifth criterion "media facilia" ("simple means" or "easy means"), a term employed by some manualists. He goes on to explain that those who used this term described it as representative not necessarily of the absence of difficulty but rather of a level of difficulty that is reasonable. Thus, criteria four and five bear considerable overlap.

expense; or 4) intense abhorrence.[37] The gravity of each of these is determined in relation to the individual concerned. Means are limited absolutely at their ceiling but bear only a relative norm at their floor.

> Cronin constructs the following definitions of ordinary and extraordinary means:
>
> *Ordinary means of conserving life* are those means commonly used in given circumstances, which this individual in his present physical, psychological and economic condition can reasonably employ with definite hope of proportionate benefit.
>
> *Extraordinary means of conserving life* are those means not commonly used in given circumstances, or those means in common use which this individual in his present physical, psychological and economic condition can not reasonably employ, or if he can, will not give him definite hope of proportionate benefit.[38]

From these definitions, it is apparent that in judging a means to be morally ordinary or extraordinary, there is more than one kind of consideration at work. To review, the first consideration, the common use standard, creates a ceiling beyond which no obligation may be assigned. One cannot make mandatory a means that "exceeds the strength of men in general."[39] This consideration is often perceived as an objective aspect of the assessment.[40] It is without question that physicians may determine what is common medical practice and therapeutically effective with the kind of certitude they cannot bring to a determination of the burdens that will arise for a particular patient. However, medical routine has changed over time and is always adapted to the socio-economic and medical-technological condition of the health care system and facilities of a region. This has been observed by Pope Pius XII, who held that ordinary means were determined according to circumstances of individuals, places, times, and culture.[41] This being the case, generalizations about the common use standard will adhere to some broadly contextual factors.

Furthermore, in referencing the common use standard, one must bear in mind that the manualists used the terms "ordinary" and "extraordinary" in a strictly moral sense,

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[37] Ibid., 98-111. Cronin also notes that the subjective impression of abhorrence can be unduly burdensome even if it is irrational. In such cases, there is no moral obligation to use the means, but patients should make an attempt to overcome irrational responses. Cf. Kelly, "The Duty of Using Artificial Means," 206.
[38] Cronin, "The Moral Law," 112-13.
[39] Ibid., 90.
[40] Pontifical Council *Cor Unum*, "Questions of Ethics Regarding the Fatally Ill and the Dying," in *Conserving Human Life*, ed. Smith, 291. Reprinted from Pontifical Council *Cor Unum*, Vatican City (1981).
[41] Pius XII, "The Prolongation of Life," (1958), 395-96.

which means that assigning them is a normative move relating to the level of obligation associated with the use of a means, rather than a pronouncement on what is effective therapy or medical convention. Whereas all morally ordinary means are commonly used, not all ordinary medical procedures are morally ordinary. The differentiation bears significance especially in an age and place in which many procedures are medically common and easily obtained. Cronin's definitions, then, do not imply that the common use standard is a substitute for other kinds of consideration. Rather, it is only one element that factors into the moral judgement. When medical aggression becomes common—such as the use of a ventilator to prolong the life of a dying patient in intractable pain—the other considerations can be brought in to correct this.[42]

The second consideration, the contextual factors pertaining to a patient's particular situation, expands out to the physical, psychological, and economic burdens posed by potential life preserving means. Considerations of both the type and severity of burdens are relevant. It is true that the manualist discussion of burdens reflects particular and recurring examples—those associated with anaesthesia, amputation, moving to a different climate, eating choice foods, and so on. But Cronin is generally followed in his opinion that the manualists did not intend to limit the consideration of burden to these examples. Rather, these examples elicit *categories* of burden that must be contemplated, including pain, expense, difficulty or inconvenience, and abhorrence. Not all expected burdens will be severe enough to present a moral or physical impossibility. But if any are considered unreasonable or disproportionate to the patient's resources, the means is deemed extraordinary.

This consideration, of course, places a check on the common use standard. To illustrate the relationship, Cronin provides the example of an appendectomy.[43] Certainly, this is a common or routine procedure. As a remedy for appendicitis, it will likely be ordinary. However, in extreme circumstances, the features of a patient's situation can make the operation extraordinary. It may be that the patient's life is already threatened in other ways that override the obligation to undergo the operation at this time. Moreover, in particular locations, there might be undue expense or inconvenience involved in carrying

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[42] Cf. John Paul II, *Evangelium Vitae*, (1995), §65.
[43] Cronin, "The Moral Law," 84.

out the surgery. Thus, even the most common practices are subject to the analysis of burdens particular to the patient in question.

There is also a third consideration at work, one that both the evaluation of common practice and contextual burdens are brought up against: hope of proportionate benefit. This consideration presents two major conditions to the means being evaluated. In the first place, the expectation that a means will benefit the patient must be certain. As indicated, there must be certitude in terms of both quality and duration of the benefit. A means offering only a brief recovery or an insignificant measure of improvement is of negligible moral value. In the second place, even a means that offers a great and lasting benefit is extraordinary if the burdens it poses are even greater.[44] This remains true even if the given means is commonly used and even if the patient is capable of bearing these burdens. In short, life preserving means are extraordinary if the hope of benefit is absent or uncertain, negligible, or disproportionate to the burdens posed.

3.2 Contemporary Protestant Interpretations

Protestant engagement with the OEMD has been much briefer than the Catholic discussion and its articulation has been lacking in a measure of subtlety. Still, Protestant bioethicists have tended to treat the Catholic model as paradigmatic, choosing to adopt selected aspects of this benefit-burden calculus. This merits some discussion. Although Protestant ethicists do not hold to the same methodology as Catholic moralists, many share the same orienting concern: to provide a basis for distinguishing between suicide and euthanasia, on the one hand, and legitimate instances of forgoing life preserving means, on the other. So, it has been convenient for Protestant ethicists to use the manualist discussion as a resource for their own reasoning on end-of-life cases. They do so, however, to different conclusions. This can be observed in the study of two primary examples.

3.2.1 First Example: Center for Bioethics and Human Dignity

It is the inclination of contemporary Protestant interpreters of the OEMD to focus on the subjective nature of the application of the OEMD—the patient's (or proxy's) own judgement. This is apparent in the publications of the medical practitioners and scholars

[44] Ibid., 89.

associated with the Center for Bioethics and Human Dignity, a Christian institution made up largely of Protestants. Robert Cranston, a physician and fellow of the center, points out that many Protestants do not make use of the OEMD proper.[45] However, they often do employ some derivative form of burden-benefit analysis. Cranston's own approach to problems of life preserving means is to outline the burdens and benefits of a case by way of setting up a debate. He presents various arguments in favour of and against withdrawing or withholding these means. Cranston concludes that Christians may legitimately decide differently on the same case largely due to the subjective nature of the decision that creates a moral uncertainty. He has reinforced this position in an additional case study on forgoing treatment.[46]

Protestant physician and bioethicist John Dunlop, also associated with the Center for Bioethics and Human Dignity, favours the terms "proportionate" and "disproportionate" as alternatives to "ordinary" and "extraordinary."[47] It should be noted that these newer terms were introduced by the Catholic Church in the *Declaration on Euthanasia* as a way to differentiate between medically ordinary and morally ordinary means.[48] But in Dunlop's view, such alternative terms are appropriate because they move the decision "from the blanket 'yes, no' response into the realm of 'maybe,'" making the decision context-dependent. Dunlop appears to be under the impression that decisions about the moral nature of life preserving means made in the Catholic context are taken prior to an examination of the particular features of a case. It may be, however, that this misunderstanding has been prompted by the recent papal pronouncement on the *per se* ordinary nature of ANH when applied to the PVS patient. Dunlop observes: "All too frequently, however, a statement is made in very categorical terms whether or not to use a feeding tube."[49]

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[45] Robert E. Cranston, "Withholding or Withdrawing of Artificial Nutrition and Hydration," Center for Bioethics and Human Dignity (November 19, 2001), http://www.cbhd.org/resources/endoflife/cranston_2001-11-19.htm.
[46] Robert E. Cranston, "Is It Permissible to Forego Life-Saving Dialysis?" *Ethics & Medicine* 24, no. 2 (2008): 83-85.
[47] John T. Dunlop, "The Feeding Tube Dilemma: Key Questions," Center for Bioethics and Human Dignity (January 27, 2006), http://www.cbhd.org/resources/endoflife/dunlop_2006-01-27.htm.
[48] Congregation for the Doctrine of the Faith, *Declaration on Euthanasia*, Part IV.
[49] Dunlop, "The Feeding Tube Dilemma."

Others also comment on a tendency toward *a priori* judgements associated with the OEMD. The concern is emphasized by John Kilner, the senior scholar of the Center for Bioethics and Human Dignity. His observation is that there is a problematic tendency to absolutize the moral status of particular kinds of treatments in applying the OEMD. Most people, he says, do not follow the manualists in applying only a relative norm:

> The problem here is not with the concerns underlying the extraordinary/ordinary distinction as much as it is with the form that the distinction takes. In this form, the distinction implicitly places the emphasis on the nature of the treatment itself and how it is to be classified rather than on the way it is experienced uniquely by each patient.[50]

Kilner shows sensitivity to factors specific to the patient, such as spiritual perspective and level of family support available. Insisting that the patient's own assessment must be made central, Kilner points out that the patient's judgement would be better respected if the "subjective" language of benefit and burden was used in place of the language of ordinary and extraordinary. Kilner takes the latter to encourage an *a priori* normalization of particular treatments. It might be said that he observes a floor of moral obligation being smuggled into the OEMD judgement.

3.2.2 Second Example: Paul Ramsey

Paul Ramsey had what is perhaps the most sustained Protestant engagement with the OEMD. If Kilner exhibits concern that the OEMD judgement will digress into a focus on the nature of treatment, Ramsey feared that it would diminish the patient into a collection of medical conditions. In his classic work, *The Patient as Person*, Ramsey insisted on the significance of the patient's entire life and identity—medical and nonmedical, physiological and nonphysiological—for the moral judgement: "the unity of the person in whom the diseases inhere is the important point, and not a texture of interrelated diseases."[51] In his language, the success of the life preserving means must provide a benefit to the patient as a *person*. Ramsey went on to revise the meanings of ordinary and extraordinary, denying them their status as moral categories of obligation and reducing them to judgements of what is "useful and useless" to the whole person. But in so doing, he agreed with the manualists that it is important to determine whether there

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[50] John F. Kilner, *Life on the Line: Ethics, Aging, Ending Patients' Lives, and Allocating Vital Resources* (Grand Rapids: William B. Eerdmans, 1992), 143.
[51] Ramsey, *The Patient as Person*, 1st ed., 131.

are nonmedical factors involved that indicate against the application of treatment. In particular, he named the burdens of excessive inconvenience (referring to the example of leaving home to receive treatment), abhorrence, and expense.[52] If no proportionally beneficial treatment could be applied, what was left to the community was "only to care" for the patient.

It is not clear—even to Ramsey—that this was a successful move. In the book he published eight years later, *Ethics at the Edges of Life*, his analysis of life preserving means shifted.[53] The change in trajectory was made largely in relation to what Ramsey perceived as prevalent contextual concerns. His earlier interest had been with combating the aggressive treatment of the dying—the kind of treatment that was coming into common use and (incorrectly) rendered morally ordinary. His new concern became the euthanasia movement that quickly blossomed in extreme counter-reaction to overmedicalized dying.[54] Especially troubling to him was the call to end the lives of the disabled on the basis of "quality of life" concerns. Ramsey's new appraisal of the OEMD was that a distinction originally intended to expand freedom had opened the door to private and arbitrary judgements and, most significantly, the devaluation of life. His critique could indeed be made against the Protestant bioethicists mentioned above. They make the moral decision too subjective, so that, in the words of Richard McCormick, "a decision is right solely *because* the patient makes it."[55] In this context, Ramsey was persuaded to reduce the OEMD to a "medical indications policy" for decision making. Whereas what is medically indicated is conventionally understood as the treatment to which a patient's physiological condition will respond favourably, Ramsey took this idea further. Essentially, the policy limited treatment refusals to patients who were imminently dying, bracketing quality of life concerns. What needed to be emphasized, in his mind, was the objective nature of the final judgement made using the OEMD. However, he

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[52] Ibid., 138-39.
[53] Paul Ramsey, *Ethics at the Edges of Life: Medical and Legal Intersections* (New Haven: Yale University Press, 1978), 153-88. This shift was first articulated in an article that would become the focus for *Ethics as the Edges of Life*: "The Indignity of 'Death with Dignity,'" *Hastings Center Report* 2, no. 2 (1974): 47-62.
[54] This much is evident from Ramsey's own text. Meilaender offers an additional analysis of this in "'Love's Casuistry': Paul Ramsey on Caring for the Terminally Ill," *Journal of Religious Ethics* 19, no. 2 (1991): 133-56.
[55] Richard A. McCormick, "The Quality of Life, the Sanctity of Life," *Hastings Center Report* 8, no. 1 (1978): 31.

chose to underscore medical objectivity, not, primarily, moral objectivity. Ramsey allowed for the relativity of the OEMD judgement only insofar as the medical indications for a particular patient departed from what was medically routine.

Ramsey's second innovation was, by most accounts, a failure. Removing the subjective element of the contextual judgement meant that he lost his orientation toward a concern for the whole, unified life of the patient—medical and nonmedical indications alike. It is, perhaps, the case that what Ramsey observed to be an inherent flaw of the OEMD was actually an observation of the OEMD being applied in a clinical context by individuals who placed a conditional value on human bodily life. Any confusion that contextualism reduces the OEMD to a purely consequentialist or situational judgement is averted when it is recalled that the OEMD was developed out of an anthropological understanding akin to that outlined in the previous chapter, one that makes room for the values of human ontology and human flourishing. As William Stempsey puts it, "the Roman Catholic tradition emphasizes the moral responsibility to form one's conscience according to the norms dictated by the natural law….Moral answers in this approach are only as secure as the visions of human nature from which moral norms are derived."[56] A departure from these anthropological foundations will lead to a fragmentation of ethical perspectives, even to the point of allowing euthanasia and assisted suicide.[57]

The major premise of the OEMD is that bodily life has intrinsic worth and is a good in itself. Yet it is only one constitutive element of the complete human good and not an ultimate value in itself. This rules out the kind of absolute control that would legitimate quality of life concerns in disregard for the intrinsic value of life. It also rules out the kind of medical aggression that inflates the concern for health or longevity over the concern for the complete good of the patient. Decisions against preserving life are to be made with the intention of avoiding excessive burden, or avoiding the pursuit of a benefit to health that is negligible in relation to the pursuit of higher human ends. An understanding of the good and a will that is ordered toward it are both necessary for making a prudential judgement about preserving life. This subjectivity is meant to

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[56] William E. Stempsey, "End-of-Life Decisions: Christian Perspectives," *Christian Bioethics* 3, no. 3 (1997): 259.

[57] For more on this fragmentation see James R. Thobaben's discussion of the United Methodist approach to providing moral guidance on the matter. "A United Methodist Approach to End-of-Life Decisions: Intentional Ambiguity or Ambiguous Intentions," *Christian Bioethics* 3, no. 3 (1997): 222-48.

provide an advantage. It responds to the objective features of the Christian ethical perspective—the intrinsic but limited nature of the value of human life—and admits that there is a broad range of practical circumstances that interact with that objective truth.

Having said this, it appears that the contextuality of the OEMD continues to present difficulties for its contemporary Catholic proponents. The development within Ramsey's thought is interesting in this respect. It depicts the tension held in the Catholic discussion—a tension between the insistence on the value of life preserving means to the patient *as a whole* and the refusal to judge lives in certain conditions as being of negligible value. The other Protestant ethicists discussed here have rejected the moral rigour of OEMD because they have mistaken it for a noncontextual judgement. They have been uncomfortable with the way in which Catholic authorities have likened common medical procedures to morally ordinary procedures. In order to make this plain, I turn to certain new and controversial innovations made to the OEMD.

3.3 Controversial Innovations

In more recent documents issued by Catholic authorities, and notably in the 2004 papal allocution, "Life-Sustaining Treatments and Vegetative State," a cluster of innovations of the manualist articulation of the OEMD can be observed. As will become evident, some of these have been supported by Meilaender, who, as a Protestant concerned with end-of-life care, largely adopts the Catholic articulation of the OEMD. These innovations include 1) limiting the occasion for the use of the distinction to times when death is imminent and inevitable; 2) limiting the life-preserving means considered to those that are artificial; 3) reducing the standards of quality and duration of recovery; and 4) attaching *a priori* obligations to certain classes of treatment decisions. This catalogue is not exhaustive, but these innovations are particularly interesting in a context of expanding options for treatment. Such efforts to confine the reaches of the OEMD are particularly relevant to the situation of the PVS.

3.3.1 Imminent and Inevitable Death

Clearly, from the nature of the cases the manualists raise, the OEMD was constructed to respond to possibilities for preserving life at any point in time. The distinction did, of course, have something particular to say about treatments in situations of imminent death, as is evident in de Lugo's examples. However, questions about the

quality of food one must eat or the location in which one may live also pertain to individuals who are not terminally ill or dying. These examples indicate the importance of the OEMD for day-to-day decision making, as well as for the deliberation necessitated by illness and imminent death.

However, some moral theologians have placed limitations on the deliberation procedure outlined by the OEMD in those times when death is not imminent and inevitable. One innovative reading of the OEMD was provided by John Connery, who claimed that confusion is caused by engaging considerations of both burden and benefit in all kinds of cases. Needless to say, if a means offers little or no appreciable benefit, one need not proceed to measure this against the potential burdens the means may impose. However, Connery went further than this. In practice, at least, he regarded the concept of burden as decisive for deliberations about the patient who is not terminal, limiting consideration of benefit to those decisions pertaining to the patient whose death is imminent.[58] For the dying patient, he said, even a treatment void of burdens may be regarded as futile or as providing only minimal benefit—the protraction of life for a few days longer. On the other hand, the ordinariness of treatments prescribed to nonterminal patients is threatened primarily by burden, not by lack of benefit. It is not entirely apparent in his analysis just why Connery perceives little room for evaluations of benefit in nonterminal cases. Although it is often the case that what prevents a healthy individual from applying a means is the burden imposed, and not a lack of benefit, the medical futility of snake oil would hold as extraordinary for a patient who is not dying as much as it would for a patient who is dying. And although a judgement about treatment may turn out differently for two cases in which the only variation is the projected time of death, this does not invalidate the consideration of benefit in any kind of case. Connery himself has claimed that the duty to preserve life "runs through the whole spectrum of human activity."[59] As long as this duty persists, the OEMD remains the tool that adjudicates its acting out.

The shift in focus toward imminent and inevitable death has been even more apparent in certain authoritative Catholic documents. In outlining this development, it is

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[58] John R. Connery, "Prolonging Life: The Duty and Its Limits," *Linacre Quarterly* 47, no. 2 (1980): 155.
[59] John R. Connery, "The Ethical Standards for Withholding/Withdrawing Nutrition and Hydration," *Issues in Law and Medicine* 2, no. 2 (1986): 87.

important to begin with Part IV of the *Declaration on Euthanasia*. Like the manualists, the aim of the discussion of ordinary and extraordinary means in this document is to distinguish legitimate instances of forgoing life preserving means that end in a patient's death from suicide or euthanasia. It is doubtful that this statement was composed with the intention of restricting the use of the OEMD to situations of imminent and inevitable death. The focal question addressed is, "Is it necessary *in all circumstances* to have recourse to all possible remedies?"[60] And in the outline of the OEMD that follows, there is no mention of cases in which death is imminent and inevitable until the last few lines. These read: "When inevitable death is imminent in spite of the means used, it is permitted in conscience to take the decision to 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."[61] Several years later, the encyclical letter *Evangelium Vitae* referred to the *Declaration on Euthanasia* as a resource for articulating the OEMD. However, it cites only these last lines of Part IV. Some scholars have recognized in this a subtle but definite shift in the interpretation of the passage.[62] In the encyclical, Pope John Paul II limits his own analysis of treatment refusal to the context "when death is clearly imminent and inevitable."[63] The same selective repetition of the *Declaration on Euthanasia* passage was later made in an authoritative commentary on the 2004 papal allocution on the vegetative state that was supplied by the Congregation for the Doctrine of the Faith.[64]

These later documents do not go so far as to say that making an extraordinary judgement about a means is illegitimate when death is not imminent and inevitable, or when death can be avoided medically. But the fact that they include no treatment of a burden-benefit judgement applied to nonterminal cases has led others to constrict the

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[60] Congregation for the Doctrine of the Faith, *Declaration on Euthanasia*, (1980), Part IV. Emphasis added.
[61] Ibid.
[62] Kevin W. Wildes, "Ordinary and Extraordinary Means and the Quality of Life," *Theological Studies* 57, no. 3 (1996): 509; Shannon and Walter, "Assisted Nutrition and Hydration and the Catholic Tradition," 656-57; and Kevin D. O'Rourke, "The Catholic Tradition on Forgoing Life Support," *National Catholic Bioethics Quarterly* 5, no. 3 (2005): 549-50.
[63] John Paul II, *Evangelium Vitae*, (1995), §65.
[64] Congregation for the Doctrine of the Faith, "Responses to Certain Question of the United States Conference of Catholic Bishops Concerning Artificial Nutrition and Hydration: Commentary," (August 1, 2007), http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20070801_notacommento_en.html. (Hereafter, "Commentary.")

OEMD in just this manner, with particular implications for the PVS debate. For example, the website for the Catholic Diocese of Erie interprets *Evangelium Vitae* in the following way: "When trying to define extraordinary means, the pope uses two sets of terms. For treatment to be considered extraordinary, death must be 'imminent and inevitable' and the treatment would result in 'precarious and burdensome prolongation of life.'"[65] This follows from a statement of the Pennsylvania Bishops, which indicates lack of terminality as a defining difference for decisions regarding PVS patients.[66] In its commentary, the Congregation for the Doctrine of the Faith also coupled its mention of the context of imminent and inevitable death with an assertion that patients in a vegetative state generally are not facing imminent death.[67] Meilaender and May, though not limiting the OEMD to terminal contexts, also use the PVS patient's lack of terminality to argue that ANH cannot be considered useless, since it preserves life.[68]

One point must be clarified here. Most participants in the debate on PVS refrain from arguing that the PVS patient is not imminently and inevitably dying. Many Catholic proponents who advocate for allowing treatment withdrawal from PVS patients concur with this assessment. For instance, in an article originally published in 1988, Shannon and Walter pointed out that the PVS patient's brainstem is intact and that, with ANH, survival can be extended by years.[69] So, imminent death is not inevitable. At the same time, it is not obvious that PVS patients should be classed among those who are not terminally ill. The deaths of these patients, though forestalled, are due to complications of this condition. A further point to take into account is the global atrophy of the brain that occurs in this state. A recent study has confirmed that the brain atrophy concurrent with long-lasting vegetation (and minimal brain activity) has progressively negative effects on

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[65] Diocese of Erie, "End of Life Issues," http://www.eriercd.org/charities4g.asp.
[66] Bishops of Pennsylvania, "Nutrition and Hydration: Moral Considerations," rev. ed. (1999), http://www.pacatholic.org/bishops-statements/nutrition-and-hydration-moral-considerations.
[67] Congregation for the Doctrine of the Faith, "Commentary," (2007). Lack of terminality was a principal claim of the statement issued at the congress at which the papal allocution was first delivered. See Pontifical Academy for Life and World Federation of Catholic Medical Associations, "Joint Statement on the Vegetative State," (March 17, 2004), §4, http://www.vatican.va/roman_curia/pontifical_academies/acdlife/documents/rc_pont-acd_life_doc_20040320_joint-statement-veget-state_en.html.
[68] Gilbert Meilaender, "Ordinary and Extraordinary Treatments," *Theological Studies* 58, no. 3 (1997): 529; and May et al., "Feeding and Hydrating the Permanently Unconscious," 209.
[69] Shannon and Walter, "The PVS Patient and the Forgoing/Withdrawing of Medical Nutrition and Hydration," 153.

the structural, metabolic, and functional status of the brain.[70] Thus, as time goes on, emergence from this state becomes less and less likely and patients become more and more subject to neurological degradation. For this reason, many are careful to note that the application of ANH to PVS patients is not strictly equivalent to an individual who eats to stay healthy.[71] PVS indicates the presence of a fatal pathology, the deterioration of the brain, and ANH circumvents some of its effects for a time.[72]

A separate issue for this case, however, is the validity of the judgement that a means can be both capable of preserving life for a long time and yet not obligatory. At stake is the distinction between a physiologically useful means and a proportionally beneficial means. According to some sources, there is virtually no question that the effect of stabilizing and preserving life benefits a patient. For instance, the *Catholic Charter for Health Care Workers* indicates: "The administration of food and liquids, even artificially, is part of the normal treatment always due patients when this is not burdensome for them: their undue suspension could amount to euthanasia in a proper sense."[73] Here there is consideration of overriding burden, but no mention that ANH could possibly be lacking in benefit. This could be taken as being in direct contradiction with the earlier reasoning of Pope Pius XII. In the same address in which he claimed that life, health, and all temporal activities are subordinated to spiritual ends, he allowed for the withdrawal of ventilator support from the kind of patient who would now be called brain dead.[74] This allowance was made despite the ventilator's effect in stabilizing the patient's condition and despite the pope's own uncertainty that the soul had left the patient's body. Evidently, the pope did not limit treatment withdrawals or judgements about benefit to instances of imminent and inevitable death.

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[70] M. C. Rousseau et al., "A MRS-MRI-fMRI Exploration of the Brain: Impact of Long-lasting Persistent Vegetative State," *Brain Injury* 22, no. 2 (2008): 123-34.

[71] Texas Bishops and the Texas Conference of Catholic Health Care Facilities, "On Withdrawing Artificial Nutrition and Hydration," (1990), 111; Kevin D. O'Rourke, "Should Nutrition and Hydration Be Provided to Permanently Unconscious and Other Mentally Disabled Persons?" *Issues in Law and Medicine* 5, no. 2 (1989): 182.

[72] O'Rourke has also argued that the inability to coordinate chewing and swallowing is itself a fatal pathology. See "Should Nutrition and Hydration Be Provided," 182.

[73] Pontifical Council for Pastoral Assistance to Health Care Workers, "The Charter for Health Care Workers," (1995), §120, http://www.healthpastoral.org/text.php?cid=256&sec=4&docid=26&lang=en.

[74] Pius XII, "The Prolongation of Life," (1958), 396-97. An excellent ethical comparison of ANH to ventilator support is provided by Daniel Sulmasy in "End-of-Life Care Revisited," in *Artificial Nutrition and Hydration and the Permanently Unconscious Patient*, ed. Hamel and Walters, 187-99.

It would appear that those who would limit the consideration of benefit to cases of imminent and inevitable death are motivated by fear of a certain danger. Perhaps withdrawing a means that imposes none of the traditional burdens and is effective in warding off imminent death is equivalent to intending to kill the patient or willing the patient's death. For instance, the Congregation for the Doctrine of the Faith states: "Still less can one interrupt the ordinary means of care for patients who are not facing an imminent death, as is generally the case of those in a 'vegetative state'; for these people, it would be precisely the interruption of the ordinary means of care which would be the cause of their death."[75] Since one does not normally stop eating and drinking completely except at death, the fear that any withdrawal that leads to death is always identical to euthanasia deserves some discussion. One strategy to avoid allowing the intention toward death has been to draw a distinction between medical treatments and basic care. This is the next innovation to be taken up.

3.3.2 Basic Care

The moral distinction between natural and artificial means of life preservation is well established in the OEMD tradition. A later manualist, Joseph Sullivan, articulated it in the following way. He avoided aligning the *moral* categories of ordinary and extraordinary with the *descriptive* categories of natural and artificial means in a way that would make all natural means ordinary and all artificial means extraordinary. Instead, he clarified that natural means are *per se* ordinary (obligatory), although they may *per accidens* be made extraordinary (nonobligatory) due to unusual circumstances. Artificial means, on the other hand, might be either ordinary or extraordinary, according to the particulars of the case.[76] In accordance with the nuances present in the thought of Vitoria and those who followed after him, this indicates that natural means are often but not always ordinary means. Thus, the Catholic Church justifies holding a presumption to apply natural means, including food, by the fact that these means are necessary to sustain any human life.[77] Only in unusual circumstances is the presumption overruled. For

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[75] Congregation for the Doctrine of the Faith, "Commentary," (2007).
[76] Joseph V. Sullivan, *The Morality of Mercy Killing* (Westminster: Newman Press, 1950), 65. Cf. Regatillo-Zalba, *Theologiae Moralis Summa*, II, 268f; C114-15.
[77] United States Bishops' Committee for Pro-Life Activities, "Nutrition and Hydration: Moral and Pastoral Reflections," *Catholic International* 3, no. 13 (1992): 631.

instance, one's body might be unable to assimilate nutrients, making the natural means futile. This would represent a physical impossibility. But moral impossibilities, too, might render a natural means *per accidens* extraordinary. Moreover, whether there is benefit to be achieved by these means is a valid consideration. As indicated in the *Ethical and Religious Directives*, there is no obligation to apply natural means that will not result in "sufficient benefit to outweigh the burdens involved to the patient."[78]

Nevertheless, the descriptive categories (natural and artificial) and the moral categories (ordinary and extraordinary) continue to be confused. Kelly is best known for falling into this error, identifying intravenous feeding as being always ordinary. This is the result of his constructing a definition of ordinary means around those medical means that can easily be obtained and used.[79] That is, he mistakes what is medically ordinary (a routine procedure) for what is morally ordinary (a means bearing proportionate benefit and no disproportionate burden). But he is also known for showing awareness of his own confusion, indicating that perhaps "ordinary" intravenous feeding might not be obligatory, and that there must be a moral difference between removing ordinary means and removing "useless ordinary means."[80] It is, of course, a contradiction in terms to call a means both useless and ordinary. By definition, ordinary means are of some use to the patient. What Kelly means to say is that it is acceptable to remove *natural* means that are useless and, thus, *per accidens* extraordinary.

Despite the precision Sullivan and Cronin have brought to the matter by separating the descriptive and moral sets of categories, some continue to conflate morally ordinary and natural means, compromising the integrity of the obligatory nature of ordinary means. For instance, philosopher David Braine has written: "Certain means, e.g. natural feeding, are ordinary in *all* circumstances and, where available, obligatory where not contraindicated by, for instance, intestinal complication."[81] And Peter Cataldo subtly but wrongly imposes a change to the notions of *per se* ordinariness / *per accidens* extraordinariness by replacing these terms with *per se* usefulness / *per accidens*

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[78] United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, Directive 58.
[79] Kelly, "The Duty of Using Artificial Means," 204.
[80] Ibid., 218-19.
[81] David Braine, *Medical Ethics and Human Life*, 2nd ed. (Great Britain: Palladio, 1983), 44. Emphasis added.

uselessness.[82] In both of these cases, the fact that a natural means can be rendered *per accidens* extraordinary by something other than physical impossibility or medical futility is overlooked. The physical condition of the patient, and not the patient's larger benefit, is given focus.

This confusion continues to take root in the Vatican and the magisterium. It occurs, first of all, in the specification of certain natural means as obligatory apart from contextual consideration. For example, in 1998 Pope John Paul II indicated a need to clarify a *moral* difference between the two stark and unqualified alternatives of "discontinuing medical procedures that may be burdensome, dangerous or disproportionate to the expected outcome…and taking away the ordinary means of preserving life, such as feeding, hydration and normal medical care."[83] Although the pope went on to claim that there is (only) a presumption to feed patients, the initial classification of feeding and hydration is that they are ordinary, not *per se* ordinary. Other documents have indicated an obligation to use these means that is stronger than a presumption. In a document issued in 1981 by the Pontifical Council *Cor Unum*, it was claimed: "There remains the *strict* obligation to apply under *all* circumstances those therapeutic measures which are called minimal: that is, those which are normally and customarily used for the maintenance of life (alimentation, blood transfusions, injections, etc.)."[84] There is no mention of any exemption from this strict obligation. In indicating that some means must always be used, the *Cor Unum* document imposes a floor of moral obligation, making some means always ordinary, something the manualists were not prepared to do.

Further, one will note that the category of "minimal" means, which are obligatory, extends beyond purely natural means of preserving life or providing care to certain interventions that are without doubt artificial. This notwithstanding, most authoritative sources do confine the *per se* ordinary judgement to what has come to be known as "basic

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[82] Peter J. Cataldo, "Pope John Paul II on Nutrition and Hydration: A Change of Catholic Teaching?" *National Catholic Bioethics Quarterly* 4, no. 3 (2004): 514 and 522. May et al. also make "usefulness" central in "Feeding and Hydrating the Permanently Unconscious," 209.

[83] John Paul II, "To the Bishops of the Episcopal Conference of the United States of America (California, Nevada and Hawaii)," (October 2, 1998), §4, http://www.vatican.va/holy_father/john_paul_ii/speeches/1998/october/documents/hf_jp-ii_spe_19981002_ad-limina-usa_en.html.

[84] Pontifical Council *Cor Unum*, "Questions of Ethics Regarding the Fatally Ill and the Dying," (1981), 292. Emphases added.

care," distinguishing this from "medical treatment." This distinction was introduced by the Pontifical Academy of Sciences in 1985. It identified medical treatment as "all those medical interventions available and appropriate in a specific case, whatever the complexity of the techniques involved."[85] Care basic to human life, on the other hand, was described as "ordinary help due to sick patients, such as compassion and spiritual and affective support due to every human being in danger."[86] Whereas medical treatment ought to be applied to patients who have a possibility for recovery, for the patient in "permanent, irreversible coma…treatment is not required, but all care should be lavished on him, including feeding." Thus, basic care came to be identified with providing such things as adequate feeding and hydration, hygiene, shelter, clothing, and other measures of comfort and signs of care.

The distinction between treatment and care was reaffirmed in other magisterial sources. For instance, in 1987 the Bishops of New Jersey claimed, "nutrition and hydration, which are basic to human life, and as such distinguished from medical treatment, should always be provided to a patient."[87] The distinction was also emphasized in the 2004 papal allocution on the vegetative state. Although the Pontifical Academy of Sciences did not explicitly identify *medically* assisted feeding as basic care, Pope John Paul II placed ANH squarely in this category:

> The sick person in a vegetative state, awaiting recovery or a natural end, still has the right to basic health care (nutrition, hydration, cleanliness, warmth, etc.)….The administration of water and food, even when provided by artificial means, always represents a *natural means* of preserving life, not a *medical act*.[88]

Meilaender has long shared this interpretation.[89] But many others outside the Catholic community disagree, deeming ANH a medical treatment.[90] Although it delivers nutrients

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[85] Pontifical Academy of Sciences, "The Artificial Prolongation of Life," in *Conserving Human Life*, ed. Smith, 306. Reprinted from *Origins* 15 (December 5, 1985): 415.
[86] It is not clear that the responsibilities of physicians include the spiritual care of the patient, or that spiritual and affective support should be viewed in the same moral category as ordinary medical support. However, the relation of the care provided by medical practitioners to the spiritual state of the patient will be discussed in chapter five.
[87] New Jersey Catholic Conference, "Providing Food and Fluids to Severely Brain Damaged Patients," (1987), in *Quality of Life: The New Medical Dilemma*, ed. Walter and Shannon, 343-48.
[88] John Paul II, "Life Preserving Treatments and Vegetative State," (2004), §4. Emphases in original.
[89] Gilbert Meilaender, "On Removing Food and Water: Against the Stream," *Hastings Center Report* 14, no. 6 (1984): 11-13.
[90] In the secular literature, see, for example, Jennett, *The Vegetative State*, 108ff; and American Academy of Hospice and Palliative Medicine, "Statement on Artificial Nutrition and Hydration Near the End of

naturally required to sustain the human body, it is required to circumvent the inability to eat and drink orally caused by the PVS. ANH supplies nutrition and hydration in a formula through tubes, a procedure that requires surgical intervention in cases of long-term application, as well as continued medical supervision.

The commentary on "Life-Sustaining Treatments and Vegetative State" explained that removal of basic care is admissible in cases of physical impossibility.[91] For instance, in a remote or impoverished community it could be impossible to obtain adequate feeding and hydration. Alternately, a patient might be physically incapable of assimilating nutrients. The document also allowed that in some other cases the provision of basic care can impose undue pain and discomfort; consequently, it may be removed. This represents a moral impossibility. But, of course, this particular moral impossibility does not apply to unconscious patients who cannot experience pain or discomfort. There is no admission in this document of any other circumstance in which supplying ANH to a PVS patient would present a grave burden. Going along for a moment with the pope's pronouncement that ANH is a natural means, what makes this so significant is that, in addressing the possibility that ANH could represent a *per accidens* extraordinary means for PVS patients, no prospect of a *moral* impossibility is admitted. What is more, the question of whether the preservation of life, apart from the restoration of health, can be reckoned a proportionate benefit to the patient is entirely disregarded. Without the consideration of these moral obstacles in the case of PVS, natural means move much closer to the realm of absolute obligation.

Indeed, it is difficult to interpret what the distinction between treatment and care intends to accomplish. Bishop Elio Sgreccia identified treatment as that which eliminates or controls a pathology; care, on the other hand, alleviates suffering.[92] Of course, this is a distinction not easily made in practice. (Moreover, by this definition, ANH would seem to fit in the treatment category if applied to a PVS patient. The alleviation of suffering is not a concern for this patient, and the achievement of the means is to circumvent the

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Life," (December 8, 2006), http://www.aahpm.org/positions/nutrition.html. In the Christian literature see End of Life Task Force, General Convention of the Episcopal Church, *Faithful Living, Faithful Dying*, 43.

[91] Congregation for the Doctrine of the Faith, "Commentary," (2007).

[92] Elio Sgreccia, "Questioni etiche dell'assistenza medica di pazienti in stato vegetativo persistente," in *Né accanimento né eutanasia*, ed. J. Noriega and M.-L. Di Pietro (Rome: Lateran University Press, 2002), 62. Cited in de Malherbe, *Le respect de la vie humaine*, 97.

effect of the pathology on the ability to take in food and water.) The distinct moral classifications of natural and artificial means notwithstanding, the manualist tradition shows that treatment and care cannot be definitively distinguished from one another in the manner Sgreccia specifies. This is apparent in the descriptive terms used for various interventions. "Intensive care," for one, admits of some ambiguity. For another, Kelly has said that proper *treatment* of the dying patient can include the use of all *natural* means of preserving life.[93] He does not make the distinction between a natural means of care and a medical means of treatment. Moreover, even in Vitoria's time it was evident that food was sometimes consumed as simple nutrition and sometimes "taken" for "medical" reasons.[94] Natural and artificial means have always abhorred strict differentiation on the basis of function. ANH would appear as a prime contemporary example of this. It indicates that a distinction between care and medical treatment is an inadequate way to limit medical aggression.

But this question of classification must be put aside in favour of a more pressing matter. Although a moral difference can be perceived in the respective obligations imposed by natural and artificial means, nowhere in the manualist tradition is a means belonging to either category exempt from a burden-benefit assessment, since using a means to preserve life is based on an affirmative command. Whether a means is natural or artificial, whether it is "basic care" or medical treatment, what makes it ordinary is that it provides a significant benefit to the patient without imposing physical or moral impossibility. The manualist presumption to provide natural means certainly admitted of exceptions that went beyond medical futility or physical impossibility.

Despite Vitoria's insistence that the possibility of death can fail to overturn the extraordinary judgement, some depart from his conclusion. The *Cor Unum* document's insistence on the application of basic care was coupled with the assertion: "To interrupt these minimal measures would, in practice, be equivalent to wishing to put an end to the patient's life."[95] A few years later, Meilaender indicated that "withdrawing the

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[93] Kelly, "The Duty to Preserve Life," 556.
[94] In addition to the descriptions provided above, see Fleming, "When 'Meats are Like Medicines,'" 105 and 111.
[95] Pontifical Council *Cor Unum*, "Questions of Ethics Regarding the Fatally Ill and the Dying," (1981), 292.

nourishment of [the permanently unconscious] is, indeed, aiming to kill."[96] The commentary on "Life-Sustaining Treatments and Vegetative State" supports this by differentiating ANH from the aim of medical treatments, claiming, "it is not, nor is it meant to be, a treatment that cures the patient, but is rather ordinary care aimed at the preservation of life."[97] Of course, this is to avoid the fact that the manualists were concerned with both curative and (merely) preservative means. Despite this, Pope John Paul II insisted: "death by starvation or dehydration is, in fact, the only possible outcome as a result of their withdrawal. In this sense it ends up becoming, if done knowingly and willingly, true and proper euthanasia by omission."[98]

This evidences a leap from foresight to intention for cases in which removal of ANH inevitably leads to the death of an otherwise stabilized vegetative patient. Others have argued that foreseeing an unavoidable consequence of one's action is indeed equivalent to intending that consequence.[99] But the key issue here is what is being willed. What is the volitional object of the action to withdraw ANH from the PVS patient? Although the external features of many acts allow the outsider to make inferences about the intentionality underlying them, a proviso needs to be made in the case of withdrawing basic care. Since such a withdrawal might well be the proximate cause of the patient's death, the external observer might condemn the act as euthanasia by omission. However, as the potential for medical aggression increases, the plausibility of the agent bearing an intention to forgo extraordinary measures increases. If the intention is to remove treatment that is a) lacking in sufficient benefit, or b) disproportionately burdensome, this is something distinct from willing the patient's death.[100] The context of the intention is much broader, subsisting in a vision of medicine and of the preservation of life and health that is enlarged beyond the mere extension or prolongation of life. This should be as clear to us now as it was to Vitoria and the manualists who followed him. The argument from

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[96] Meilaender, "On Removing Food and Water," 13. Others agreed. See Connery, "The Ethical Standards for Withholding/Withdrawing Nutrition and Hydration," 88.
[97] Congregation for the Doctrine of the Faith, "Commentary," (2007).
[98] John Paul II, "Life-Sustaining Treatments and Vegetative State," (2004), §4.
[99] See secular bioethicist Helge Kuhse, "A Modern Myth: That Letting Die is Not the Intentional Causation of Death," in *Bioethics: An Anthology*, 2nd ed., ed. Peter Singer and Helge Kuhse (Oxford: Blackwell, 2006), 315-28.
[100] This has long been argued by Kevin O'Rourke. See, for example, "On the Care of 'Vegetative' Patients," Part 1, *Ethics & Medics* 24, no. 4 (1999): 4.

foresight to intention proves too much in that it threatens to undermine the OEMD itself. The basis of the OEMD is that certain instances of forgoing means—even means that are known to be life-preserving—can be morally distinguished from an illicit intention to end life.

Joseph Boyle, who defends both the papal allocution and a theoretical distinction between intention and foresight, interprets the allocution as identifying only certain acts of withdrawing ANH from PVS patients—those done with the intention to end the life of the patient—as euthanasia. It may be assumed, he says, that many such acts are done with illicit intention because of the "dismal future prospects for recovery of a person in PVS."[101] It is very difficult, Boyle suggests, to make the decision to withdraw ANH apart from an illicit intention. However, Boyle can only say this because his understanding of extraordinary means is unduly limited. He identifies extraordinary means as those presenting an excessive burden, and does not extend his definition to include those means that simply provide negligible or no benefit.[102] Thus, it is easy for him to support the judgement that natural means need not be subject to the OEMD in cases of PVS, or for other patients whose death is not imminent and inevitable but for whom hope of recovery or significant improvement in health is not real.

It would be inconsistent with the manualist account of the OEMD to make an absolute judgement against the indefinite feeding of PVS patients, since nonmedical, contextual factors need to be taken into account prior to judgement. But what I insist upon is that ANH always has the *potential* to be extraordinary for any patient. The presumption to provide feeding proceeds from what is commonly the case: food is naturally ordered to preserve both life and health. But because this is commonly but not absolutely the case, all means, including ANH—indeed, even customary eating and drinking—must remain subject to an evaluation of their moral ordinariness. No means is out of the reach of a standard that holds a means up against its projected results—the level of the recovery expected. Kelly claimed as much when he maintained that the hope of benefit principle applicable to curative measures is also applicable to any artificial

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[101] Joseph Boyle, "Towards Ethical Guidelines for the Use of Artificial Nutrition and Hydration," in *Artificial Nutrition and Hydration: The New Catholic Debate*, ed. Tollefsen, 116.
[102] Ibid., 115.

means that supplants a natural means of preserving life.[103] He singled out intravenous feeding as an example. Finally, it is impossible, according to the manualists, to establish an absolute norm regarding ordinary means, even natural ones. They argue

> that such a purely ordinary and common means of conserving life as food, admits of relative inconvenience and difficulty. Furthermore, they point out that this very common means, food, sometimes can offer no proportionate hope of success relative to a particular individual.[104]

3.3.3 The Standards for Recovery

A proportionate hope of success and benefit has been a criterion of the ordinary judgement from the beginning of the development of the OEMD. As outlined by de Lugo, this hope referred to the expectation of a recovery that was of reasonable quality and duration. Recovery might not mean a return to full health or even to the standard of health enjoyed prior to illness. But it does entail some measure of improvement that is both significant to the patient and proportionately greater than the burdens imposed by the treatment.

Some Catholic authorities have been consistent in following this judgement. For instance, the Texas Bishops insisted that moral obligation was dependent upon a reasonable level of foreseen benefits associated with the intervention.[105] Among these they listed cure, pain reduction, restoration of consciousness, restoration of function, and maintenance of life with reasonable hope of recovery. This seems to be in keeping with the manualist understanding of success. For example, Kelly observed, "There are degrees of 'success.' It is one thing to use oxygen to bring a person through a crisis; it is another thing to use it merely to prolong life when hope of recovery is practically negligible."[106]

However, some have made efforts to diminish the standards for recovery that life preserving means must meet. One new difficulty that is faced by contemporary bioethicists is the increase of chronic illness made sustainable through medical intervention. In this context, some Catholic sources argue that a focus on a reasonable level of recovery causes quality of life concerns to override the obligation to preserve

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[103] Kelly, "The Duty of Using Artificial Means," 213-14.
[104] Cronin, "The Moral Law," 90.
[105] Texas Bishops and the Texas Conference of Catholic Health Care Facilities, "On Withdrawing Artificial Nutrition and Hydration," (1990), 110.
[106] Kelly, "The Duty of Using Artificial Means," 214.

life—the concern that occupied Ramsey. One way of addressing this concern is to construct a barrier between the burdens directly imposed by the treatment and the burdens that accompany a so-called low quality of life. This barrier, the United States Bishops' Committee for Pro-Life Activities has remarked, enables one to "distinguish between repugnancy to a particular procedure and repugnance to life itself."[107] Only the burdens directly imposed by the treatment represent an appropriate reason to forgo life preserving means, as "remaining alive is never rightly regarded as a burden."[108] In picking up on the "spiritual ends" statement of Pope Pius XII, May has represented this distinction in a slightly different way. He demarcated a difference between a means that imposes a moral impossibility, hence preventing the patient from pursuing spiritual ends, and a means that is in itself simply ineffective in enabling a patient to pursue spiritual ends.[109] In his view, only the means that itself presents a hindrance to reaching spiritual ends would be extraordinary. But this is to evade the primary justification for requiring life preserving means: that it *provide* a proportionate benefit to the patient.

Meilaender is another strong proponent of separating the burdens of the treatment from quality of life burdens. He warns against any view that a life could be futile: "We may reject a treatment on grounds of excessive burden. But if I decide not to treat because it seems a burden just to have the life this person has, then I am taking aim not at the burdensome treatment but at the life."[110] From this he concludes, in agreement with May, that applying ANH to a permanently vegetative patient is not useless. It does, in fact, provide a benefit since it preserves life. This being the case, the removal of ANH can be judged as an act against the value of that patient's life. Along the same lines, the authoritative commentary on "Life-Sustaining Treatments and Vegetative State" indicates that ANH is proportionate to accomplishing its purpose for the PVS patient, "which is to keep the patient from dying of starvation and dehydration."[111] Here success is measured only in terms of the proximate end of the means used and not in the context of the patient as a whole.

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[107] United States Bishops' Committee for Pro-Life Activities, "Nutrition and Hydration: Moral and Pastoral Reflections," (1992), 626.
[108] May et al., "Feeding and Hydrating the Permanently Unconscious," 205.
[109] William E. May, "Tube Feeding and the 'Vegetative' State," *Ethics & Medics* 23, no. 12 (1998): 2.
[110] Meilaender in Robert D. Orr and Gilbert Meilaender, "Ethics and Life's Ending: An Exchange," *First Things* 145 (August-September 2004): 37. Cf. Meilaender, "Living Life's End," 18-19.
[111] Congregation for the Doctrine of the Faith, "Commentary," (2007).

Meilaender and the Catholic proponents of the papal allocution have good intentions here—to respect the equal, intrinsic dignity of all people. However, it is not clear from the manualist accounts that a distinction between the burdens imposed by treatment and the burdens of a "low quality of life" should obtain. Cronin provides the example of amputation. Whereas the earlier noted burden of extreme pain and the uncertain hope of benefit became largely diminished in the context of contemporary medicine, later manualists argued that the burden of intense abhorrence at the prospect of life with a mutilated body could remain along with the extreme inconvenience in which such a condition results.[112] As Catholic moralist Kevin Wildes has pointed out, this burden pertains to the quality of life that persists after the treatment.[113] Another quality of life burden presented was that of a very harsh or troublesome convalescence following treatment.[114] Still another was the burden of needing to use a drug for many years in order to prolong life.[115] Sometimes these could present a moral impossibility—although it is important to recognize that they do not do so necessarily. When it is remembered that many of the decisions that fall under the OEMD pertain to common choices regarding what kind of food to eat or in what kind of location to live, it becomes evident that quality of life, cast according to the characteristics of a particular theological anthropology, is an important concern for the manualists. In many cases, the burdens associated with a means and the burdens associated with life during and following the use of that means are inextricably bound together. If this is so, it makes sense that a particular standard of recovery in terms of quality and length would be a condition attached to the ordinary judgement.

The question must be asked, then, did the manualists differentiate between the value of one patient's life and that of another? Did they work from a dualist concept of the human being, one that values the body only instrumentally? It is arguably the case that they were instead interested in differentiating between the direct efficacy of a treatment toward a medical condition and the hope of benefit for the patient's whole life. The implication for the OEMD is that when sustained bodily life no longer serves as a

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[112] Ballerini-Palmieri, *Opus Theologicum*, II, 645, n.868, ftnt.b; C111.
[113] Wildes, "Ordinary and Extraordinary Means and the Quality of Life," 504-05.
[114] Regatillo-Zalba, *Theologiae Moralis Summa*, II, 269; C104.
[115] This burden was recognized during a time when medicines were expensive and difficult to obtain. Sanchez, *Consilia seu opuscula moralia*, Tom. II, Lib. V, Cap. I, dub. 33; C81-82.

constitutive part of the final human end—when life revolves around treatment instead of around God, as St. Basil would have it—it is acceptable to allow this good to pass away. To do otherwise is to accept the position of May and the other new natural law theorists. That is, life in itself is a benefit sufficient to warrant the use of life preserving means. The papal allocution on the vegetative state appears to say just this when it claims, "no evaluation of costs can outweigh the value of the fundamental good which we are trying to protect, that of human life."[116] It is, of course, this very perspective that the OEMD attempts to avoid. The statement of Pope John Paul II stands in severe contrast with de Lugo's remark that the *bonum* of a human life is not so great as to demand its conservation by all available means.[117]

3.3.4 *A Priori* Judgements

The OEMD is a moral tool that is constructed for use by the patient in conjunction with the advice of medical personnel and family as appropriate. It is conventionally understood that this makes the decision contextual, but not baseless. It follows a norm that is responsive to the entire circumstances of the patient. The manualists, who saw the need to construct a ceiling of obligation, making certain means always extraordinary, were loathe to build a floor of obligation or to impose the use of any means in all circumstances. It is fitting, then, to make absolute judgements about the nonobligatory nature of *certain* extraordinary means, but not to pronounce the obligatory nature of *any* ordinary means in abstraction from a particular case.[118] The contextual nature of the OEMD was confirmed in the *Declaration on Euthanasia*, which admitted, "in numerous cases, the complexity of the situation can be such as to cause doubts about the way ethical principles should be applied."[119] It also confirmed:

> It will be possible to make a correct judgment as to the means by studying the type of treatment to be used, its degree of complexity or risk, its cost and the possibilities of using it, and comparing these elements with the result that can be expected, taking into account the state of the sick person and his or her physical and moral resources.[120]

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[116] John Paul II, "Life-Sustaining Treatments and Vegetative State," (2004), §5.
[117] de Lugo, *De justitia et jure*, Disp. 10, sec. 1; C53.
[118] Cronin, "The Moral Law," 143.
[119] Congregation for the Doctrine of the Faith, *Declaration on Euthanasia*, (1980), Part III.
[120] Ibid., Part IV.

Evangelium Vitae also spoke against "medical procedures which no longer correspond to the real situation of the patient, either because they are by now disproportionate to any expected results or because they impose an excessive burden on the patient and his family."[121] Of course, others prefer to emphasize the objective features of the particular case. May claims that the extraordinary judgement may be made if "objectively discernable features in the treatment itself, its side-effects, and its negative consequences impose grave burdens on the person being treated or on others."[122] But May mistakes objectively discernable moral factors for an objectively correct moral judgement—the same mistake, I have shown, that Ramsey made in his later work, *Ethics at the Edges of Life*.

But beyond this, some have observed that certain Catholic documents have overturned the very contextuality of the application of the OEMD.[123] Particularly highlighted is the *a priori* judgement of the *per se* ordinariness of ANH for PVS patients.[124] The papal allocution has played a particular role in this shift, claiming the following:

> I should like particularly to underline how the administration of water and food, even when provided by artificial means…should be considered, in principle, *ordinary* and *proportionate*, and as such morally obligatory, insofar as and until it is seen to have attained its proper finality, which in the present case consists in providing nourishment to the patient and alleviation of his suffering.[125]

Support for this statement has been offered by way of arguing that the manualists did not actually consider the patient's entire situation in presenting case studies, nor did they present a broad concept of relative assessment. They instead limited their observations to particular classes of factors—physical condition, pain, abhorrence, finances, and the threat of imminent death. Cataldo claims that each of these specific factors is significant

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[121] John Paul II, *Evangelium Vitae*, (1995), §65.
[122] William E. May, "Criteria for Withholding or Withdrawing Treatment," *Linacre Quarterly* 57, no. 3 (1990): 88.
[123] Ronald P. Hamel and Michael Panicola, "Must We Preserve Life?" in *Artificial Nutrition and Hydration and the Permanently Unconscious Patient*, ed. Hamel and Walters, 82-83.
[124] See Pontifical Council *Cor Unum*, "Questions of Ethics Regarding the Fatally Ill and the Dying," (1981), and Pontifical Academy of Sciences, "The Artificial Prolongation of Life," (1985).
[125] John Paul II, "Life-Sustaining Treatment and Vegetative State," §4. Of course, PVS patients do not suffer and ANH would be dubious means of alleviation if they did. This is taken up at the end of the thesis. At this point, I treat the "proper finality" of ANH only insofar as it refers to the nourishment of the patient.

insofar as each affects "the *way* in which a person is obligated to preserve life."[126] One makes a mistake, he says, in taking their consideration to be akin to allowing the patient's total situation to cancel out the duty to preserve life. The duty to preserve life is not one whose force is relative to circumstance; it is only permissible to avoid any disproportionate conditions under which the duty is carried out. In other words, "identifying specific burdens in relation to specific benefits ought not to be confused with a summing up or an amalgamation of factors which vitiate particular moral obligations that remain in force based on the real situation."[127]

This interpretation of the manualist tradition would not render the OEMD judgement entirely noncontextual, but it would limit considerably the factors that make feeding and hydration *per accidens* extraordinary, thus allowing noncontextual ordinary verdicts. PVS patients are not imminently dying and experience no pain or abhorrence. Their care, some maintain, requires minimal financial input. On the other hand, is the physical condition of the PVS patient of no matter? Although the patient is not imminently and inevitably dying, and although ANH does not often present a physical impossibility, persistent and indefinite vegetation is a condition that is unprecedented in human history. It may well be argued that such a novel state of affairs deserves a fresh evaluation of benefit and burden.

Another matter must be brought to bear on the trend of making *a priori* judgements about classes of patients. When one takes into consideration the shift in the aim of the moral manuals described in the first chapter—from providing general direction for the moral life to providing instruction on the boundaries of professional medical activity—it becomes clear that there has been a corresponding shift in emphasis from the patient's judgement to the medical practitioner's judgement about life preserving means. According to Cronin, the manualist tradition affirms that physicians are obliged to offer and employ all means deemed ordinary for a particular patient.[128] At the same time, his above quoted definitions of morally ordinary and extraordinary means depend upon the judgement of the *patient*. So, it could be said that the physician is obliged to employ those means deemed ordinary by the patient in good conscience.

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[126] Cataldo, "Pope John Paul II on Nutrition and Hydration," 528. Emphasis added.
[127] Ibid., 529.
[128] Cronin, "The Moral Law," 125-26.

But alongside this is the more contemporary problem of proxy judgements. In cases in which the patient is incompetent, the proxy will take on the final responsibility for treatment decisions. Here the difficulty is that the OEMD was not constructed for use by proxies, but the need to distinguish between euthanasia and legitimate treatment withdrawal remains even when the patient is not the one making the treatment decision. Due to this need, Protestants and Catholics alike tend to allow proxies the decision-making role. This is the norm for those patients in PVS who have no advance directive.[129] The Catholic Church upholds: "In the final analysis, it pertains to the conscience either of the sick person, or of those qualified to speak in the sick person's name, or of the doctors, to decide, in the light of moral obligations and of the various aspects of the case."[130] The difficulty is, of course, that the moral evaluations made by the physician and by the proxy can conflict. It is certain that the proxy will make these decisions from a perspective very different from the patient's. No one has access to the patient's subjectivity. Indeed, the patient's subjectivity no longer functions. However, this is not the same as saying that the judgement will be any less *contextual*. There will always be moral factors, alongside the medical factors, to consider. This must be kept in mind if one is to draw a line between the legitimate obligation to make available all ordinary means and the dubious *a priori* imposition of means that an incompetent patient might have been expected to deem extraordinary.

But more recent documents have muddied the waters on this. The *Ethical and Religious Directives* have been unclear on how a conflict between the judgement of an informed conscience and that of Catholic teaching ought to play out. Directive 32 restates the obligation of patients to use ordinary means, also saying that one is not obliged to submit to a procedure that one has "judged, with a free and informed conscience, not to provide a reasonable hope of benefit without imposing excessive risks and burdens on the

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[129] The magisterium has been inconclusive on the matter of the legitimacy of advance directives that indicate against the use of ANH in the case of PVS. See Carol Glatz, "Ambiguities Cloud Moral, Medical Issues as End of Life Nears," *Catholic News Service* (February 29, 2008), http://www.catholicnews.com/data/stories/cns/0801177.htm. Also see Canadian Catholic Bioethics Institute, "Reflections on Artificial Nutrition and Hydration: Colloquium of the Canadian Catholic Bioethics Institute," (July 22, 2004), no. 7, http://www.iacbweb.org/ANHstatement.html#_ftnref1. I return to this subject in the final chapter.

[130] Congregation for the Doctrine of the Faith, *Declaration on Euthanasia*, (1980), Part III.

patient or excessive expense to family or community."[131] Directive 56 goes on to add that the patient's judgement about life preserving means should be respected and complied with, "unless it is contrary to Catholic moral teaching."[132] The problem for PVS cases is that the consciences of individuals often clash with the recent teachings on ANH. It would appear from the some of the documents quoted above that authority has been wrested from the consciences of individuals and placed in the hands of the magisterium.

Often the concern about proxy judgements is that a decision to withdraw life preserving means will be motivated by a desire to rid caregivers of the burdens of caring for the patient. In considering the legitimacy of proxy judgements that go against the conclusions of the 2004 papal allocution on the vegetative state, it must be kept in mind that concern for the burdens placed on a patient's family and caregivers has been expressed by numerous Catholic authorities. Such burdens have received increasing attention in the past century. Pope Pius XII claimed that ordinary means are those that do not gravely burden oneself or another.[133] In the *Declaration on Euthanasia* it was accepted that the patient's refusal of life preserving means could be licit when it represents "a desire not to impose excessive expense on the family or the community."[134] This was repeated in the *Ethical and Religious Directives*.[135] The burdens placed on those who surround the patient are no less present when the patient is incompetent to make treatment decisions. On the other hand, in this case a new risk exists. The decision to remove life preserving means might be marred by the desire to see the patient die. With this in mind, Meilaender insists that the proxy judgement must become a more "objectified" decision—one that avoids the appearance of any intention toward euthanasia—even at the expense of altering the OEMD tradition.[136] The objectified decision to maintain ANH for PVS patients is made on the basis of the usefulness of the means for preserving life and the absence of excessive burdens *for the patient*. The fear that the OEMD will be used deliberately to end a patient's life is legitimate. It is the same

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[131] United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, Directive 32. The directive does not speak specifically to proxy judgements.
[132] Ibid., Directive 56.
[133] Pius XII, "The Prolongation of Life," (1958), 396.
[134] Congregation for the Doctrine of the Faith, *Declaration on Euthanasia*, (1980), Part IV.
[135] United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, Directives 32 and 57.
[136] Meilaender, "Ordinary and Extraordinary Treatments," 529.

fear that Ramsey expressed. Meilaender is correct to observe that it is one thing to allow one's own life to expire in order to avoid unduly burdening another individual and another thing to allow the life of someone else to expire in order to avoid burdening oneself.[137] A danger persists that the community will regard its own interests above those of the vulnerable patient.

These innovations on the OEMD have been made in response to the growing power of the euthanasia and assisted suicide movement. The hedge erected around PVS patients is perceived as a protection against the wholesale devaluation of those human lives that are fragile, declining, or unactualized in terms of sentience. This response is understandable given the ease with which certain criteria of extraordinary means, such as extreme abhorrence, might be manipulated. Abhorrence of a life with multiple amputations, for instance, might be used to justify suicide.[138] Still, I am not persuaded that the proper response to this risk is to threaten the integrity of the OEMD. It is arguable that, in avoiding the direction of euthanasia, these innovations go too far in the other direction. Instead, I contend, decision makers should be encouraged in a right moral orientation toward legitimate human ends. Proper intention on the part of the patient has always been a prerequisite for making an objectively correct judgement using the OEMD, and surreptitious intentions toward death by the few have always been a tolerable risk. Meilaender shows little sensitivity to the fact that decades of convalescence that offer no hope for recovery can overwhelm the stamina of even the most sincere families and caregivers. Furthermore, it is far from certain that his kind of objectified decision avoids the appearance of an ill will. The ongoing administration of ANH requires periodic medical supervision, but it does not require the continued attention of family members. As I point out later (5.3.1), many patients left to linger on ANH are, for all intents and purposes, abandoned.

The 2004 papal allocution on the vegetative state has acted to clarify what were thought to represent ambiguities in Catholic teaching—ambiguities relating to the

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[137] Ibid., 130.

[138] One might argue that the extreme abhorrence elicited by multiple amputations in the sixteenth century would today be alleviated by social support systems and increased accessibility. Such improvements do not cancel out consideration of abhorrence, but they can relieve many burdens that fall under this category, bridging the gap between capacity and actualization. However, an additional conclusion that can be drawn from the substance of the chapter to follow is that innovations also have the potential to bring about novel situations that elicit new objects of abhorrence.

significance of imminent death, the moral status of natural means, the value of quality of life concerns, and the subjective nature of the OEMD decision. In each case the "clarification" represents a departure from the manualist articulation of the OEMD. Each of the enumerated innovations ought to be regarded as threats, rather than corrections, to the OEMD. In compensating for the dangers of euthanasia and assisted suicide that attend a devaluation of patients unable to flourish—a danger against which certain Protestant bioethicists may be defenceless—these innovations fail to attend to the qualifications placed upon the affirmative obligation of preserving life. Instead, they present an additional danger: the danger of being blind to the changes that increased abilities to preserve life can render on our perception of how best to act out the moral obligation to preserve life.

In the chapter to follow I address this danger specifically. Today's medical situation is characterized by the paradox that fewer treatments are, in a physiological sense, futile. But more of them fail to attend to the larger aims of human life. A changed context for medical action means ethics must pay attention to technology without being determined by it. The OEMD should not be reduced to a mechanism limiting medically futile care. Ethics—and anthropology—must remain at the helm.

Chapter 4
Hans Jonas and Technology: Informing Christian Bioethical Responsibility

Each of the four innovations made to the OEMD discussed in the previous chapter—limiting its use to times when death is imminent and inevitable, applying it only to purely artificial means, reducing the standards of quality and duration of recovery, and attaching *a priori* obligations to certain classes of treatment decisions—represents an overturning of the manualist work to distinguish between illicit intentions toward suicide and legitimate refusal of life preserving means. In a time of increasing options for life preservation, these innovations decrease the possibilities for treatment refusal. Such a trend is curious and reveals that the dynamics of technological progress have been allowed, in the name of the sanctity of life, to overtake an independent or autonomous ethical evaluation of health care. With the help of Hans Jonas, in this chapter I outline the problematic dynamics of technology that make it pervasive in the current age. Jonas argues that the relationship between ethics and technology must be hierarchical: technology must be submitted to ethics. The starting point of ethics is the ethical aim, or the *telos* of human life. In moving from aim to obligation (the movement outlined in the first chapter), technology informs a prudential judgement, so it must be taken into account in the moral evaluation of a given situation. On its own, however, technology does not impose new obligations for action. Certainly, the options for fulfilling the moral duties prompted by the ethical aim are often opened up by technology. Nonetheless, this does not entail that the scope of moral obligation for action enlarges in direct proportion with the expansion of technological capacity. The only legitimate expansion in correspondence with increasing technology occurs at the level of ethical reflection.

This chapter begins with an orientation to Jonas' thought. Following this, I take up an account of Jonas' philosophical anthropology, which he initiates by means of a philosophical biology. This account demonstrates his kinship at several critical junctures with Aristotelian-Thomistic theological anthropology. The next section of this chapter is devoted to a discussion of the formal and substantive dynamics of technology as outlined by Jonas. As the central problem of this thesis is the limited goodness of life preserving means in the medical context, I augment this discussion with an account of how the

dynamics of technology have shaped and been shaped by the practice of medicine. The ethical response Jonas offers to these dynamics is given in terms of substantive responsibility. What this looks like in the medical context of end-of-life care is discussed, with a more thorough treatment of the consequences for medical ends to be reserved for the chapter to follow. Dangers are perceived in the expansion of a moral obligation to implement life preserving technologies relative to the availability of the latter, and Jonas indicates that such expansion is often difficult to avoid. For these two reasons, I put forward a cautionary principle for technological development and application, one that allows space to consider the normative role of human anthropology for a particular case of technological intervention.

The ambiguity of contemporary medical technology will be raised in relation to the changed context for action. Although the dynamics of modern technology differ from those of previous ages, the technology-related problems presented today are not insuperable. Jonas argues that they can, in fact, be surmounted if the instrumental worth of particular technologies and their applications are evaluated according to a prior concept of human nature and ends. This being the case, his technologically aware ethics is not representative of a new ethical theory. Instead, Jonas attends to the need to discern the deviations from traditional values and ends encouraged by technology. At the commencement of the second chapter it was pointed out that ethical affirmations of the good can be refined (in distinction from simply being misdirected) through experience. This chapter will indicate room for such refinement, contending that Christian anthropology and human ends, rather than being determined by technological capacities, must serve to direct the engagement of technology. Indeed, much of this chapter substantiates the following statement of Gerald McKenny, a commentator on Jonas: "The problem is not technology itself but our lack of a moral framework that can tell us how rightly to resist and appropriate it."[1]

4.1 The Foundations of Jonas' Thought

Hans Jonas (1903-1993) was a German Jew who studied under Rudolf Bultmann, Edmund Husserl, and Martin Heidegger. His biography includes service for the British in the Second World War, the loss of his mother at Auschwitz, participation in Israel's war

[1] McKenny, *To Relieve the Human Condition*, 6.

of independence, and academic service in Canada at Carleton and McGill Universities and at the New School for Social Research in New York. Jonas' work, like that of so many of his contemporaries, was profoundly influenced by his experience of the Second World War and the Holocaust. It also reflects a diversity admirable for any philosopher. Jonas' publications began with a history of philosophy and proceeded to phenomenology, social philosophy, and Jewish theology. His ethical works are rooted in a critique of technology but pertain to various related areas of application, including medicine and the environment. Despite his wide-ranging interests, Jonas' thought demonstrates a definite cohesion and development. The descriptive component of this chapter must, of course, necessarily be limited in scope to pertain to the concern at hand. It is the expectation, however, that this cohesion will be made evident.[2]

Jonas is best known for his philosophical critique of technology made in *The Imperative of Responsibility*, a book that has received both scholarly and popular attention. Certainly Jonas is not the only philosopher to offer a critical analysis of modern technology or even, perhaps, the most renowned of them. Others who recognize the extensive effects of technology on human life and culture, such as Martin Heidegger and Jacques Ellul, eye them with certain pessimism. Jonas, too, is quite wary of the human will to power exercised in technology. Yet he is not deterministic about the direction of technology, and not entirely without hope. This fact has particular significance for a Christian ethical analysis. Engaging in prescriptive ethics, in Christian perspective, requires some sense that there can be movement toward the good. The bleakness of nihilism is rejected. Although Jonas checks the utopian thrust of technological progress, his project does not preclude the notions of Christian hope and theodicy.[3] It rather reinforces the necessity of ethical responsibility in an age of pervasive technology. Despite the overwhelming force of technology, Jonas demonstrates faith in the role of

[2] For a fuller account of the cohesiveness of Jonas' thought see Lawrence Vogel, "Hans Jonas's Exodus: From German Existentialism to Post-Holocaust Theology," introduction to Jonas, *Mortality and Morality*, 1-40.

[3] Jonas even provides his own version of a Jewish theodicy in "The Concept of God after Auschwitz: A Jewish Voice," in ibid., 131-43. Admittedly, this theodicy avoids proposing any *assurance* of hope.

prudence for good action.[4] His interest in engaging applied ethics, and bioethics in particular, makes him particularly helpful to my analysis.

Jonas aids the present ethical analysis of medical technology in a second way. Prescriptive ethics, especially as it pertains to the hospital bedside, requires that attention be paid not only to sweeping issues raised by technological advances but also to the common and minute details of the human life engaged with technology. Not all philosophers of technology give expression to the latter. Ellul, for example, has been described as a prophetic theologian and philosopher occupied with the larger questions of the philosophical ethos of technology at the expense of being able to deliberate about particular technological innovations and applications that are of concrete, practical concern.[5] I will demonstrate that Jonas does not fall prey to this criticism, although he does not neglect the larger, sweeping questions of the technological ethos. In fact, Jonas reveals an important continuity between the large- and small-scale questions that arise from the technological situation. He shows great circumspection toward the incremental movements of technology—those nearly imperceptible, often unforeseeable developments that move the larger enterprise of technology forward.

4.1.1 A Philosophical Biology

There are two reasons to begin this chapter on technology by giving yet further attention to philosophical anthropology. Embracing Jonas' ethics does not require one to accept the content unique to his philosophical anthropology outlined in this section. This content is, rather, indicative that Jonas' view of the human being shares certain critical characteristics with the theological anthropology defended in this thesis. These characteristics are outlined in the second chapter: the intrinsic value of human bodily life (and of all natural life), the uniqueness of the human soul amongst all forms of natural life, and the unity of being that is produced by the relation of soul and body. This descriptive work, then, aims at establishing Jonas as a welcome ally to the argument being constructed in the Christian context.

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[4] Cf. David J. Levy, *Hans Jonas: The Integrity of Thinking* (Columbia: University of Missouri Press, 2002), 9. Jonas' account of the significance of prudence is found in *The Phenomenon of Life*, 199.
[5] James M. Gustafson, "Theology Confronts Technology," in *On Moral Medicine*, 1st ed., ed. Lammers and Verhey, 39.

Jonas is anything but a dualist. He began his academic career with a study and refutation of Gnostic metaphysical dualism, for which he is well known in the North American context.[6] This brought him into contact with the anthropological dualism at work in Heideggerian existentialism. "I was increasingly struck," he wrote, "by the familiarity of the seemingly utterly strange"—a familiarity manifest in the denial of a good ordering of the cosmos and the affirmation of a transcendent, acosmic self.[7] Metaphysical dualism, Jonas asserted, is responsible for the view that nature is not an intrinsic good and, thus, that technology is free to make nature—including human nature—its object.[8] This suggests the second justification for beginning this chapter with Jonas' anthropology. Internal to his own system of thought, his construal of the human being is foundational for his perception of technology as a problem. Jonas' work, whether in the vein of philosophy, ethics, or theology, reacts against the influences of dualism and nihilism by affirming the teleological ordering of all life and the human responsibility to preserve life—especially human life—grounded in an affirmation of the goodness of being. It is unmistakable that Jonas draws from and innovates the Aristotelian tradition of marrying ontology and ethics.

Also quite like Aristotle, Jonas' anthropological work is grounded in a philosophy of life, or a philosophical biology. Denying that an ontologically grounded ethics contradicts the modern causal explanation of nature, Jonas claims it is rather that natural science does not explain all there is to know about nature. Contra Heidegger and, indeed, the trend of the modern physical sciences, Jonas affirms the connection between the value found in human bodily life and that of the rest of natural life.[9] He admits that his work can be dismissed as speculation, but insists that there is legitimacy to his own phenomenological reading of life. Whereas the notion of "soul" for Aristotle indicated the formal principle of organization continuous throughout life, Jonas connects form with "purpose," which he sees as present, to differing degrees, in all living beings.[10] It is a

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[6] Hans Jonas, *The Gnostic Religion: The Message of the Alien God and the Beginnings of Christianity* (Boston: Beacon Press, 1963).
[7] Jonas, *The Phenomenon of Life*, 211. Lawrence Vogel makes this point explicit in his foreword to the same work, xiii.
[8] See Jonas' essay "Gnosticism, Existentialism, and Nihilism," in ibid., 211-34.
[9] For instance, Jonas remarks that Heidegger refused to extend his concept of "care" to the natural body or to address it to physical needs. See his *Mortality and Morality*, 47.
[10] Jonas, *The Phenomenon of Life*, 84.

being's level of purposiveness that determines its organization and manner of living. This is neither to suggest that all life forms have conscious awareness nor to deny that many organisms are nonvolitional. To be sure, the human will, informed by reason and affection, is a prerequisite for the human pursuit of the good and unique to human beings. But Jonas sees this kind of subjective purposiveness as the endpoint of a continuum of directedness that is "indigenous" to nature, existing at every level of life to different degrees.[11] The seed of human purpose is found in the most primitive forms of life.

What is the purpose immanent in nature, then? Jonas is prudent enough to avoid claiming comprehensive knowledge of all of nature's purposes. He does, though, assert that life itself, or "purposive being" itself, is key among them. That is, being *strives against* nonbeing.[12] As Jonas uses the word, purpose need not be linked with consciousness, knowledge, or planning, but only, at a minimum, discrimination. Life persists by giving selective preference to those conditions favourable to it. Discrimination is a sort of disposition toward receptive exploitation or opportunism on the part of life, rather than the kind of active awareness and volition that is evident at the level of the human being.[13] So, the continuum begins with a basic thrust toward self-perpetuation proper even to the smallest organism. This self-perpetuation is a kind of inwardness, but it is not without a concurrent openness to the outside world. In fact, the organism's identity is dependent on the latter. The purposiveness evident at all levels of life is exhibited in the manner of existence experienced at all levels, which is characterized as "needful freedom." Whereas dualist interpretations of being emphasize transcendence in terms of a radical discontinuity of the human soul or mind and the human body, Jonas recognizes that all life seeks transcendence, and that this transcendence has a counterpart. The transcendence proper to life requires an "outwardness" to complement "inwardness." Every being must exceed its own boundaries and reach beyond itself simply in order to live.[14] This is the *function* of metabolism. Metabolism directs an organism's continual exchange of matter with its environment. Interestingly, very similar observations have been issued by the President's Council on Bioethics in its reworking of a defence of the

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[11] Jonas, *The Imperative of Responsibility*, 74.
[12] Ibid., 74 and 81.
[13] For nonhuman forms of life it is understood that discrimination, exploitation, and opportunism are void of moral connotation.
[14] Jonas, *Mortality and Morality*, 4-5.

brain death standard. According to this body, a brain dead patient can be described as one who has irreversibly lost "a fundamental openness to the surrounding environment as well as the capacity and drive to act on this environment on his or her own behalf."[15]

The material composition of any living organism is always in flux. What this means, in Jonas' analysis, is that an organism's material identity at a given time is not equivalent to the identity of the organism itself: "Internal identity of the whole, transcending the collective one of the present and vanishing substratum, must span the shifting succession. Such internal identity is implicit in the adventure of form."[16] The transcendence or freedom of the organism, then, does not entail the independence of form from matter but rather prevents strict identification of form with matter. Metabolism sustains form, but form generates metabolism. However, there is a shadow side of freedom: "can" entails "must."[17] If metabolic exchange ceases, the organism dies, losing both transcendence and inward identity. The inwardness of life, from its most basic to its most complex levels, is intimately linked with internal and external matter.[18] The struggle of being against nonbeing is ongoing.

Mediacy is the term employed by Jonas to indicate the distance between organism and environment. Metabolism is the beginning of the transcendence experienced by life. For those organisms whose possibilities for actualization are restricted to this level there is a very low level of mediacy. The progression of mediacy happens in concert with the progression from merely discriminatory life to purposive human life, in which a rational will is present. For the plant, which can draw nutrients from an external but immediate supply of soil, the relationship to the environment is quite proximate.[19] Freedom is limited to transcendence from its own material constitution, not from its environment. Further, constant supply is inimical to the development of appetite. Animal life, however, is appetitive (which is the form of its purpose or self-concern) because its supply is sometimes lacking. The animal's relationship to its environment is not so immediate. It

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[15] President's Council on Bioethics, *Controversies in the Determination of Death: A White Paper* (Washington, D. C.: President's Council on Bioethics, 2008), 90-91; cf. 59-65. I return to this in the final chapter.
[16] Jonas, *The Phenomenon of Life*, 82. Cf. Jonas, *Mortality and Morality*, 64.
[17] Jonas, *The Phenomenon of Life*, 83.
[18] Jonas argues this more thoroughly in "Matter, Mind, and Creation: Cosmological Evidence and Cosmogenic Speculation," in *Mortality and Morality*, 165-97.
[19] Jonas, *The Phenomenon of Life*, 103.

must have perception and movement to locate and approach sufficient matter for exchange. So, unlike the plant, it can transcend its environment. The relationship between the human being and the environment incurs the greatest levels of mediacy and freedom found in natural life, although humans are never completely transcendent or independent of their matter. Human beings must not only seek out and obtain external, exchangeable matter; they must also manipulate matter and produce the artificial in order to better procure their survival. Jonas describes this manipulation in terms of the tropes of tool, image, and grave.[20] All three belong to the distinctiveness of humanity, although it is tool that has dominated because it has a close association with progress, representing less of a "luxury" than do image and grave.

This means that human distinctiveness will not be seen over against the qualities of nonhuman life but as deriving from them. The polarities of transcendence and need, freedom and finitude, are shared with the rest of creation. But, what is more, this distinctiveness is a gift, the crest of nature's efforts. The event of human subjective awareness and striving is considered the fulfillment of a purposive natural movement:

> What looks like a leap is in reality a continuation; the fruit is presaged in the root; the "purpose" which becomes visible in feeling, willing, and thinking was already present, invisibly, in the growth leading up to its manifestation: and that not just in the sense of permissive openness to it in case it should one day ingress into physical causality from above, but in the sense of a positive predisposition and selective tendency toward its eventual manifestation, should conditions open the way for it. The growth, then, was really *toward* it.[21]

Mind and matter, humanity and nonhuman nature, are not totally separated. All the same, humanity's particular freedom and transcendence are specifically human.

4.1.2 The Image of Humanity

These "biological" dialectics of internal and external, self and environment, form and matter, move toward a duality, rather than a dualism, and this has implications for an account of human nature. Importantly, the ultimate end of human life cannot be complete independence, as "life is just that mode of material existence in which being has exposed itself to dependence (of which metabolism itself is the prime form) in exchange for a

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[20] See his essay "Tool, Image, and Grave: On What is beyond the Animal in Man," in *Mortality and Morality*, 75-86.
[21] Jonas, *The Imperative of Responsibility*, 69. Emphasis in original.

freedom closed to the independence of stable matter."[22] Human beings are neither independent and complete on their own nor incapable of reaching beyond themselves. Jonas' philosophical biology upholds the diversity of human experience in terms of the interplay of freedom and finitude, an interplay that by nature cannot be circumvented.

Jonas is also aware that a purely biological interpretation of humanity would result in a reductionist anthropology. He counters those who would dismiss humanity as nothing but the product of its genetics, maintaining that explaining the evolutionary continuity of life is no substitute for understanding its meaning.[23] It is in the turn to meaning that Jonas proposes an "image" of humanity that serves as normative for human activity.

Jonas begins the discussion of the meaning of nature by asserting the goodness of being in relation to purposiveness. To have purpose, he says, is to have value.[24] Although Jonas shows acuity in presenting an account of the troubled relationship between the "is" and the "ought" in philosophy, and although he does offer supportive philosophical argumentation for the value of being ranging beyond what I can articulate here, in the end Jonas must treat his acceptance of this value rather axiomatically. To say that being is a good in itself is, ultimately, to prefer this interpretation of life to a nihilistic account. Jonas trusts that this axiom can stand because he knows it to be in continuity with his own observations of life. Being, he claims, does not display indifference toward itself. This is very much like the position of natural law: one naturally loves oneself.[25] So, for Jonas, the good is "by its very concept a thing whose being possible entails the demand for its being or becoming actual and thus turns into an 'ought' when a will is present which can hear the demand and translate it into action."[26]

This statement provides a clue as to why existing in radical continuity with nature does not render the human species indistinct. Jonas indicates:

> Reality, or nature, is one and testifies to itself in what it allows to come forth from it. What reality is must therefore be gathered from its testimony, and naturally from that which tells the most—from the most manifest, not the most hidden; the

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[22] Jonas, *The Phenomenon of Life*, 103.
[23] Jonas, *The Imperative of Responsibility*, 71-72.
[24] Ibid., 49-50 and 80-81.
[25] Aquinas, *Summa Theologica*, II-II, q.64 a.5. Cf. Aristotle, *Nicomachean Ethics*, 9.9.1170b1-5.
[26] Jonas, *The Imperative of Responsibility*, 79.

> most developed, not the least developed; the fullest and not the poorest—hence from the "highest" that is accessible to us.[27]

It is in the human being that the highest level of the purposiveness characteristic of nature is achieved, and thus the significance of purposiveness is perceived in human being and doing. In the human being purpose is linked with ethics, among other things. Whereas other creatures can discriminate at various levels of activity, they do so in "self-affirmation of being."[28] Human beings, on the other hand, have a unique capacity, in concert with superior cognition and affectivity, to expand the scope of concern, even directing volition in ways that conflict with personal interest. For this reason, the ultimate end of human life is not merely independence or self-perpetuation. There is something beyond these goals. In his secular ethics, Jonas emphasizes the human task of responsibility. A fuller explanation of responsibility will come later. It is enough at this point to draw attention to the correlation of Jonas' idea with a notion in the theological anthropology outlined earlier: the complete good for human beings consists not only of the intrinsic value given with their nature. It is not enough simply to exist as member of the human natural kind. It is also important to pursue the ends proper to the human constitution.

There are additional connections between Jonas' philosophy and a theological anthropology that illustrate the dynamic of given nature and possible actualization. Although Jonas declared theology to be a "luxury of reason," in his later work he would go on to develop theological ideas consistent with his ontological account and that appeared to ground his own conviction that being is better than nonbeing.[29] Even in his earlier work, Jonas rationally defended certain tenets of a Judeo-Christian worldview against a nihilistic interpretation of life. There are four in particular that were of concern to him: 1) God created the heavens and earth; 2) God saw that creation was very good; 3) God created humanity in God's own image; and 4) God makes known to humanity what is good.[30] Rather than developing its theological content, Jonas chose to recast the third proposition, the notion of the *imago Dei*, in philosophical terms: humanity is an event of

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[27] Ibid., 69-70. This is Jonas' justification for undertaking a philosophical biology.
[28] Ibid., 81.
[29] See Jonas, *Mortality and Morality*, 115-97. For comments on Jonas' relationship to theology see Michael S. Hogue, *The Tangled Bank: Toward an Ecological Ethics of Responsible Participation* (Eugene: Pickwick Publications, 2008), 169-80.
[30] Jonas, *Philosophical Essays*, 169; cf. Vogel, "Hans Jonas's Exodus," 20.

cosmic importance largely because of the capacity for responsibility.[31] The objective importance of humanity entails some objective account of human value and ends, which Jonas alternately calls an "image" or an "idea" of humanity. His works are steeped in references to this image, references that are often explicitly connected with the biblical *imago Dei*.[32] Depicting the image of humanity in terms of responsibility may appear to be akin to the functionalist or task-oriented interpretation of the *imago Dei*. On the other hand, responsibility is ontologically grounded, so Jonas also views human nature itself as valuable and normative. Being self-aware, humans must measure their self conception and their activity against this image. Apart from an image of humanity, Jonas fears, humans are unprepared to meet the challenges of the contemporary technological age.

Jonas is very spare in outlining the content of the image of humanity. This is intentional. He admits there are certain enduring features of humanity, but also allows that external circumstances (place and time) and internal circumstances (advances in the power of the human being) can result in developments in the *perception* of the human being. This is not necessarily a bad thing. One instrument Jonas commends for the proper shaping of the image is education.[33] He also accepts that it is often easier to recognize deviations from the good than establish the content of the good.[34] But as the perception of the image can also be ill affected by progress or new possibilities, it becomes an exercise of imagination and foresight to anticipate possible changes to this image. In an age when the human genome can be altered, distaste for the imagined consequences of certain actions for human nature rightly becomes more pronounced.[35] So, Jonas tends to limit his own account of the image of humanity to those characteristics he views as being under threat in the present age. In particular, he is concerned with the reductive tendencies of modern science and technology concerning this image. The irony he observes is that, in

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[31] Vogel, "Hans Jonas's Exodus," 21.
[32] For instance, see the following works by Jonas: *The Phenomenon of Life*, 278; *Philosophical Essays*, 78-79, 123, 168-80; "Responsibility Today: The Ethics of an Endangered Future," *Social Research* 43 (Spring 1976): passim; "Toward a Philosophy of Technology," *Hastings Center Report*, 9, no. 1. (1979): passim; "Response to James M. Gustafson," in *Knowing and Valuing: The Search for Common Roots*, ed. H. Tristram Engelhardt, Jr. and Daniel Callahan (New York: Institute for Society, Ethics and the Life Sciences, 1980), 212-15; *The Imperative of Responsibility*, x, 9, 20, 26-27, 43-44; "Ethics and Biogenetic Art," *Social Research* 52, no. 3 (1985): 497; and *Mortality and Morality*, 5, 14, 99-112.
[33] Jonas, *Philosophical Essays*, 180.
[34] Ibid., 99.
[35] Jonas calls this a "comparative futurology." *The Imperative of Responsibility*, 26.

"improving" upon humanity, these forces can impoverish the refined dialectic of needful freedom. In accepting a dualist model and asserting the transcendence of humanity over against humanity's finitude, something is lost. Moreover, something is transgressed. Jonas instead commends the interplay of necessity and freedom as asserting a middle ground between a static concept of human nature and anthropological nihilism.[36] He implores:

> We simply must not try to fixate man in any image of our own definition and thereby cut off the as yet unrevealed promises of the image of God. We have not been authorized, so Jewish piety would say, to be makers of a new image, nor can we claim the wisdom and knowledge to arrogate that role. If there is any truth in man's being created in the image of God, then awe and reverence and, yes, utter fear, an ultimate metaphysical shudder, ought to prevent us from meddling with the profound secret of what is man.[37]

All this is to indicate that the great promise of humanity for responsibility is accompanied by a grave threat. For other beings, goodness is actualized in the exercise of their nutritive or sensitive capacities. Goodness is realized simply in being. Human beings are under increased pressure when it comes to actualization; to be is not enough for the complete realization of the human good. Human beings have the ability to deviate natural capacities from their ordered end. Human beings can be innocent or betray their own image.[38] This is reminiscent of C. S. Lewis' famous line: "Man's final conquest has proved to be the abolition of man."[39] As I will go on to show, nowhere is this threat more evident, in Jonas' view, than in the blessing and curse of technology.

4.2 The Jonasian View of Technology

The uniqueness of human nature is not only in its moral freedom, its elevation of purpose, but also in its other capacities. One of those capacities, as I have noted, is artefactual: the capacity to conceive of, construct, and use tools. Jonas regards technology as a human *power*, one means of enabling human beings to pursue appropriate ends. This can be likened to the Christian notion of medicine indicated in the previous chapter: artificial means can supplement those means naturally ordered toward realizing certain goods. Jonas agrees that natural capacities are good in themselves and only become

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[36] Jonas, *Mortality and Morality*, 105.
[37] Jonas, *Philosophical Essays*, 181.
[38] Jonas, "Response to James M. Gustafson," 212.
[39] C. S. Lewis, *The Abolition of Man* (New York: Harper Collins, 2001), 64.

deviated from the good in their misuse and abuse.[40] His analysis is concerned primarily with the character human power takes on when it is mediated through particular technologies. The human capacity for actualization admits of a certain freedom. But this freedom is not infallible.[41] The ambivalence of technology is the ambivalence of human power.

Christian attitudes toward technology reflect this ambivalence. Benedict Ashley observes this to be the case even in the scriptures.[42] In Exodus, the capacity for technology is likened to the work of God's spirit in the human being.[43] But in the story of the Tower of Babel, in which crafts are used to assert the power of humanity over God, the use of technology is connected with the idea of evil.[44] For Ashley, these conflicting moral evaluations indicate that humanity, in its freedom and intelligence, has a share in God's dominion of creation.[45] This dominion, however, is to be exercised in cooperation with God and amounts to a stewardship circumscribed by God's will. Consider the following passage from the Vatican II document *Gaudium et Spes*:

> Thus, far from thinking that works produced by man's own talent and energy are in opposition to God's power, and that the rational creature exists as a kind of rival to the Creator, Christians are convinced that the triumphs of the human race are a sign of God's grace and the flowering of His own mysterious design. For the greater man's power becomes, the farther his individual and community responsibility extends. Hence it is clear that men are not deterred by the Christian message from building up the world, or impelled to neglect the welfare of their fellows, but that they are rather more stringently bound to do these very things.[46]

There are, however, problems evident in this expression, to which I will return (see 4.3.1).

Technology is an integral, and not merely epiphenomenal or accidental, component of human action. The adaptation of the environment to human needs has been with humanity from the beginning.[47] In this sense, there is nothing new about technology;

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[40] Hans Jonas, "Technology as a Subject for Ethics," *Social Research* 49 (Winter 1982): 891.
[41] Jonas, *The Imperative of Responsibility*, 33.
[42] Benedict M. Ashley, "Dominion or Stewardship? Theological Reflections," in *Birth, Suffering and Death*, ed. Wildes, Abel, and Harvey, 85.
[43] Exodus 31: 2-5.
[44] Genesis 11.
[45] Ashley, "Dominion or Stewardship?" 87.
[46] Paul VI, *Gaudium et Spes*, (1965), §34.
[47] Levy, *Hans Jonas: The Integrity of Thinking*, 86.

homo faber has always been inscribed in *homo sapiens*.[48] But, as will be shown, this does not mean there is nothing novel about contemporary technology.

Technology employed in the practice of medicine offers a unique subject for consideration. Certainly, many Christians have a negative attitude toward those interventions that unjustifiably cut life short, such as euthanasia, or press the limits of human capacities or longevity, such as genetic manipulation and other "transhumanist" innovations. These technologies overtly threaten their understanding of the kind of life that is fitting for humans. In contrast, there is often a generally positive attitude toward those innovations that preserve life from illness because this appears to honour the dignity of human life. The Vatican and like-minded Catholic and Protestant bioethicists tend to view physiologically effective applications of these means as benign. The force of their position increases with the identification of ANH as a purely natural means,[49] equivalent to supplying food and water to a hungry patient, despite the artefactual production and administration of the means. In so doing, they effectively remove ANH from consideration under the OEMD in cases of PVS—this despite the indication of the OEMD that the preservation of life, whether by natural or artificial means, can, in certain cases, go against the wellbeing of the patient. Building on Jonas' foundation, it will be defended that the level of circumspection concerning life preserving means must be made adequate to the current technological situation, in which there have arisen an increasing number of instances demonstrating discontinuity between the preservation of life and human benefit.

In particular, three insights gleaned from Jonas' philosophy of technology will serve to refine and buttress the larger bioethical project. These insights are peppered throughout the description of Jonas' view of technology. They include 1) an observation of a changed context for action brought about by technological development; 2) awareness of dangers posed not only by dramatic, catastrophic developments, such as the atomic bomb, but also by incremental and *apparently* beneficial innovations, such as those characteristic of medical technology; and 3) an assertion of the need to preserve the

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[48] Jonas, *The Imperative of Responsibility*, 9.
[49] John Paul II, "Life Preserving Treatments and Vegetative State," (2004), §4.

"image of humanity," or a concept of human nature and ends, as normative guidance in the current technological situation.

4.2.1 The Dynamics of Technology

Long ago Aquinas differentiated the speculative or theoretical sciences from the practical sciences.[50] The speculative sciences, he said, were engaged for their own sake. Practical sciences were "for the sake of some work to be done." That is, their value was in their pragmatism and not intrinsic like the knowledge of speculative science. Moreover, speculative sciences represented the study of the unchangeable whereas practical sciences studied the changeable. Study of the changeable was first of all dependent on the observations about the unchangeable. The value of the practical sciences was determined by considerations independent of pragmatism. This is preparatory to understanding what Jonas means when he claims that the current age, which is one of pervasive technology, has created a changed context for action. In his description of the unique threat posed by today's technology, Jonas presents an interesting innovation on the familiar idea of the technological imperative.

Jonas differentiates the formal and the substantive dynamics of technology.[51] Though these categories are distinguished conceptually from each other, together they represent a connection between the large- and small-scale dynamics of technology. Formally, technology exists as a continuing, collective enterprise that advances according to its own "laws of motion." It is not merely a supply of tools and talents that increases over time.[52] It has a constitution of its own, although it overlaps with many other fields, including medicine. The substantive or concrete sense of technology, however, refers to the whole panoply of artefacts available for human use. (It should be noted that, by this definition, ANH is technology. So are bedpans.) The substantive dynamics of technology also comprise the particular powers conferred by these artefacts, the new purposes made available or imperative by these powers, and the changes that take place in human action in order to achieve these purposes. The questions raised by the substantive dynamics of technology are practical in nature.

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[50] Thomas Aquinas, "Aristotle's *De Anima* and Commentary," trans. Kenelm Foster and Silvester Humphries, in *The Collected Works of St. Thomas Aquinas*, 1.3. Cf. Jonas, *The Phenomenon of Life*, 188.
[51] Hans Jonas, "Toward a Philosophy of Technology," 34-43.
[52] Hans Jonas, *Technik, Medizin und Ethik. Zur Praxis des Prinzips Verantwortung* (Frankfurt: Suhrkamp Taschenbuch, 1987), 21.

Prior to the modern age, the formal dynamics of technology amounted, for the most part, to an equilibrium of ends and means. Artefacts were invented for a pre-determined end. This is because, normatively speaking, technology is not imbued with the teleological purposiveness that living beings bear; only the human being can infuse something else with purpose.[53] Technology, as a human power, may serve, but not determine, human purposes. Traditionally, its end has properly been externally imposed.[54] This end might be to remove an existing impediment to the achievement of further human ends. Whatever the end, the artefact has always before been subject to evaluations in terms of its adequacy in serving this end.[55] Certainly, it is possible to adapt a particular technology to ends other than those for which it was invented, and many technological successes have been accidental. This does not threaten the normative observations of technology, says Jonas, so long as the accidental technological success remains a means only, properly directed toward human ends, rather than mistaken for an end in itself. That is, it must not impose its own implementation, its further development, or new kinds of implementation as its end.[56] Regrettably, changes in the substantive dynamics of technology, Jonas observes, have been responsible for this imposition in recent times.

In terms of these substantive dynamics, Jonas observes that artificial means were originally developed to supplement natural means because particular natural means were either ineffective or unavailable.[57] The ends of these artificial means were limited to the achievement of that to which natural means were ordered but failed *per accidens* to accomplish. As the technological enterprise has carried on, however, its cumulative, substantive results have allowed it to become independent in purpose. It has not been limited in terms of its meeting pre-existing needs but has generated advances that themselves bear a "fluidity of ends." As Jonas puts it:

> New technologies may suggest, create, even impose new ends, never before conceived, simply by offering their feasibility….Once incorporated into the socioeconomic demand diet, ends first gratuitously (perhaps accidentally)

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[53] See Jonas, "Cybernetics and Purpose: A Critique," in *The Phenomenon of Life*, 108-34.
[54] Jonas, *The Imperative of Responsibility*, 52.
[55] Jonas, *Philosophical Essays*, 90.
[56] Jonas, *The Imperative of Responsibility*, 56.
[57] Jonas, "Toward a Philosophy of Technology," 39.

> generated by technological invention become necessities of life and set technology the task of further perfecting the means of realizing them.[58]

Technology can do this by offering novel options for action, surpassing the formerly physically impossible. It can also remove the burdens associated with a particular application such that an end that is desirable but was formerly morally impossible becomes realizable. In this way, technology has been altered from an art of substitution that bridged the gap between capacity and activity to a more radically creative enterprise eliciting new capacities with new demands for actualization. These capacities imitate nothing known before.[59] Unsolicited purposes become perceived as vital. No longer is technology merely an option. Driven by its own self-improvement, it acts to surpass human values and disvalues, substituting for them infinite "progress." It is in this sense that technology is considered pervasive.

At this point it is important to reinforce that the ethical problem is not human potency *per se*. Nor must the new avenues technology presents necessarily go unexplored. Jonas is no Luddite. When it comes to innovation, to meeting legitimate human need, progress is critical. But progress does have a certain moral ambiguity. In speaking of the new formal dynamics of technology, or of technology as an enterprise, "the danger lies more in success than in failure, and yet the success is needed in the press of human affairs."[60] That technology has the potential toward perpetual development and use is incontrovertible. That the development and use of particular technologies preclude containment is not. What is problematic, then, is the change that has been brought to technological dynamics. Jonas is concerned with the wholesale acquiescence of humanity to the notion of progress in itself as a moral imperative. Technology is no longer simply a response to necessity. In a scientific age in which "is" and "ought" are absolutely separated, there is a freedom without norms and a disregard for the very humanness of finitude. There is license to exercise power but no indication of the direction in which it ought or ought not to be exercised. The end result, according to Jonas, is a kind of nihilism, an emptying of the image of humanity that threatens to violate the human

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[58] Ibid., 35.
[59] Jonas, *The Imperative of Responsibility*, 32.
[60] Jonas, "Technology as a Subject for Ethics," 892.

natural kind.[61] He describes this as the triumph of *homo faber* over *homo sapiens*: "Outshining in prestige and starving in resources whatever else belongs to the fullness of man, the expansion of his power is accompanied by a contraction of his self-conception and being."[62]

A dramatic change has taken place in the context for human action. The moral and technological situation entails that humanity itself has become the object of its own power, vulnerable to its own refashioning. Jonas calls this recursivity the "dialectic of power."[63] With this, humanity itself is not altered, but the perception of its nature, value, and ends is under threat. And the threat has been with humanity from its beginning, embedded in its constitution. Thus, humanity, the pinnacle of the purposiveness inherent in nature, is also the point at which the most danger to nature—both human and nonhuman nature—is present.

4.2.2 The Substantive Dynamics of Medical Technology

In terms of the varieties of technology, Jonas is comfortable with outlining specific "ages," including the mechanical, electric, and information ages.[64] But it is obvious that among the greatest substantive influences (and effects) of technology toward progress are medicine and medical technology. Jonas recognizes that medicine was never an unapplied science; it is an inherent fusion of theory and practice and the first example of a scientific technology.[65] Furthermore, it is the most recent advances in medical technology that cause Jonas the greatest discomfort. The final stage of the technological revolution, he observes, pertains to human biology. With the expansion of the human life span and the advent of genetic manipulation, medicine directs the biological capacities of the human being to new ends.[66] These ends might bear some likeness to the "noble" ends that are given with human nature. They are, however, "gratuitous" and inappropriate in their meliorism.[67] They challenge the most basic notions of human anthropology: the

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[61] Jonas, *The Imperative of Responsibility*, 127-28. Cf. "Toward a Philosophy of Technology," 41.
[62] Jonas, *The Imperative of Responsibility*, 9.
[63] Ibid., 141. Cf. McKenny, *To Relieve the Human Condition*, 40.
[64] Jonas, "Toward a Philosophy of Technology," 39-40.
[65] Jonas, *Philosophical Essays*, 73. In a footnote to this observation, Jonas points out: "Descartes, in his curious concern with health, had wished for this and indeed regarded the conquest of disease and the lengthening of life as the principal fruit to be expected of the new science of nature."
[66] Jonas, *The Imperative of Responsibility*, 21.
[67] Jonas, *Philosophical Essays*, 118.

substance of the human good, the meaning of life, death, and dignity, and the integrity of the image of humanity.[68]

In his oft-quoted historical account of the practice of medicine, P. Lain Entralgo reflects that in the medieval monasteries, where much of the medical activity of the time took place, particular illnesses were seen as conditionally necessary.[69] That is, they were not outside of the medical capacity to cure. The conditional necessity of particular ailments and the attending drive to cure them were balanced by the notion that illness itself was "absolutely necessary," or an inexorable component of the human condition. So, the task of medicine, from this perspective, was not extended toward the perfection of the human body, but limited to allow human beings who experience untimely and unnecessary physiological impairment to return to a reasonable state of health or level of comfort. Healing the patient, not dominating the patient's physiology, was the original aim of the profession.[70] Today, medicine bears the kind of technology that can provide curative means to any number of conditions and ameliorative effects on any number of human "flaws." This means the depiction of the ends of medicine is substantially different. It has become increasingly difficult to integrate the idea of the necessity of illness itself with the goodness of medical-technological progress. Being absorbed by power, instead of focused on the limited aims behind the practice of medicine, medicine has become deviated toward more "ambitious" goals.

These goals, says Jonas, are too far removed from his own normative view of the image of humanity. The human being is constituted by the dialectic of necessity and freedom. Technological progress attempts to "flatten out" this dialectic and escape the uncomfortable ambiguities of human nature.[71] Jonas sees this plainly in the advent of genetic manipulation. Indeed, McKenny is wont to say that, in the medical context, the technological threat Jonas perceives pertains directly only to this kind of nontherapeutic experimentation.[72] It is certain that nontherapeutic genetic technologies do represent a dramatic and acute example of the dialectic of power, and Jonas is quite concerned with

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[68] Jonas, *Le droit de mourir*, trans. Philippe Ivernel (Paris: Editions Payot & Rivages, 1996), 93; and *Mortality and Morality*, 111.
[69] P. Lain Entralgo, *Doctor and Patient*, trans. Frances Partridge (New York: McGraw-Hill, 1969), 88-90.
[70] See Paolo Becchi, "Technology, Medicine, and Ethics in Hans Jonas," *Graduate Faculty Philosophy Journal* 23, no. 2 (2002): 168.
[71] Jonas, *The Imperative of Responsibility*, 201.
[72] McKenny, *To Relieve the Human Condition*, 63.

them. But the alteration of the human genome ought not to be viewed as being at the heart of his fears. At stake, rather, are the alteration of the perception of the image of humanity and the consequences for the integrity of ethics that attend its diminishment. McKenny himself suggests this concern as being compelling for Jonas.[73] But it must be recognized that the human image is threatened by more than the prospect of genetic modification.

The most dangerous effects for a normative portrait of human being and doing are those that are subtle, the result of cumulative innovation and action. To illustrate, Jonas has described himself as not being preoccupied with concern about the atomic bomb.[74] Its effects are foreseen and it presents, in his mind, an unmistakable evil. Moreover, releasing the bomb lies in the realm of choice; its use is not inevitable. The evils of certain forms of genetic manipulation are not universally apparent. Those who do not hold an objective image of humanity might not perceive them. But it is at least possible to persuade them of the evil of these means.[75] The consequences of some other technological advances and actions are much more elusive even for those who do hold to a philosophical or theological anthropology. Many of these advances and actions are not representative of acute, dramatic steps forward. Many are beneficent, appropriate, and even necessary in appearance. But as they accumulate, their use can overwhelm human ends. Once implemented, it becomes difficult to turn back the clock on these advances. Medicine is the prime example of a practice that has been deviated in surreptitious ways through human technological powers. Without doubt, medicine provides a welcome service directed toward human physiology. There is no denying that medicine *per se* is a good human activity. But the cumulative effects of its technological advances can threaten to overtake its goodness.

How does this happen? William Stempsey suggests that the capitulation to human medical-technological power encloses human physiology within the paradigm of technology.[76] Here a comparison can be made to an issue in environmental ethics. It is often remarked that modern industry reconceptualizes the natural environment as "natural resource." The use of nature as resource is inevitable; Jonas has pointed this out even at

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[73] Ibid., 66.
[74] Hans Jonas, "*Wissenschaft* as Personal Experience," *Hastings Center Report* 32, no. 4 (2002): 34.
[75] Jonas, "Response to James M. Gustafson," 215.
[76] William E. Stempsey, "Emerging Medical Technologies and Emerging Conceptions of Health," *Theoretical Medicine and Bioethics* 27 (2006): 230-31.

the level of metabolism. Moreover, the use of nature results in many positive effects. But if nature is viewed only as resource its intrinsic value as part of a good creation is neglected. Employing this narrow view, humans have demonstrated the tendency to abuse nature. In a similar way, the benefits that result from medical technologies go hand-in-hand with a recasting of human health. Whereas nature is reduced to natural resource, the ideas of health and illness are conformed to the shape of medical management. Stempsey's example is that losing one's teeth, formerly a sign of old age, is now identified as pathology of the gums. What was once vaguely representative of a "normal" deficiency is now subject to precise medical classification and treatment. The development of pharmaceuticals that modify certain behaviours helps create other kinds of pathologies. As with the recasting of nature as natural resource, this concept of human health is not wrong in itself. Many of its effects are beneficial. But apart from great and continued moral circumspection and continued subjugation of this model to a prevenient anthropology, it can become totalizing for the image of humanity. Its reductive effects become difficult to see if it is taken as the primary or only way to understand human physiology and psychology. In this way, the ends of medicine become atrophied and impoverished even as medical practice is expanded and "enriched" to incorporate the growing capacities of medical technology.

Put differently, an account of the dynamics of medical technology reveals that when technology cannot adequately achieve a particular human end, it is sometimes allowed to substitute what it *can* do for what one might *wish* it to do. The degree of separation between the effects medicine is capable of producing and the actual need of the human patient can swell along with the progressive use of artefacts. ANH provides an example of how the substantive dynamics of medicine work in nearly imperceptible and even trivial ways, resulting in massive effects for the way the role of medicine is viewed vis-à-vis a certain class of patients. Secular bioethicist Daniel Callahan, who dialogued with Jonas at the Hastings Center,[77] has observed that ANH was originally developed for short-term use, to aid a patient's recovery over the period of time following a surgical

[77] See Daniel Callahan, "Response to Hans Jonas," in *Knowledge, Value and Belief*, ed. H. Tristram Engelhardt, Jr. and Daniel Callahan (New York: Institute of Society, Ethics and the Life Sciences, 1977), 199-206.

intervention or illness.[78] Yet today, ANH is applied in other ways not aimed at bridging a temporary gap in health. These other applications make novel conditions possible for the human body. For the unconscious patient with very severe brain damage, the protracted application of ANH is exceedingly ineffective in the role it plays in attempting to restore health. But one would *wish* these means to restore health. It is ironic, then, that in the case of vegetation, the longer the application, the weaker the patient's chance of recovery becomes. When the vegetative state is deemed permanent, ANH is only effective in postponing death, possibly for quite a long time, by supporting (only) nutritive functioning. Of course, the application of ANH to this kind of patient was not originally intended to produce persistent vegetation. This innovative application began, rather, as a way of preserving life until a coma reached its conclusion, either in emergence or death. Persistent vegetation came about as a "side effect" of this application. As Callahan points out, it is doubtful that any technology would be invented for the sole purpose of imposing persistent vegetation on an otherwise dying patient.[79] The condition of PVS, then, is not properly a goal of medicine. The application of ANH to vegetative patients is only a "halfway application" of a "halfway technology"[80]—a medical ministration that preserves life without improving health and apart from any appreciable proportionate benefit. Yet those who consider ANH to provide proportionate benefit simply by maintaining the physiological life of the PVS patient argue otherwise. This change in the perception of what is good for the unconscious, severely brain damaged patient has occurred upon the simple location of a new application for ANH to an entire class of patients—an application that, without foresight of unwanted side effects, seemed appropriate. Indeed, providing ANH to this class of patients prior to the prognostic indication of the permanence of the vegetative state can remain an appropriate treatment decision. But once such a prognosis is made, indicating lack of hope for emergence, there is reason to question that ANH can provide proportionate benefit to that patient if the patient's good is brought up against the anthropology outlined in chapter two.

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[78] Daniel Callahan, "Terminal Sedation and the Artefactual Fallacy," in *Terminal Sedation: Euthanasia in Disguise?* ed. Torbjörn Tännsjö (Dordrecht: Kluwer, 2004), 99-100.
[79] Ibid., 100. Cf. Daniel Callahan, *The Troubled Dream of Life: Living with Mortality* (New York: Simon and Schuster, 1993), 184.
[80] See Thomas, *Lives of a Cell*, 33-36.

Medical technology can alter medical practice in such a way as to correspond with the goals that technology enables. Determining medicine's ends according to medicine's growing inventory of capacities can also affect the ways in which patients are perceived to benefit from medicine. These present significant challenges for ethical action in the medical context. As Paolo Becchi observes, technology used to be subordinate to nature; today, the ends found in nature are no longer paramount.[81] Instead, technology "generates a 'nature' of its own, that is, a necessity with which human freedom has to cope in an entirely new sense."[82] What is required in the current medical context is a cautionary stance, one that considers the broad scope of the effects of medical action in light of a normative image of humanity.

4.3 The Imperative of Responsibility

4.3.1 Substantive Responsibility

The more abstract questions pertaining to the formal dynamics of technology include the question of whether humanity can wrest its moral freedom out of the hands of the dialectic of power.[83] To answer this I take up the original component of Jonas' reflections on technology: his turn to the ethical. This turn, in itself, signals a kind of hope not found in Heideggerian and other purely critical examinations of the question.[84]

The change in the context for action requires a re-examination of ethics. As Jonas says, "that doesn't necessarily mean we need a new ethics, but there is undoubtedly a completely new area of application for morality, for duty, and for the 'Thou shalts' and 'Thou shalt nots.'"[85] Ethics has traditionally focused on the intentions of the agent, an account of the immediate circumstances and consequences of action, and the moral status of the act itself.[86] But this is because the effects of actions were generally proximate and under human control. A re-examination of ethics must recognize the present situation as one in which the gap is closing between the everyday moral decision and issues of

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[81] Becchi, "Technology, Medicine, and Ethics in Hans Jonas," 159.
[82] Jonas, *The Imperative of Responsibility*, 10.
[83] Jonas, "Toward a Philosophy of Technology," 41.
[84] Cf. Vittorio Hösle, "Ontology and Ethics in Hans Jonas," *Graduate Faculty Philosophy Journal* 23, no.1 (2001): 40.
[85] Marion Donhoff, and Reinhard Merkel, "Not Compassion Alone: On Euthanasia and Ethics" (An Interview with Hans Jonas), trans. Hunter and Hilde Hannum, *Hastings Center Report* 25, no. 7 (1995): 44.
[86] Jonas, *The Imperative of Responsibility*, 4-6.

ultimate importance.[87] Consequently, it is in the notion of responsibility that Jonas perceives the answer to human technological power.

Freedom, for Jonas, signals power, potency of being. But freedom is not, for the moral being, unchecked. Responsibility acts as the correlate of power. Having this capacity for responsibility entails the obligation to actualize it.[88] Although responsibility has always been an ethical term, Jonas claims that an emphasis on responsibility has new meaning in a changed context for action. The scope of responsibility is expanding along with human power. This is reflected in Jonas' account of formal and substantive responsibility, and his elevation of the latter.[89] Formal responsibility is akin to being accountable for one's *action* and its proximate consequences. This kind of responsibility on its own does not involve the task of setting or determining ends. It only involves bearing the burden of the activity.[90] This is a beginning for ethics, but it is an ineffective response to the magnitude of human power. Admitting formal responsibility for bad action is not the same as regretting that action or willing to act differently in similar situations. In light of a changed context, Jonas advocates a concentration on substantive responsibility instead. This is responsibility taken for particular *objects* that then commits one to particular ways of acting. Not only is one liable for the consequences of one's actions; one wills to care for the matter that makes a claim on oneself. The capacity for substantive responsibility places its actualization among the proper ends of human life, according to Jonas. Responsibility is an ontological distinction of the human being.[91] Humans have great power to effect change. But more than this, they alone have the capacity to be responsible as the rational and the affective interact with the will. The affective move is toward the objects of responsibility, that is, anything bearing some level of purpose.[92] There is also rational understanding of the implications of action for these objects. So, substantive responsibility is also forward looking, anticipatory of long-range and far-reaching consequences.

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[87] Ibid., 21.
[88] Ibid., 128-29.
[89] Ibid., 90.
[90] Ibid., 92.
[91] Jonas, *Mortality and Morality*, 101 and 106.
[92] Putting forth the archetype of the parent-child relationship, Jonas argues that a sense of having "responsibility for" is rooted in human nature. *The Imperative of Responsibility*, 130-31.

It was pointed out earlier (see 4.2) that *Gaudium et Spes* affirmed an extension of a substantive kind of responsibility coincident with an extension of human power. But it also affirmed that, in an age of greater power for action, humans are "more stringently bound" to attend to the welfare of others.[93] Are these expressions two ways of saying the same thing? Or do they represent different measures of ethical obligation? Undoubtedly, substantive responsibility must follow wherever technology expands the effects of action, and wherever it extends action to new objects. In this sense, there is a correlation between technological progress and the expansion of ethical responsibility. But this expansion does not necessarily entail an obligation to engage available technologies toward the ends they make possible. Indeed, responsibility often indicates the need for restraint. This does not conflict with my affirmation that there is a certain obligation in the Christian tradition to work toward the prevention or cessation of natural evils. To be sure, good ways are innovated to help with the "building up of the world," as *Gaudium et Spes* puts it. When evaluated as such, these should be enacted. But not all innovative ways of building up the world are good, or unequivocally good. As Jonas says, ethical responsibility that expands with power shows that a whole new space is opened up for "Thou shalts" *and* "Thou shalt nots." The legitimate kind of expansion of ethics, then, is the one pertaining to substantive responsibility: in light of the ends already provided in human nature, responsibility must be taken for the new capacities of humanity. True responsibility is not found in imposing a predetermined obligation to act in novel ways to reach or even "improve upon" established ends. Instead, it entails the examination of the consequences of these novel ways prior to allowing or imposing their implementation.[94] As one member of the Pontifical Academy for Life has put it, healing is a moral obligation "as long as this undertaking does not work against other goods and does not end up by obfuscating the 'truth' about man, projecting into desire the basis of truth itself."[95]

To illustrate the difference between these two perceptions of expanded responsibility, one that is accurate and one that is mistaken, I turn again to medicine. In particular, the distinction between efficacy and benefit, to which I have already alluded,

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[93] Paul VI, *Gaudium et Spes*, (1965), §34.
[94] Cf. Jonas in "Not Compassion Alone," 44.
[95] Adriano Pessina, "The Culture of Life and the Technological Mentality," paper presented at the Seventh Assembly of the Pontifical Academy for Life, (March 1-4, 2001), http://www.academiavita.org/english/Pubblicazioni/indice/cultlife.html.

can be taken up. Technology can often generate profound effects without producing the particular benefits consonant with human ends. Lawrence Schneiderman, Nancy Jecker, and Albert Jonsen observe that the scientific development of modern medicine and medical technology has frequently focused on producing a certain effect on the body, such as emetics for purging or sudorifics for sweating.[96] The technological goal has been to increase the availability of such means and improve their level of efficacy. It was simply presumed that these effects would entail benefit when applied to a particular patient. Initially *confused* with human benefit, medical efficacy came to *displace* benefit as the end of the practice of medicine. More and more means of preserving life were developed; more and more of them became accessible and affordable with fewer abject side effects. Thus, within the paradigm of medical technology, an increasing number of interventions seemed to meet many of the criteria of morally ordinary means. It is a virtue but also a vice that modern medicine is able to make the extraordinary appear ordinary. The consequent danger of replacing benefit with efficacy is that conditions like coma and vegetation—which were never formerly considered consistent with the human good—can be imposed on patients. Medicine can now save lives by obliging results unintended by its practitioners.

The ability to produce an effect on the human body that thwarts some disease or alleviates the burdens of some condition need not translate into a moral imperative to act out this ability when the benefit of such intervention is in question. But effect and benefit can be confused when the feasibility of a new medical end is confused for a new but legitimate *expression* of an old medical end. Sometimes the natural evils of the world, such as illness, suffering, and death, no longer appear simply as potential reasons for moral activity and technological progress. Failure to try to overcome natural evil becomes viewed as outright *moral* failure. As Callahan explains it:

> The scientific imperative of progress, part of the idea of medical science, is broadened to include a moral imperative: if we do not pursue the conquest of disease, we are open to moral blame. People will die who need not die….The hidden, but hardly arcane, premise here is that we have a duty to relieve suffering and to save life. If medical progress makes that possible, then we are *obliged* to

[96] Lawrence J. Schneiderman, Nancy S. Jecker, and Albert R. Jonsen, "Medical Futility: Its Meaning and Ethical Implications," *Annals of Internal Medicine* 112, no. 12 (1990): 950.

> pursue it….If we do not use our newly available technologies to save lives, we can be held accountable for the loss of those lives.[97]

As the previous chapter demonstrated, this kind of reasoning has been expressed by Meilaender and others who equate the withdrawing of means required to preserve life necessarily with the intention to kill. Callahan calls this the artefactual fallacy, or deducing an "is" from an "ought."[98] His comments on progress can be used against a utopian view of medicine. Utopia is the temptation Jonas' philosophical writings address: a future without disease and death, one inconsistent with given (human) nature.[99] But Callahan's comments also speak out against a new area of inquiry, one of which Jonas was unaware. The religious vitalism that makes medical progress its aide is the new risk in Christian bioethics. Christian bioethicists do not, I think, envision a utopian kind of medicine. The necessity of illness is not forgotten. What is forgotten in the thrust of medical technologies forward is the limitation that is placed on intrinsic human value and on the obligation to preserve life. In the case of ANH, "where once nature had killed people by robbing their bodies of the capacity to take nutrition, now the blame has been shifted to the human beings who fail to provide artificial nutrition."[100]

In quoting Callahan, I am not making the argument that there is no moral failure when a given medical technology, which is expected to restore health or provide comfort to a patient apart from overriding burden, is not applied. The OEMD indicates that there is something morally suspect about an unqualified right to refuse treatment. It gives way too easily to suicidal and euthanasist intentions, even to the point of endorsing them. It allows for action prior to and apart from a close moral evaluation of the medical situation. There certainly are cases in which, regardless of the moral evaluation of the means, failure to provide or use ANH is the result of such illicit intentions. But in any case, this intention ought to be recognized as a final cause that is added onto the efficient causality of the underlying illness itself. The point is not that moral evils cannot be committed in refusing to combat natural evils. Rather, in allowing a natural evil, it does not *necessarily* follow that one commits a moral evil. Otherwise, what is to regulate the number of

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[97] Callahan, *The Troubled Dream of Life*, 61. Emphasis in original.
[98] Callahan "Terminal Sedation and the Artefactual Fallacy," 93.
[99] Jonas discusses this further in terms of the complementary values of natality and mortality. See "The Blessing and Burden of Mortality," in *Mortality and Morality*, 87-98.
[100] Callahan, *The Troubled Dream of Life*, 81-82.

resources put toward developing technologies that forestall death? What is to prevent the accusation that a lack of technological proficiency leaves humanity morally responsible for any death? Technological capacity can, at times, be deceptive in presenting an occasion to act out the moral obligation to preserve life. When this happens, it becomes easy to deviate the ends of medicine at the end of life so as to avoid a perceived evil.

Another example of this translation from natural evil to moral evil, and the concomitant deviation of human ends, can be seen in the context of neonatal care. The example also pertains to PVS patients. The case is of anencephalic infants, those who have a brainstem but whose cerebrum and cerebellum are seriously underdeveloped or absent. This condition allows only for a very short, unconscious life. The bioethical quandary is made all the more complex by the technological capacities available for extending that life a bit longer. Despite a continued will to do good to an infant, and to fulfill any responsibilities occasioned by the infant's intrinsic value, Hauerwas admits it is difficult to tell what good can be done in the face of the natural evil of this kind of medical condition.[101] With the newfound ability to prolong the lives of such patients, there is often a perceived requirement to do so. Here the creeping expansion of moral obligation is observed. Proximally, prolonging the infant's life might appear to fulfill the duty to honour life. Yet, in this case, medical efficacy is quite limited, even allowing for further damage to the brain as time progresses. It happens that "our charity has been amplified by an overwhelming technology that threatens the very presumptions of that care."[102] In other words, beyond a reasonable limit, expanding the scope of the affirmative law to preserve life fails to correspond with larger human ends. As an expression of honour for another, this particular act of preservation becomes incoherent, out of proportion with the expected results for the patient as a whole. The blessings of life preserving means can easily become burdens if technology is allowed to impose unchecked obligations to use the new avenues it presents. This is the final danger of the power of medical technology: not that it will alter the human genome, but that it will alter the perception of the ethical aim of the human being.

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[101] Hauerwas, *Truthfulness and Tragedy*, 171.
[102] Ibid.

4.3.2 Responsibility for the Image of Humanity

The matter that makes a claim on the responsible human being is manifold. Certainly, anything that falls under the influence of human technological power is an object of responsibility since, for Jonas, responsibility is the correlate of power. Recognizing value in purposive life, and recognizing the power held over it, human responsibility extends to all of nature. However, it is the image of humanity for which Jonas is fundamentally concerned. If humanity is the crest of nature's efforts toward purposiveness, if responsibility is the gift of nature to humanity, the image of humanity must be preserved. The aim of Jonas' ethics is to "arrive at a conception of the human as an objective good that we are responsible for maintaining against the threats posed to it by our technological power."[103] Only a secure anthropology, one that allows for a response to technology consistent with articulated human ends, can serve as a basis for circumscribing medical technology.

Jonas worries that human nature, being vulnerable to its own dialectic of power, will not be able to "assert itself against all defacements of man-made conditions."[104] The internal purposiveness of humanity compels people to continue to be responsible. But, as indicated, this purposiveness also allows humanity the capacity to prevent the actualization of being. Humanity and the image of the human being are now radically under the control of human power. So, they must also be considered objects of substantive responsibility. If nothing else, the peril of this position should be signalled by the fact that, despite the marvels of technological progress, human beings are still not the masters of their own destinies. Instead, Jonas argues, humans must accept the role as "trustees of a heritage."[105]

That Jonas is concerned with the forward looking dynamics of technology is evident in his new "categorical imperative." It is imperative to preserve the conditions necessary for future ethical beings. His focus on a deontic move does not make his concerns inconsonant with the ethical methodology set out in the first chapter. Rather, it accepts Kantian deontology in its formal role. Jonas' imperative assumes that the substantive, ends-defining function of ethics is engaged by a prior ontological and

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[103] McKenny, *To Relieve the Human Condition*, 40.
[104] Jonas, *Philosophical Essays*, 178.
[105] Ibid., 179.

anthropological account. One way he articulates this imperative is: "Never must the existence or essence of man as a whole be made a stake in the hazards of action."[106] Many have emphasized Jonas' concern for the *existence* of future human beings. Indeed, if Jonas were to issue a first command, it would be against mass suicide.[107] However, I am not alone in interpreting Jonas to perceive the essence or image of humanity as the primary object of responsibility.[108] The existence of future human beings is, doubtless, a necessary condition for the preservation of this image. It is not, however, a sufficient condition. On its own, the preservation of the human species would not fulfill the ends of the human being. This is akin to the separation of capacity from activity, since the ends of the human being are not limited to being itself. The forward-looking aim of Jonas' ethics is to preserve the kinds of humans who can pursue the complete human good. To be clear, Jonas states that the capacity in human nature for responsibility will never be extinguished. What is at stake is a certain "psychological openness to it…that can be lost collectively, even if calculative reasoning and the power arising from it survive with the biological subject."[109] Human beings are responsible for how they affect the *way* in which human life persists. Thus, "we must make sure the *conditions* of [human] existence do not cause this capacity (which depends upon the freedom of the subject) to disappear."[110]

The point, for this project, is that the object of substantive responsibility is not merely biological human life. Jonas is not, strictly speaking, a vitalist. Any duty to preserve life is apparent because human nature bears particular capacities that entail a possible actualization. This is consonant with the Christian tradition. As Hauerwas and Berkman have put it,

> Christians simply do not have an overriding stake in…our own survival. As God's creatures, our "chief end" is not to survive but to be capable of serving one another, and in doing so to serve as signs of the kingdom of God. In comparison to this service, survival is a secondary commitment.[111]

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[106] Jonas, *The Imperative of Responsibility*, 37.
[107] Jonas, *Mortality and Morality*, 106.
[108] Cf. Hans Jonas, "Responsibility Today," 94. Also see Olivier Depré, *Hans Jonas (1903-1993)* (Paris: Ellipses, 2003), 23-24.
[109] Jonas, *Mortality and Morality*, 106.
[110] Ibid.
[111] Stanley Hauerwas and John Berkman, "The Chief End of All Flesh," in *Good News for Animals?* ed. Jay McDaniel and Charles Pinches (Maryknoll: Orbis Books, 1992), 203-04.

Separating vitalism from the obligation to preserve the image of humanity speaks to the crucial role of a theological anthropology for informing action. Only a concept of the image of humanity—one that orients the ethical aim and imposes corresponding affirmative and prohibitive obligations—can sustain this kind of forward-looking ethics.[112] "Only the idea of Man, by telling us *why* there should be men, tells us also *how* they should be."[113] An effective anthropology, informing action, can adjudicate between the certain obligation to express honour toward the dignity of others and the certain reality that particular expressions of honour, such as the preservation of life, sometimes fail to contribute to the ethical aim. An ethics of responsibility, grounded in foundational values, will support a critical evaluation of the technological expansion of opportunity.

In his philosophical ethics, Jonas recommends hesitation in using technology that expands human ends, a hesitation he calls a "heuristics of fear." It is a fear of that which "has never yet happened and has perhaps no analogies in past or present experience."[114] As already noted, Jonas accepts that it is often easier to recognize deviations from the good than to describe the content of the good itself. This is proved true in the exercise of human power over human beings.[115] One positive aspect of particular medical technologies, even prior to their use, is that imagining their effects on human beings aids in self-reflexive understanding. It can encourage caution in the exploration of technological application. In this sense, technology does have some role to play in articulating a human anthropology and corresponding human ends. But its role is not normative but descriptive of various options.

The heuristics of fear is, perhaps, one of the more maligned elements of Jonas' philosophy, as it appears to imply technophobia and a lack of hope in the future of humanity. But as Olivier Depré observes, Jonas speaks of a heuristics of fear and not of an ethics of fear.[116] Jonas himself insists that fear is not the last word in the search for goodness, although "it is at least an extremely useful first word" for secular ethics.[117] For the theist, however, he recognizes that inherent respect for given human nature is often

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[112] Jonas, *Mortality and Morality*, 100.
[113] Jonas, "Responsibility Today," 94.
[114] Jonas, *The Imperative of Responsibility*, 27.
[115] Jonas, *Philosophical Essays*, 99.
[116] Depré, *Hans Jonas*, 55.
[117] Jonas, *The Imperative of Responsibility*, 27.

already present. This is the point at which Christian theological anthropology enters. Already, Christian bioethicists are in a different place than Jonas' secular audience since the former accept human nature as presenting certain norms.

To take this respect as analogous to a heuristics of fear is to realize that Jonas' fear is not paralyzing or pathological. It does not entail utter hostility toward science and artefactual progress. Rather, it is a matter of disposition or character. It is the first step in exercising the kind of prudence or *phronesis* compatible with the dangers of an alluring technological age.[118] This fear is akin to a pause that reminds one to deliberate before acting, to discern whether what is at stake is ethically permissible to gamble. It places the burden of moral proof on the new possibilities for action. Thus, it is not a fear without hope, but a fear that keeps hope alive.[119] This kind of caution is what can preserve humanity against its own dialectic of power. It allows theological anthropology to play its rightful formative role in the discernment of when it is fitting to assimilate the use of a technology into the ethical aim, and when an application of technology would oppose the moral norm.[120] The challenge for the Christian bioethicist is to regulate technological power in a way that corresponds with properly human ends.

4.3.3 Implications for Medicine

Medical technologies clearly have the capacity to influence medical standards of care. They can also affect bioethical guidelines for the worse, for instance, in the four innovations on the OEMD. The first innovation, that of limiting the application of the OEMD to cases of imminent and inevitable death, allows great latitude to new life preserving technologies. According to this innovative reading of the OEMD, only when technology is physiologically futile—when it can no longer prevent the patient's final decline—can it be judged burdensome and removed. The very terminology of death being "imminent and inevitable" heightens the moral obligation for those in charge of patient care, making it necessarily subject to technological capacity. For, even prior to modern medical technology, some untimely deaths that were not inevitable—perhaps because expensive food or a change in climate could prevent them—were allowed by the OEMD.

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[118] Ibid., 35.
[119] Cf. Hans Jonas, "Technique, liberté et obligation," in *Une éthique pour la nature*, ed. Wolfgang Scheider, trans. Sylvie Courtine-Denamy (Paris: Desclée de Brouwer, 2000), 154-55.
[120] Cf. McKenny, *To Relieve the Human Condition*, 218 and 74-75.

The second innovation made to the OEMD is the introduction of a distinction between medical treatment and basic care. At first glance, this might appear to present a welcome limiting factor to technological treatments as it continues to allow artificial means to be evaluated in terms of their benefit according to the particulars of the case. However, ANH has now been identified as a natural and not medical means, contrary to the opinions of many medical bodies. This illustrates that life preserving means do not admit of a clear bifurcation between the medical or artificial and the basic or natural. One reason for this classification that has not yet been addressed is the symbolic significance of food and water in the Christian tradition. It is appropriate to consider this element of the narrative context for moral action. As symbols, food and water carry a number of interrelated meanings. There are scriptural stories of God miraculously sustaining human life by providing food and water to hungry people in a desolate wilderness.[121] Jesus' ministry includes the feeding of thousands.[122] One of his final acts with his disciples is the sharing of the Passover meal, now memorialized in the sacrament of the Eucharist.[123] These stories connect food and water symbolically to the qualities of charity or care, generosity, and community. Feeding the hungry has become a characteristic Christian practice.

If the custom of providing others with food and water is extracted from this narrative context and treated merely as a rule, or if it is considered an activity that *necessarily* conveys care, generosity, and community, withholding food and water can become a mere taboo. But it is questionable that the administration of ANH to a PVS patient adequately reflects the narrative meanings of food and water. Certainly, many who care for PVS patients by providing ANH are motivated by charity and generosity. Some caregivers do remain present with the patient who is nourished in this way. Many others do not. But even in the case of dedicated caregivers, it is highly questionable that the patient benefits from this charity, generosity, and community. To offer care does not entail the receipt of care. If this is disregarded, a new moral obligation to treat is imposed, obscuring the fact of the existing terminal condition, and moving the ends of humanity toward a more vitalist position. This is an example of the deviation Hauerwas notices: the

[121] Exodus 16-17:7; 1 Kings 17:2-7.
[122] Mark 8:1-9.
[123] Mark 14:12-25.

intention to care is confounded by what the expansion of technological options makes feasible. Although the efficacy of ANH resembles the efficacy of food and water, even surpassing the latter's efficacy in the case of PVS, its benefits are not always the same.

To be clear, this is not to say that no application of ANH is obligatory or that patients should always allow for the progression of terminal illness rather than employ the long term use of ANH. There are many cases in which use of the OEMD will render a judgement that ANH is morally ordinary. But in the case of PVS, the expansion of the "natural means" category to ANH is coupled with the reduction of the standards for recovery. Standards that used to require a reasonable length and quality of recovery from life preserving means are now diminished to mere "usefulness" for extending physiological life. The application of ANH to severely brain damaged patients allows, in some cases, for coma to develop into a vegetative state, and for the vegetative state to be stabilized. Although the terminology "persistent vegetative state" was not familiar to Jonas, he took up an analysis of this kind of condition in referring to Karen Ann Quinlan, a notable PVS patient. In his mind, the dignity of the patient is affronted through the imposition, "totally by grace of our artifice,"[124] of a perpetually unconscious condition.[125] Sustained by ANH, the PVS represents an unprecedented condition, the actualization of which is limited in terms of metabolism. No one could view this as conducive to human flourishing.

MacIntyre has observed that virtues become vices when "the effects of a practice change so that the character of the relevant actions change."[126] So, when the availability of ANH allows for the preservation of life to override the goal of procuring a physiological condition that supports other human activities, this refashions the moral meaning of providing food and water. But if this revision is accepted, the moral situation that ensues can also be inaccurately described: the medical practitioners and the proxy are left to decide whether to feed a starving patient or to dispose of innocent human life.

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[124] Hans Jonas, "The Right to Die," *Hastings Center Report* 8, no. 4 (1978): 35.
[125] Jonas, *Technik, Medizin und Ethik*, 258-64 and 267-68. In defending this he cites his understanding of the Catholic opinion at the time, which is opposite to the current stance. But Jonas' ruling is stronger than this earlier papal ruling or my own; in his view, the removal of life preserving means is not merely allowable but absolutely obligatory. Cf. *Philosophical Essays*, 129.
[126] Alasdair MacIntyre, "How Virtues Become Vices: Values, Medicine and Social Context," in *Evaluation and Explanation in the Biomedical Sciences*, ed. H. Tristram Engelhardt, Jr. and Stuart F. Spicker (Dordrecht: D. Reidel Publishing, 1975), 109.

Under this description, it becomes appropriate, even compulsory, to issue *a priori* judgements about this class of treatment decisions. But this description must be recognized as inaccurate precisely because it extends the moral obligation to act as far as the possibilities for action allow.

Each of these innovations to the OEMD is, admittedly, made with the intention of raising up more rigorous defences against the euthanasia and assisted suicide movement, a movement that has gained ground with the expansion of possibilities for preserving life at its terminus. In this case, it is not a view of utopia that makes technology so tempting, but rather the opportunity to counter extreme disregard for human life with extreme regard for it. The danger, however, is that in being so concentrated on countering the "culture of death," myopia can develop, and the threats of a "culture of technology" will go unseen. Already technology is being given some sway over theological anthropology. In a world in which science and technology are rendered value-free, in which the "is" and the "ought" are separated, technology is taken to impose its own ends upon human ones. But even in the theological context in which human ends are posited and human value is considered intrinsic, technology has ways of distorting the moral vision by blurring the distinctions between noble and gratuitous, or inappropriately melioristic, ends. In providing new options for preserving life, it can encourage some ethicists, Meilaender and the new natural law theorists among them, to inflate the value of biological life. Technological intrusion upon human life in a vegetative state is rendered an authentic way of upholding the duty to preserve life. These Christian bioethicists and moral theologians might perceive themselves to be upholding the intrinsic value of all human life, whereas what they are really doing is allowing the anthropological account of the human being to be distorted such that the contingency of human life and dignity is marginalized.

Unfortunately, this move has already been made, though it is not yet thoroughly embedded in Christian bioethics. Those who pay attention to theological anthropology can see two different slippery slopes associated with the same problem. On the one hand, there is the danger that illicit intentions toward suicide and euthanasia will be disguised in the use of the OEMD. On the other, there are the effects that limitations placed on the use of the OEMD have on the image of humanity in fuelling the fire of the euthanasia lobby.

In other words, euthanasia becomes the response to the overuse of life preserving technology at the end of life. In this case, prudence is the result of a critical evaluation of the results of ANH, one governed by the pre-existing ends of human life. This is the way to discern which danger is worse. Now that the condition of PVS has brought the dynamics of technology to the fore, it becomes easier to see the second slippery slope and the wisdom of a cautious view toward life preserving means. It becomes easier to stress the proportionate or reasonable standard of the OEMD against which an obligation to preserve life should be measured. This is in accord with how Jonas views the effects of the unfolding technological situation on the moral imagination. Seeing and imagining the broader adverse consequences of technology can bring to light the significance of certain recessive notes in anthropology and ethics that before were lacking attention.[127] But they come to light only if the original anthropological perspective is not fully replaced with a more vitalist version of itself.

How is the notion of human benefit to be protected in an era of increasing medical efficiency? Due to the change in context for action, which includes the propensity of the extraordinary (whether natural or artificial) to be made ordinary, ANH needs to be used with circumspection. Several practical ways for articulating a Jonasian hermeneutics of fear in the context of end-of-life medicine have been put forth. I have observed that Callahan, for instance, suggests there should be no *prima facie* obligation to use life preserving means for purposes that on their own would not encourage the invention of that means. In this way, it can be ensured that moral laws are not unduly extended. What is required in extending any technology to a new condition is a moral evaluation of the effects of that extension. Hauerwas agrees, also doubting that a technology should be applied to a new and "unexpectedly enlarged class of patients" when this application can appear inconsistent with the kind of caring human beings are obligated to provide to one another.[128] Alfonso Gómez-Lobo, a Catholic philosopher who examines the ANH-PVS debate, calls for a reassessment of the notion of medical futility that goes beyond mere physiological futility and takes theological anthropology into account.[129] None of these

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[127] Cf. Jonas, *The Imperative of Responsibility*, 29.
[128] Hauerwas, *Truthfulness and Tragedy*, 171.
[129] Alfonso Gómez-Lobo, "Quality of Life and Assisted Nutrition," in *Artificial Nutrition and Hydration: The New Catholic Debate*, ed. Tollefsen, 108.

proposals would propose that ANH should never be used over long periods of time or that its use is *prima facie* morally extraordinary. What is indicated is that ANH requires the same ethical evaluation as any other means of preserving life, especially as its efficacy in preserving life becomes more feasible.

The ethical aim of the Christian faith in general and Christian bioethics in particular—that is, the *telos* of human life—ought never change. At the same time, changes in the context for action will elicit new responses to contextual considerations, not the least of which is how to integrate medical technology into the established ends of medicine. This is the task of the chapter to come. Jonas' ethical critique of technology shows how important it is to ask why a technology is being applied. In a forward looking mode, it is critical to examine how the use of technology will affect the understanding of the image of humanity and of the moral obligations toward human life. Jonas is concerned to defend life's mortality and fragility against the transformation and even attempted overturning of these by the imprudent application of life preserving means. The imprudence of such applications comes in their exchange of the dying process for an indefinite, liminal condition.

Making ethical responses intelligible in the present context requires a re-emphasis of certain recessive notes at the level of ethical obligation. This has taken place in the secular context: an expansion of the availability of medical treatment and a perceived "right" to it are now being checked by the right to refuse treatment. The latter right is, in large part, the product of aggressive life preserving means that have imposed burdensome conditions on patients and taken unjustifiable and undesired control over death. Similarly, in the Christian context, the duty to preserve life always stands. But its acting out is circumscribed according to physical and moral impossibility and in light of the kind of benefit its fulfillment presents. Such circumscription has particular consequences in an age when pervasive technology can so easily and so radically alter the way duties toward human lives are viewed.

Chapter 5
Insights for a Philosophy of Medicine: Medicine as a Species of Care

It is little acknowledged that the ends of medicine incur tension for bioethics. What the practice of medicine is supposed to accomplish can be assumed to be self-evident. Medicine has a quite distinct role to play, characterized by specialized techniques, in supporting human actualization and flourishing. But unacknowledged differences in the perception of the nature of this role result in disagreements over how to manage care for particular patients at the end of life and, in the Christian context, how to interpret correctly the moral demands of the situation according to the OEMD. Given the changed context for action made possible by the dynamics of technology, much work needs to be done to determine what medicine's aims are exactly. For those who hold to a normative concept of the human being, medicine must conform to the ends of human life. It must also take into account the availability of specialized techniques for healing and caring for the human body.[1] But more than this, it must recognize that the extent of human powers sometimes transgresses the ends of human life. With this in mind, an articulation of the ends of medicine is called for here.

This constructive work will necessarily be limited to a description of medical ends as they influence end-of-life care in the Christian context. It will give attention to how a philosophy of medicine can allow for the withholding or withdrawal of life preserving means in certain circumstances. That is to say, it will address the factors that medicine must come to see in order to allow itself to lay down its tools.

The virtue account of medicine has been made popular for both Christian and secular audiences by Catholics Edmund Pellegrino and David Thomasma. The two bioethicists speak of medicine as a "practice." Their theory is not without its difficulties, but from it I glean that the practice of medicine must be considered a moral art justified by the universal obligation to care for the ill. Their account must be conditioned by the claim that medicine is a species (and only a species) of care. Further, caring for the ill takes on a particular meaning in a technological context wherein the ill can be sustained

[1] The object of medicine will be limited to the physiological. When human or bodily health is referenced, this should be presumed to incorporate the health of the brain, especially as the capacity for conscious awareness is dependent on its intactness. Psychological healing is not a concern of this chapter.

without being made well. This has been illustrated already in the discussion of Jonas' critique of technology. Here I complete this illustration philosophically, by drawing on his observations of mortality as a moral duality bestowing both curse and blessing. This leads to an engagement with Hauerwas' thought coming from the Protestant context. His account of the ends of medicine is less systematic than that of Pellegrino and Thomasma, but it is equally thought provoking. From his work, the full force of what it means for medicine to be a practice limited by its status as one species within the genus of care is felt. Medicine is rightly called a beneficial and indispensable practice. But the underemphasized truth of medicine is that it is also constrained by human ends. Furthermore, it is a tragic practice, a practice whose end is often in retreat.

5.1 Medicine as Moral Art

5.1.1 Medicine as a Practice

The idea of medicine as a practice has been promoted by a cluster of thinkers who have together constructed their portrait from an Aristotelian basis. This group includes philosopher Alasdair MacIntyre along with Pellegrino and Thomasma. They distinguish medicine within a particular class of human activity and apart from other activities and occupations that are not practices. MacIntyre first put forward the term practice to express the ends-oriented structure of human activity, highlighting particular activities that are ends in themselves. This is, of course, a derivation of Aristotle's *praxis*, the arena for the exhibition of virtue. As discussed earlier, in contrast with *poiesis*, *praxis* has its end in its own good acting out (*eupraxia*) apart from any temporal termination point. It is complete in itself. MacIntyre adds to this, defining practice as

> any coherent and complex form of socially established cooperative human activity through which goods internal to that form of activity are realized in the course of trying to achieve those standards of excellence which are appropriate to, and partially definitive of, that form of activity.[2]

Practices are elaborate but systematic ways of engaging human excellence in the service of human ends. By internal goods, MacIntyre means those goods that are identified through the acting out of the practice.[3] The internal goods of baseball, for instance, exemplify a particular excellence in sport—the strength and sense of timing required to

[2] MacIntyre, *After Virtue*, 187.
[3] Ibid., 188.

hit a ball out of the park, or the cunning and agility needed to steal a base. Hitting a home run and stealing a base are the internal goods; they exist only within this sport and are valued within the context of the game being played. Of course, there are other goods that arise alongside the practice but which are external to it. For instance, professional baseball players are well paid. The sport itself is highly lucrative. But financial gain is not (or ought not to be!) central to or definitive of the sport. Rather, it is a good accidental to the practice. Without it, the integrity of the practice of baseball is not compromised, as little league players can attest.

Along with goods that are internal to a practice, MacIntyre speaks to internal standards of excellence that define the activity. These include sets of technical skills or requirements, rules and guidelines for proceeding, and codes of ethics. When practitioners fail to meet these standards, this compromises the internal goodness of the practice, whether or not certain external goods are achieved. So, for instance, the World Series might be won by a team of players who cork their bats. In this case, an external good would be achieved—the esteem and admiration of others. (Of course, this external achievement can be compromised if the violation of the rules is found out.) But the good internal to baseball would not be achieved, despite the appearance of its achievement. The evaluation of whether the team reaches baseball's good end is conditioned by baseball's own standards of excellence, which denounce certain "enhancements" to bats as cheating. Winning by cheating would be discordant with the excellence achieved through baseball—the internal goods of the practice. Suggesting that all practices have such standards of excellence allows MacIntyre to associate practices with virtue—those excellences required for achieving the goods internal to the practice.[4]

One subcategory of practice is the profession. Professions are good examples of practices because they have goods that are specific to them, as well as standards for excellence, including a set of technical skills required for effective action and defined procedures for engaging those skills. Pellegrino, along with his colleague Thomasma, picks up where MacIntyre leaves off, aligning the concept of practice with the profession

[4] The centrality of standards of excellence also demonstrates that moral character is necessary to the concept of practice and the contiguous notion of human flourishing. For, even if the cheaters were never found out, they ought to feel some sense of shame for having won the season in a counterfeit way. Corruption is evident when the internal goodness of a practice becomes less desirable than its external goods, or when the practice itself becomes only a means to external goods.

of medicine. Pellegrino focuses on the clinical encounter, rather than medical research or public health, as the "omega point" of medicine. All other medical activities are undertaken for the sake of this encounter.[5] This kind of focus is helpful for an account of the ends of medicine that focuses especially on the context of end-of-life decision making. It is also consistent with Jonas' observation that medicine is intrinsically an applied science.

Here I focus on Pellegrino and Thomasma's notion that the practice of medicine, along with its internal goods and standards of excellence, has an "internal morality," a morality grounded in the particular kind of relationship that exists between the medical practitioner, or healer, and the patient, or the one who is ill. By way of clarification, it should be understood from the outset that illness need not only refer to disease. More generally, it refers to any physiological condition that prevents actualization of a physical kind. Moreover, physical health is a concept that relates to good and integrated functioning at the level of the living being. However, different standards of physical health will be pursued for different patients depending on their circumstances and the medical possibilities for them.

In regard to the relationship between the healer and the ill, Pellegrino observes there to be "something essentially in the nature of medicine as a kind of human activity which determines its ends and its ethics internally."[6] This being the case, the health care provider will have certain distinct obligations toward the patient that arise both from the fact of illness and the skill of the practitioner in healing.[7] Certainly, he admits, the obligations to care for the other *simpliciter* and to care for the ill in particular are not absent outside the medical profession. But the kind of care that is specifically medical bears obligations relevant to the expertise demonstrated in the practice. Medical practitioners can be obliged to provide a specialized kind of care pertaining to human health that is not available to nonpractitioners. Moreover, the goods at stake—health and

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[5] Pellegrino and Thomasma, *A Philosophical Basis of Medical Practice*, 24.
[6] Edmund D. Pellegrino, "The Internal Morality of Clinical Medicine: A Paradigm for the Ethics of the Helping and Healing Professions," *Journal of Medicine and Philosophy* 26, no. 6 (2001): 560. Cf. Edmund D. Pellegrino, "Philosophy of Medicine: Should It Be Teleologically or Socially Construed?" *Kennedy Institute of Ethics Journal* 11, no. 2 (2001): 175. For the most part, Pellegrino limits his focus to the *physician*-patient relationship. For my purposes, this relationship can be extended to include the team of health care providers.
[7] Pellegrino and Thomasma, *A Philosophical Basis of Medical Practice*, esp. 192-220.

life—are, at a basic level, fundamental to the patient's wellbeing. The practice of medicine aims to facilitate the physiological actualization of the patient, or the actualization of the living being. Although other kinds of human actualization can be possible apart from good health, poor health often diminishes these. Without giving too much credit to external circumstances, there are limits to the internal resources of a human being. By and large, health plays a part in facilitating human flourishing; removing the natural evil of illness is a laudable goal. Given the exclusivity of medical knowledge and resources for healing and the gravity of the goods at stake, medical practitioners might sometimes be compelled to constrict their own interests to care for their patients in ways that nonpractitioners would not. There is, for example, the matter of quarantine. Pellegrino and Thomasma conclude that the contours of medicine's particular obligation to the ill are determined in a manner internal to its own practice, tailored to its own resources and standards of excellence.

But there is conflict between this idea that medicine determines for itself how to best serve human health and the notion that the obligation to care for the ill is not alien to those who are not medical practitioners. One prominent argument against the concept of an internal medical morality relates to the fact that medical-moral obligations are indeed intelligible to those outside the medical situation. The objection is that the ends of any practice are actually external to the practice, derived from a particular conception of the ends of the human being. For this reason, comments Robert Veatch, "the ends of promotion of health and healing are themselves meaningless unless one turns outside medicine to know whether the ends are worth pursuing….Medicine is never an end in itself."[8] A rationale for the practice of medicine, he says, can only come to light in the context of an external framework of commitments pertaining to the value and purpose of human beings. Veatch is correct in observing that medicine as a practice is not disconnected from a particular vision of the human being. It is true that the values of medical practice and human health are logical extensions of an account of the complete human good. Pellegrino himself denies that medicine's internal morality is a self-justifying set of norms.[9] He affirms the importance of objective foundations for medicine

[8] Robert M. Veatch, "The Impossibility of a Morality Internal to Medicine," *Journal of Medicine and Philosophy* 26, no. 6 (2001): 635-36.
[9] Pellegrino, "The Internal Morality of Clinical Medicine," 565.

and, in particular, the critical role played by philosophical anthropology in a philosophy of medicine.[10] All the same, he insists that medicine as a practice is an end in itself.

Too often, though, things that are labelled "ends in themselves" are read as being self-justifying. Theorists who propose medicine as a practice must, I think, be more intentional to avoid the appearance of asserting the goodness of medicine apart from a more general account of the human good. A distinction is called for between a morality whose particularity stems from the unique capacities of a practice and a morality that is independent of a framework of human ends external to that practice. The call for this distinction must be especially clear in a time in which medicine's internal morality may be prone to the influence of the technological imperative. That a particular practice can represent a distinct way of pursuing or enabling the pursuit of human excellence must not come to mean that its standards of excellence are not radically contingent on the character of the ethical narrative as conceived outside of this practice. Nor, importantly, should it entail that the practice's end is abstracted from other human ends. The ends of medicine are indeed embedded in a larger paradigm of meaning and directed toward an aim that is more complete than its own practice entails. This is in accordance with the methodology outlined in the first chapter of this thesis: many genuine goods are not the complete good; they are only partly constitutive of it. Thus, these goods are means. But they are also ends in themselves because they share the character of the ultimate end. Medicine achieves a real good in a particular way according to its practice, but the activity of this practice is constrained by a vision of the ultimate end or complete good for human beings.

Another objection that has been made against the description of medicine as a practice with an internal morality is that all practices are socially constructed. Therefore, the goodness of their aim and standards of excellence will be conditioned by the values held by a particular society or community, relative to the character of its founding narrative. Indeed, MacIntyre's definition of practice highlights the social construction of practices or, at least, their embeddedness in culture. The meaning of a practice is ineluctably intertwined with the particularity of the narrative tradition in which it exists.[11]

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[10] Edmund D. Pellegrino, "From Medical Ethics to a Moral Philosophy of the Professions," in *The Story of Bioethics: From Seminal Works to Contemporary Explorations*, ed. Jennifer K. Walter and Eran P. Klein (Washington, D.C.: Georgetown University Press, 2003), 10-11.
[11] MacIntyre, *After Virtue*, 221-22.

A practice is only fully intelligible within a society that values the goods and standards of excellence internal to that practice, and the virtues or skills necessary to their achievement.[12] If medicine were to be viewed in this light, it could legitimately be constructed in very different ways according to variant social contexts. However much was shared in the way of technical skills and technological means employed, these different practices of medicine would bear little likeness to each other. For instance, the legalization of physician assisted suicide in some parts of Europe and the United States speaks to a conception of medicine that conforms to the principles of Western liberalism, including extreme forms of individual autonomy and self-determination. I would argue that loyalty to these principles has affected the way in which notions such as care, compassion, and dignity are interpreted. Loyalty to these principles has, accordingly, overturned the standards of excellence particular to medicine, which include never causing harm to the patient. If one considers the bioethical principle of nonmaleficence to be intelligible and valued only according to social context, it becomes difficult to conceive of one universal moral justification for medicine.

But Pellegrino and Thomasma modify this element of MacIntyre's theory. Some practices, they argue, are by their very nature moral enterprises that stand apart from social construction. Other practices, such as baseball, do have internal goods and particular standards of excellence. Yet the existence of these particular goods and standards are not justified by a moral consideration. So, there is a greater sense of freedom for the participants of these kinds of practices to effect internal change. For example, baseball players might collectively decide that the game would be a more valuable practice if its end were no longer a particular excellence in sport but intellectual excellence. They might change its rules and standards to meet this new end. Such a major alteration would probably be regrettable. Baseball would no longer be the same practice, incurring a loss to North American culture. But, all things being equal, the transformation of baseball could not be objected to on *moral* grounds. Baseball, though valuable and though exhibiting human excellence, does not exist as a practice because of its moral

[12] In *After Virtue*, MacIntyre completely rejected Aristotelian metaphysical biology, making practices socially teleological but not naturally or biologically teleological (see esp. 196). This prevented him from arguing for one objective account of the good, of human virtues, and of authentic human practices. More recently, he has changed his mind and accepted the normativity of nature. See his *Dependent Rational Animals: Why Human Beings Need the Virtues* (Chicago: Open Court, 2001).

worth to society. If, on the other hand, the Canadian Medical Association were to decide that medicine as it is practiced in Canada was no longer to be ordered toward the health of individuals but to health-related scientific research, something moral would be lost. It would be immoral to cease to provide health care altogether, or to provide it only as a means to the advancement of medical knowledge. This is because caring for the health of human beings is an integral good of any human society. Clearly, the narrative traditions of different societies construct the healing arts in different ways; yet certain commonalities stretch as far as our common humanity.

To reiterate, crossing home plate is a good internal to baseball, a socially-constructed practice. If the game of baseball did not exist, the act would not be comprehensible in its excellence. Moreover, the particular kind of physical prowess baseball players must achieve in order to play the game is not universally valued. Football players and tennis players train in different ways and develop different physiques and skills. Health, however, is a state that is understood and desired even apart from the systematically organized ways to achieve it. This indicates that, although there are particular narrative construals of medicine, they are based on common conditions. As Pellegrino has it, medical morality goes "beyond cultural and historical contexts to what is common to the human predicament of being ill and being healed."[13] Cultures and religious traditions contrast in their experiences of illness and means and procedures for caring; the narrative construction of each reality differs in significant ways. Distinct insights on the subjects of illness and healing, as well as distinct views of the human being, are derived from their particular medical practices. But in each one there is a common movement differently expressed: there is concern for the welfare of the one who is ill.[14] Clearly, *any* concept of human ends and the ethical aim would preclude the kind of substantive change in the practice of medicine that would cancel out the role of medicine in healing and make it a purely theoretical science. Of course, it cannot be denied that competing notions of the good do emerge and misconstrue medicine's role in particular kinds of cases, for instance, in commending assisted suicide. However, at its

[13] Pellegrino, "The Internal Morality of Clinical Medicine," 565.
[14] Pellegrino, "Philosophy of Medicine: Should It Be Teleologically or Socially Construed?" 175.

root, Pellegrino says, "medicine exists because being ill and being healed are universal human experiences, not because society has created medicine as a practice."[15]

In my view, the notion of medicine as a practice has its limits. It does promote the understanding that medicine is a unique and specialized way to realize certain human goods. Its own standards of practice reflect its internal resources and skills. Nevertheless, the moral obligations of medicine are not incoherent from an external point of view or discordant with the common obligations of human beings toward each other. Rather, they are intimately related to and conditioned by these larger spheres of obligation and morality. Defining medicine simply as a practice, then, does not do justice to this profession. Moreover, a focus on practice can tend toward the notion of medical autonomy, allowing for medical interventions that are physiologically effective but which go against the larger good of the individual patient. Preferring efficacy to benefit is inappropriate. Medicine, I would like to say, must first and foremost be looked upon as a species of care. It is a specialized way of engaging in what is a general human occupation. In more Thomistic terms, it might be said that medicine is a particular expression of charity. As Cronin sums up the manualist understanding of medicine, "the doctor's obligation from charity to assist the sick is but a simple application of the general demands of the virtue of charity."[16] Although care will be more carefully examined, it can provisionally be defined as bearing and demonstrating concern for wellbeing. Care is not a practice because it is not a socially constructed, systematic way of engaging human goods. But it is, as I will go on to show, an example of *praxis*, having its end in itself. Caring for a human being flows from the honour one gives the other occasioned by the other's intrinsic dignity. But care is often aimed practically to facilitate the other's *wellbeing*, and not merely the other's *existence* as a member of the human natural kind. Care can be evidenced, as it is in a very specialized way in medicine, through the building up of the goods that are necessary for the other's actualization at various levels (nutritive, perceptive, and so on). Although everyone has a moral obligation to care for human beings, to work toward conditions that enable human beings to flourish, those with a particular kind of relationship to a particular human being (oneself or another) can bear

[15] Pellegrino, "The Internal Morality of Clinical Medicine," 563.
[16] Cronin, "The Moral Law," 123.

more specific forms of this general obligation. This relationship often entails, but need not entail, a professional role. Parents will naturally be very involved in the upbringing of their children; their efforts extend to the provision of nurture directed at the body, the intellect, character, social skills, talent, and the spiritual life. They do this in the hope that their children will grow up to flourish in these areas. Today's professional educators, by contrast, will play a more defined, but still quite significant, role: they have the intellectual formation of their students in mind. Thus, teachers are equipped with a particular skill set designed to foster this kind of growth in others.

Medicine, then, is not only a practice with internal goods and standards of excellence; it is a universal and morally justified species of care, one whose rationale includes serving the health of others, providing protection from certain natural evils affecting the human body, and doing so in specialized ways. As Hauerwas has put it, "the very practice of medicine entails moral convictions that shape its fundamental nature."[17] The convictions that underlie medicine include the evil of illness and the goodness of the individual in need of healing.[18] In fact, a philosophy of medicine grounded in seeking the patient's good is the only way to maintain the integrity of medicine in a pluralist society since it is the only universalizable medical end.[19] The end that Pellegrino and Thomasma discern for medicine is not something that is unintelligible apart from a given perspective or radically dependent on a particular narrative or ethical system for its identification, although these narratives do shape practices of medicine. It is grounded in a commonly held value. This grounding makes medicine's status as a human practice all the more forceful in a world of competing narratives.

5.1.2 The Good of the Patient as Foundational for Medicine

In an article on medicine's internal morality, Pellegrino prefaces his argument with a quote from Plato's *Lysis*: "And the medical art is a good, and it is for the sake of health that the medical art has received the friendship, and health is a good is it not?"[20] Health—actualization at the physical level—is the primary prescriptive value in medical

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[17] Hauerwas, *Truthfulness and Tragedy*, 185.
[18] Pellegrino and Thomasma, *A Philosophical Basis of Medical Practice*, 147.
[19] Pellegrino, "Philosophy of Medicine: Should It Be Teleologically or Socially Construed?" 173. This is not to deny that the substance of the patient's good can be differently construed when alternate standards of medical excellence are employed.
[20] Plato, *Lysis* 219a. Quoted in Pellegrino, "The Internal Morality of Clinical Medicine," 559.

practice. More specifically, according to Pellegrino, the end of medicine is the health of patients and, further, the health of one's particular patient. As Aristotle says, the physician considers "human health, and presumably the health of this human being even more, since he treats one particular patient at a time."[21] Pellegrino and Thomasma observe that, apart from the value of a patient's health, the clinical relationship would never be initiated.[22]

But to say that the good of the patient's health is the end of medicine sounds overly simplistic. Veatch suggests there are at least four goals to which medicine is often ordered: preserving life, curing disease, relieving suffering, and preventing disease and promoting health.[23] These ends, he argues, are ambiguous because, although they can all be ordered toward the patient's health, they compete with each other and are at times incommensurate. The most salient example is of the conflict between the decision to preserve life through aggressive medical means and the decision only to relieve suffering by apply purely palliative medicine. If preserving life and relieving suffering are both legitimate ways of reaching the end of medicine, how can that end be unified? Anticipating this problem, Pellegrino and Thomasma reinforce their argument by contextualizing the goodness of human health within a more comprehensive account of the good of the patient.[24] Health, though the primary prescriptive value for medicine, is not the primary value for the human being or the ultimate end of human life. Thus, Pellegrino and Thomasma admit that health is a "relational good" rather than an isolated good. It provides a foundation for other goods.[25] Moreover, the ranking of health on the spectrum of patient values will change according to circumstance. As such, it is an end that exists also as a means to the final end of the human being.

So, health, as an end, can be viewed from different perspectives. It can be seen as the primary good when it comes time to consider which treatments are medically indicated for a patient. Nonetheless, health remains relative to the larger ends of human life. This is consistent with what has been said already in this chapter about medicine

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[21] Aristotle, *Nicomachean Ethics*, 1.7.1097a13-14. Following Aristotle, then, Pellegrino is against the trend that would see medicine become ordered first of all to the good of society.
[22] Edmund D. Pellegrino and David C. Thomasma, *For the Patient's Good: The Restoration of Beneficence in Health Care* (New York: Oxford University Press, 1988), 62.
[23] Veatch, "The Impossibility of a Morality Internal to Medicine," 631.
[24] Pellegrino and Thomasma, *For the Patient's Good*, 117.
[25] Ibid., 40ff and 63.

being justified by a moral concern, and with what was said in chapter three—that the OEMD is concerned with the good of the whole patient, or the good of the patient as a human being, and not only with what is medically indicated or routine. Moreover, the fact that human health can be seen as both end and means makes way for what will be said later: that medicine is not the only way to care for the ill. This being the case, the physical health of the patient will be medically pursued insofar as this pursuit remains congruous with the larger or comprehensive good of the patient, and it will be pursued through the achievement of auxiliary medical goods. One auxiliary medical end can be overridden by another auxiliary end that is more appropriate to the patient's overall good. So, measures that preserve life might be forgone in favour of providing purely palliative means that ease the dying process.

The criticism could be levelled that some legitimate medical ends, such as the relief of pain, are not auxiliary to health. That is, the relief of pain might appear ordered toward the good of the patient, but it does not appear to aim at the medical end of restoring a patient to health. In fact, pain relief measures are often relied upon when healing is impossible. Does the failure to procure a particular standard of health, measured in its quality and duration, make pain relief measures nonmedical? To this, Pellegrino says that even palliative medicine aims at healing in the sense of "making whole again."[26] This is even better understood, I think, if medicine is viewed first as a species of care, and only subsequently as a practice. When particular medical actions no longer achieve human health—when they provide no effect, or when their effect and human benefit are no longer consistent—caring, as opposed to preservative, curative, or ameliorative, actions take over.[27] Some of these are nonspecialized, such as looking after the individual's hygiene or appearance. But medicine has also found more specialized ways of achieving care for the dying. Palliative medicine might not restore patients to health, but it can "restore harmony" to them, as well as enable them to live out their last days with meaning.[28] Often dying patients in ill health can still pursue actualization of a genuine kind. For instance, patients near death might have a heightened sense of the value

[26] Pellegrino, "The Internal Morality of Clinical Medicine," 568.
[27] Edmund D. Pellegrino, *Physician and Philosopher: The Philosophical Foundation of Medicine: Essays by Dr. Edmund Pellegrino* (Charlottesville: Carden Jennings, 2001), 60.
[28] Pellegrino, "The Internal Morality of Clinical Medicine," 568.

of relationships with family and friends. In this instance, medicine is employed inasmuch as it provides the pain relief necessary for patients to pursue the varieties of actualization possible for their condition.

How do Pellegrino and Thomasma conceive of the holistic or comprehensive good of the patient? They do this without totalizing the concept of human health in the way of the World Health Organization, which is notoriously unhelpful in defining health as the "complete physical, mental and social well-being and not merely the absence of disease or infirmity."[29] As Hauerwas comments, "the tendency to describe any malfunction of the individual and society as 'illness' is but a sign of medicine's hegemony in this respect."[30] Pellegrino and Thomasma allow the state its role in achieving social and political harmony. They allow clergy their role in nurturing the spiritual wellbeing of their community. The direct concern of medical practitioners (if not their exclusive domain) is the good of the patient's physiological condition. Even so, health must be seen in light of the larger good of the patient, which might include the other aspects of wellbeing identified by the World Health Organization. The larger good of the patient, however, will go beyond how the individual exists socially or materially. Pellegrino and Thomasma situate the good of the patient according to a typology of goods, one that I find illuminating. They begin with the notion of the ultimate human good.[31] Elsewhere, Pellegrino has called this the "spiritual good" of the human being.[32] This good is primarily active in meaning-making. How one interprets the ultimate good for human beings, Pellegrino and Thomasma say, will condition one's derivative senses of one's own good. Among these derivative senses is the good for human beings or the good of the patient as person, what I have elsewhere called the natural human end. (In my view, Pellegrino and Thomasma do not do enough to show the intimate connection between this end and the spiritual good of human beings.) At this level of goodness, the concern is with the actualization of human capacities, especially the particularly human capacities at the sensitive and rational levels. This is consistent with what I have already

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[29] World Health Organization, "Preamble to the Constitution of the World Health Organization as Adopted by the International Health Conference," Official Records of the World Health Organization (1946), no. 2, 100.
[30] Hauerwas, *Vision and Virtue*, 180.
[31] Pellegrino and Thomasma, *For the Patient's Good*, 77.
[32] Pellegrino, "The Internal Morality of Clinical Medicine," 570.

argued in terms of factoring a philosophical or theological anthropology into treatment decisions such that the aim of treatment is kept consistent with the *telos* of human beings.

Another derivative sense of the good that Pellegrino and Thomasma specify is the patient's own perception of his or her best interests. This relates to the individual's particular life plan or vision. It is a more subjective kind of good, one that the OEMD includes by allowing for the contextual nature of decisions about life preserving means. This sense of the good might be considered in terms of personal narrative. For instance, one cancer patient will opt not to undergo chemotherapy, choosing to make good use of the time left rather than fight for life. Another will struggle against death to the end. The differences can derive from age, personality, responsibilities to family and loved ones, or tasks yet to be completed. Both options can be morally acceptable and fulfilling of a life narrative.

The third and final derivative sense of human good is the patient's biomedical good, the good that is the proper object of the practice of medicine. It includes the physiological functioning of the body, along with relief from pain and suffering.[33] Strikingly, Pellegrino calls this good the "lowest" good for human beings.[34] In saying this, he does not deride its intrinsic value but considers its role as foundational for other goods. Good health allows for human flourishing—fulfillment of the human good in all its senses. Thus, as indicated by the manualists, it requires that a particular quality and duration of life be achieved. But, to be clear, the quality of life required can be very minimal and yet sufficient to the patient's larger activities. Moreover, imminently dying patients, who are decidedly not healthy, can yet retain a standard of physiological actualization compatible with more particularly human acts, in the Thomistic sense. They might decide to have life prolonged a little longer in order to say goodbye to loved ones or to engage in a spiritual practice. The standard of health, or the biomedical good to be achieved, will vary from patient to patient, from situation to situation. For this reason, health care practitioners and the patient (or proxy) must be in dialogue about the expectations for the treatment. Discussions about treatment options ought to be conducted in light of those other senses of the good. The best healing action will not stop at the

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[33] Pellegrino, "The Internal Morality of Clinical Medicine," 569.
[34] Edmund D. Pellegrino, "Decision at the End of Life: The Use and Abuse of the Concept of Futility," *Life and Learning* 10 (2000): 95.

"medical indications" for the patient but will be consistent with the other ways the patient's good can be viewed. This is the gold standard for health care, although it will not always be possible to achieve. Good healing actions require a level of technical expertise on the part of the medical practitioner that is proportionate to the physiological need of the patient. They also require prudence to understand when medical intervention needs to be limited in order that medical practice does not override the patient's ultimate good or compromise other subsidiary goods.[35] Certain questions must be asked: What kinds of lifestyle changes or levels of pain are acceptable in reaching a certain health goal? How is health to be pursued—through cure, symptom relief, or preservation of life?[36]

The biomedical good, then, is understood as the good of achieving for patients the kinds of physiological conditions that support their other human activities. It should be apparent that the patient's whole good depends in large part on consciousness, or the awareness or perception required to orient oneself toward the ethical aim, to construct a plan of life, to determine one's best interests, and even to carry out much simpler tasks. For this reason, a "basic standard of health," or a standard that supports human activities beyond the nutritive level, must, in my view, achieve sentient human life, or human life active at the sensory (conscious) level, however diminished or compromised. It is this baseline of sentience that allows for further human pursuits. Moreover, and as I explained earlier in my earlier discussion of May's exclusion of certain disabled individuals from relationship with God, it is clear that a nonsentient human being cannot express the rational capacity. But it is dangerously presumptive to assume that any sentient human being is incapable of spiritual expression.

And so medicine has a limited task, but its limited task contributes to whole human lives. Medicine can have an indirect impact on patients' other derivative goods and their ultimate good. Patient accomplishments subsequent to healing are, of course, not within the domain of the activity of medicine. Whereas the internal good of medicine is the achievement of human health, any patient achievements that in part result from good health will represent goods that are external to medical practice. Whether reaching

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[35] Pellegrino and Thomasma, *For the Patient's Good*, 76-77.
[36] Ibid., 65-66.

medical ends frees a patient to play another season of major league baseball, to carry out important peace negotiations, to say goodbye to a family member, or to raise children, these things—valuable, to be sure—will be incidental to medical practice and not radically definitive of it. But this remains in tension with the fact that the practice of medicine is constructed in such a way as to better prepare patients to pursue those goods external to medical practice by helping patients avoid accidental impediments to actualization. Medicine's activity is justified on the basis of being a species of care.

To sum up, medicine is not ordered merely to the preservation of human health or biomedical flourishing, even if this is its most direct aim. The practice of medicine is consistent with the more distant human ends that extend beyond the scope of the practice of medicine itself. As a species of care, it is highly effective in preserving the health of the patient, and so it is an invaluable practice. However, its larger effects and its particular competency are two different things. Although medicine's goodness is internal, and although it is a morally justified activity, its goodness does not supervene on the goodness of other activities. Its particular competency does not determine the nature of other, higher human ends. Its excellent practice remains subject to a good already defined in human nature. It would be imposing a false distinction on personal identity to say that, *qua* medical practitioner, one cares for the patient's health and, *qua* human being, one cares for the patient's complete good. It is, however, conceptually important to indicate that the concern of the practice of medicine is the health of the medical subject or patient in light of the human being's larger good; but medicine's excellence is not in determining or achieving the individual's larger good.

5.2 The Capacities of Medicine and the Limitations of Human Life

Up to this point it has been argued that medicine is an indispensable species of the moral genus of caring for others. By now it should be apparent that its central governing principle (or virtue, as I prefer) is beneficence, displacing other candidates such as autonomy and paternalism. As Pellegrino and Thomasma describe beneficence, it includes not harming the patient and also engaging in more active ways to prevent or alleviate harm to the patient.[37] It remains to be shown just why medicine and medical beneficence are limited ventures. Before outlining the practical limitations of medicine

[37] Ibid., 26.

and the ethical responses to these limitations, I turn to reflect on the limitations of human life itself. This is an extension of theological anthropology, but one that deals particularly with the context of medicine at the end of life.

5.2.1 Preserving Life, Preserving Health

The theological anthropology foundational to this project has revealed tension between two valid presuppositions. The first is that all instances of human nature or members of the human natural kind have intrinsic dignity by virtue of their being. The second is that members of the human natural kind also actualize dignity or express their human soul by pursuing the ends proper to their nature. Although no human being is ever fully actualized, actualization is how people seek to achieve the possibilities given with human nature. Although failed actualization makes one no less human, the dignity realized in act remains a real value. Human beings are made for human flourishing.

In consideration of these two varieties of dignity, it is often argued that the intrinsic value of human nature imposes on medicine the duty to seek to restore health to the individual whose physiological condition accidentally hinders or prevents flourishing. Such individuals are not to be abandoned because they are somehow debilitated. In this way, all human life is respected or honoured. As Sulmasy has put it,

> Medicine, as a practice, is premised on the idea that losing one or another feature that is typical of the human natural kind does not render one a different kind of thing, but a damaged member of the kind in need of healing and restoration. One reaches out to help precisely because one recognizes both the humanness of the sick person and the fact that some characteristic feature is no longer functioning perfectly well.[38]

The role of medicine in honouring the intrinsic value of the individual human being is to relieve pain and also to repair the rift produced by illness between nature and task. In order to accomplish these goals, medicine has developed diverse techniques and technologies. Yet many of these, as has been demonstrated, can be used for alternate purposes. Some of these purposes are obviously outside the practice of medicine and conflict with its internal standards of excellence. The nature of other purposes is more obscure, sometimes even seeming to align with the internal goods of medicine. The particular purpose that is the subject of this thesis is the preservation of life that occurs

[38] Sulmasy, "Dignity and the Human as a Natural Kind," 84.

apart from the restoration of a very basic standard of health, one that allows for actualization beyond the vegetative level. Does preserving human life *simpliciter* honour the human being? Or can this be a misuse of medicine and a misinterpretation of what it means to honour human life? In the previous chapter I introduced MacIntyre's observation that the character of a practice can be compromised when it is faced with new circumstances that substantially alter the effects of its activity.[39] Has the context of contemporary medical technology, which allows for the radical separation of life and health, altered the effects of medical practice such that the virtuous character of certain medical actions, such as assisted feeding, has become vicious?

Even in an age of pervasive medical technology, the virtuous activity of preserving life need not be compromised if it remains subject to certain preconditions, namely those outlined by a normative view of humanity and a normative view of the ends of medicine. Bernadette Tobin has contended that the protection of life ought to be thought of as auxiliary to the protection of health, rather than the reverse.[40] The problem is that, in combating a culture of death, the emphasis has been placed on preserving life as the primary medical goal. This makes too much of the act of preserving life by allowing for the nearly unchecked use of means that preserve life long after the patient is able to work toward actualization at the sensitive and rational levels. Again, here the judgement is not made that particular human disabilities reduce quality of life to the extent that life cannot be valued. This patient is still a human being. For this reason, assisted suicide and euthanasia remain illicit. Yet in some cases, particularly in the case of the PVS, there is no *possibility* for human actualization beyond that of a certain kind at the physiological level.

Even accepting that all human lives are intrinsically valuable, it does not follow that it is medicine's task to attempt to preserve all members of the human natural kind in any sustainable condition. Others concur with this conclusion on grounds that many in the Christian tradition would deem illegitimate. Advocates of the kind of "personhood" that separates members of the human natural kind from those capable of cognitive-affective

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[39] MacIntyre, "How Virtues Become Vices," 109.
[40] Bernadette Tobin, "Can a Patient's Refusal of Life-Prolonging Treatment Be Morally Upright?" in *Issues for a Catholic Bioethic*, ed. Luke Gormally, 335.

function often claim that only persons should receive life preserving means.[41] But, on the basis of a Christian anthropology, the argument is much different: only patients whose condition offers some hope for a minimal relationship between physiological actualization and further kinds of actualization proper to the human being are candidates for means that aim at life preservation. Indeed, the development of life preserving means should be limited to measures that would apply to classes of patients for whom this relationship is or can be made possible. It is not the ontological status of patients that renders them poor subjects for medicine but, rather, the lack of possibilities left to them for actualization. Holding this at the fore, preserving life must be seen as part of the duty to preserve physical health, to achieve the biomedical good of the patient—and also the larger wellbeing of the patient—not as an obligation that stands apart from this context. The ends of medicine are taken in a much reduced fashion if the achievement of the auxiliary end of preserving life is considered sufficient for determining medical benefit.

5.2.2 The Blessing and Curse of Mortality

Partnering with Jonas in the previous chapter allowed me to demonstrate reason for caution in the application of technology to various ends. Jonas also indicates the need for caution when technology is used to sustain life at what would otherwise be life's end. In considering mortality in a philosophical fashion, he is compelled to address the ways in which medicine should be allowed to intervene in human life, as well as the restrictions that should be placed on it.

The ambiguity of death has been an important theme in Christian theology. This ambiguity goes hand in hand with the duality of human nature, or the capacity for freedom and the limitation of finitude. Authors of the Christian scriptures have considered death alternately as the wages of sin and the culmination of a full life.[42] Christian bioethicists, too, have struggled with the meaning of death. Ramsey, in *The Patient as Person*, wrote:

> Indeed, far from taking the death of the aged and the enormous death rate of zygotes and miscarriages to be a part of the problem of evil, a religious man is likely to take this as a sign that the Lord of life has beset us behind and before in this dying life we are called to live and celebrate. There is an acceptable death of

[41] Lawrence J. Schneiderman and Nancy S. Jecker, *Wrong Medicine: Doctors, Patients, and Futile Treatment* (Baltimore: Johns Hopkins University Press, 1995), 13.
[42] See Romans 6:23; Genesis 25:8; and Psalm 90:12.

> the life of all flesh no less in the first than in the last of it. An ethical man may always gird himself to oppose this enemy, but not the religious ethical man.[43]

But later on in his career, and consistent with his shift from an attitude of "only caring for the dying" to the imposition of his "medical indications" policy, Ramsey wrote very differently on the subject of death: "Death is a natural fact of life, yet no man dies 'naturally,' nor do we have occasions in which to practice doing so in order to learn how."[44] In the final analysis, death, for Ramsey, was an enemy that would only be overcome by God.

There is, however, a way of looking at human mortality that recognizes untimely death for the evil that it is without likewise rendering human finitude an evil or legitimizing human efforts to transcend mortality. Jonas indicates that mortality can be both blessing and curse.[45] He begins by drawing attention to the reality that, just as the ultimate threat to responsibility is embedded in the capacity for responsibility itself, so mortality is grounded in the very constitution of all living beings. The prerogative of a being for life is premised on the *necessity* of metabolism: "the peril of cessation is with the organism from the beginning."[46] It is certainly the case that being is better than not-being, and it is a curse to be faced with the continuous menace of death, or the threat that, at any moment, one might cease to be.[47] In this sense, death is something that is naturally to be avoided. At the same time, for the human being, the necessity of death—the bare fact that one *must* die—can be a blessing.[48] Human mortality prevents human beings from "outliving" themselves or becoming anachronistic.[49] Moreover, the inexorability of death is a blessing particularly for humans as self-reflective beings; it allows us to "number our days aright." Put differently, in order to live well, the possibility to live badly and the inevitability of death must endure. Hauerwas, concerned with the fundamentally narrative quality of human life, describes it this way: "Death creates the economy that makes it necessary to choose between life projects, between that which is valuable and that which

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[43] Ramsey, *The Patient as Person*, 1st ed., 132.
[44] Paul Ramsey, "The Indignity of 'Death with Dignity,'" 226.
[45] Jonas himself uses the terms blessing and burden, but for obvious reasons I choose to replace "burden" with "curse."
[46] Jonas, *Mortality and Morality*, 88.
[47] Jonas, *The Imperative of Responsibility*, 81-82.
[48] Jonas, *Mortality and Morality*, 87.
[49] Jonas develops this further in an exploration of youth and natality. Ibid., 94-98.

is not. As such, it is a precious gift which we literally cannot live without."[50] There might be a way to appreciate being apart from mortality, but this way is not within the grasp of human beings. Mortality may not be a good in itself, but it has value as a manifestation of human finitude. Death is at once blessing and curse, friend and enemy.

It is a problem that some interpret the blessing of death as a remedy for the "curse of life." This is making death too much of a friend. Mortality might be the solution to *ennui*, but death is not the solution to a life of unhappiness, disability, or suffering. This far, I can agree with those who confront a "culture of death." But there is a certain lack of nuance in the "culture of life"—especially as expressed by certain pro-life groups—that is presented as the alternative. Without upholding the tension of death as both curse and blessing, life becomes an absolute value to be pursued at all costs; the importance of the complete human good is neglected. This tension is absent when life preserving means are imposed on patients who receive no proportionate benefit from them.

Apart from religious bioethics, medicine, a practice that often wrests life from the grip of death, also faces the danger of making death into an absolute evil and life into an absolute good. Against this, rights of treatment refusal, patient autonomy, and even euthanasia and assisted suicide have supplemented the practice in more recent years. In fact, Jonas himself posits a kind of "right to die." But great care must be taken in describing what he means by this. He does not place himself within the euthanasist camp, nor does he advocate physician assisted suicide. The language he uses is meant to be polemical. It would be wrong to conclude from Christian theology that, since one must die in order to engage the beatific vision, or to receive transcendent dignity, Christians ought to be more enthusiastic about death than life. Just so, it would be wrong to conclude from Jonas' language that death as blessing makes euthanasia acceptable. His concern is not to deny the intrinsic goodness of life but to deny that all medical ministrations that preserve life are good.[51] By upholding a "right to die" Jonas is actually signalling the (limited) right to refuse life preserving means. Moreover, "that we can speak of a right to die," Jonas says, "is another one of those innovations made possible only by the development of medical technology—in other words, through the attainment of increased

[50] Hauerwas, *Vision and Virtue*, 177-78.
[51] Jonas, "The Right to Die," 31.

power due to modern machines."[52] In particular, Jonas takes issue with medical interventions that preserve life past the point at which the patient is capable of valuing it, or, indeed, past the point at which the patient is capable of the kind of valuation most proper to the human being.

In this regard, Jonas has addressed the case of the PVS patient, although a note of clarification must be made here. The subject of Jonas' discourse is the "patient in irreversible coma," but under this label he conflated what we now know to be two different conditions: brain death and PVS.[53] He was able to do this because he rejected the notion that "brain dead" patients really are dead.[54] Just as Pope Pius XII allowed for ventilator withdrawal from the brain dead patient despite his uncertainty that the patient was dead, so Jonas agreed that all irreversibly unconscious patients could legitimately be taken off life preserving means. A discussion of the validity of the brain death definition is decidedly beyond the scope of this project.[55] However, it is pertinent that Jonas included the patient in PVS within the category of patients in irreversible coma. Like the patient whose brain does not function but who subsists on a ventilator, a PVS patient is irreversibly unconscious and, solely by the grace of artifice, not at imminent and inevitable risk of losing all physical functioning. (Here artifice can be taken to refer not only to ANH but also to those technological means required to sustain the coma that precedes vegetation.) Jonas describes the irreversibly unconscious patient as "a lingering, artificially sustained residue of life, where not even an imaginary 'free agent' is left whose presumed own will a deputy might carry out."[56] It could be argued of human life in PVS that a kind of valuation or purposiveness persists at the nutritive level, as life at all levels is "purposive." The soul is still expressed at this level. But although this kind of expression or valuation is sustained, its sustenance fails to provide a foundation for other

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[52] Jonas, "Not Compassion Alone," 46.
[53] Jonas, "The Right to Die," 35-36. "Irreversible coma" has also been used in Catholic documents to refer to unconscious but not brain dead patients. See the Pontifical Academy of Sciences, "The Artificial Prolongation of Life," (1985), 306.
[54] See Jonas, "Against the Stream: Comments on the Definition and Redefinition of Death," in *Philosophical Essays*, 132-140.
[55] The brain death standard is increasingly being called into question in Catholic circles. See Peter Byrne, "'Brain Death' is Not Death," *Catholic World Report* (March 2005): 54-58, http://www.catholicculture.org/library/view.cfm?recnum=6647.
[56] Jonas, "The Right to Die," 35.

kinds of valuation in the human being or other expressions of the human soul.[57] When medicine sustains the patient in such a condition, the blessing of death becomes all the more apparent.

Despite including this kind of patient in his discussion of a "right to die," or a right to reject nonbeneficial life preserving means, Jonas eschews the notion of rights when it comes to a being, even a human being, lacking subjectivity. He does, however, allow that there might be a duty for others either to perpetuate or terminate the condition of persistent unconsciousness. This duty, in his mind, is dependent upon respect for the "past dignity of the patient."[58] It is on this matter of "past dignity" that I depart from Jonas. Certainly, the subjectivity of the patient, or the former biographical identity of the patient, motivates the actions of caregivers. But despite Jonas' insistence that reasonable caregivers of the irreversibly comatose will "let the poor shadow of what once was a person die, as the body is ready to do, and end the degradation of its forced lingering," respect for the identity of the patient can lead different caregivers to different actions. Some will wish to maintain the life of the patient out of respect for the intrinsic value of the individual, and others will see the withdrawal of life preserving means as the fitting response.

There is a similar ambiguity, but one played out in reverse, in decisions made about the lives of patients who are terminally ill, suffering, or disabled, but who are not prevented from all actualization beyond the physiological level. For some caregivers, respect will entail the active ending of life through euthanasia or assisted suicide. For those who view active killing as inimical to respect for life, honour will be indicated in refusing to participate in euthanasia or assisted suicide. Here the difference, though, is that those who favour active killing do so on the basis of their subjective impressions of what it means to respect a patient as person. Those who eschew active killing follow a principle forbidding direct action against life, as such action is consonant with denying life's intrinsic goodness. Likewise, it is a principled reason that must be upheld as the justification for allowing a PVS patient to die, and not, as Jonas would have it, merely a subjective reaction to the condition of the patient. The conclusions of this reaction can be

[57] In the final chapter it will be argued that consciousness is a prerequisite for human purposiveness.
[58] Jonas, "The Right to Die," 35.

wrongly manipulated if it is said that a patient has only "past dignity." Any decision regarding life preserving means—whether to remove or maintain them—will always be made in view of the *present* dignity of the human being and contingent on the possibilities for actualization and on moral possibility. In fact, such a principle is not foreign to Jonas, notwithstanding his emphasis on respect for "past dignity." Patients sustained in persistent or irreversible unconsciousness—those representing the "novel condition of the patient's impotence coupled with the power of life-prolonging technologies"—prompt Jonas to ask questions about the ends of medicine. In particular, he is led to ask, "is merely keeping a naturally doomed body this side of expiring among the genuine goals or duties of the physician?"[59]

If such a goal were to be considered legitimate for medicine, it would appear that MacIntyre's observations about the transition from virtue to vice within a practice would apply to end-of-life medicine. In this case, the transition would be the product of insufficient reflection on the relationship between technological power and medical ends. The physical actualization of the patient can be supported through preserving life, curing, circumventing the effects of a condition, palliation, and preventing further illness. The dynamics of technology, however, can encourage viewing these particular activities in isolation from larger human ends. Thus, it is possible for medicine to employ medical means (life preserving technologies) toward a legitimate, if auxiliary, end of medicine (the preservation of life) and yet fail to be oriented toward the final end of medicine (human health). In effect, the act of preserving life, apart from the concurrent preservation of consciousness, is only apparently good, in the Aristotelian sense.[60] Jonas puts it more poetically: medicine's "commitment is to keep the flame of life burning, not its embers glimmering."[61] Elsewhere he writes:

> To secure survival is indeed one end of organic endowment, but when we ask "Survival of what?" we must often count the endowment itself among the intrinsic goods it helps to preserve….The feeling animal strives to preserve itself as a feeling, not just metabolizing, creature….Even the sickest of us, if he wants to live on at all, wants to do so thinking and sensing, not merely digesting. Without these subject faculties that emerged in animals, there would be much less to preserve,

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[59] Ibid., 36; cf. Jonas, *Le droit de mourir*, 70.
[60] Aristotle, *Nicomachean Ethics*, 3.4.1113a15-1113b3.
[61] Jonas, "The Right to Die," 36.

> and this less of what is to be preserved is the same as the less wherewith it is preserved.[62]

Avoiding viciousness in practices requires having prudence to relate means to ends, lesser ends to final ends, and genuine but partial goods to the complete good. The OEMD has been constructed to aid prudence in the context of life preserving ministrations, but it does so first of all to facilitate care for one's own health and only secondarily in concern with the medical practice.

Properly speaking, then, medicine considers both the dignity inborn in human nature and the corresponding dignity that flowers in human actualization. The medical decision will be made on the basis of the consequences of the medical means for the patient as a human being. Not only must such means sustain life, but they must do so in a fashion that supports the patient's efforts toward human actualization. If these aims cannot concurrently be realized through medical efforts, it is appropriate to withhold or withdraw the life preserving means. To honour the dignity of human life entails that medicine be employed in ways that coincide with the realization of human ends.

So, it is true that medicine does have some relationship to the good of the whole patient. But medicine itself is responsible for only part of that good. Sometimes it can do very little to aid the patient in flourishing, even if it is lifesaving. This reveals a different side of what it means, according to Hauerwas, for medicine to be "defended and formed by values consistent with the normative demands of being human."[63] It reveals the limited side of medicine, the recognition of which is necessary for prudential action in an age of pervasive technology. If medicine is no longer brought in as a means of serving the physiological foundation of the goodness of human life, but rather allowed entirely to govern human ends, moral obligation will continue, wrongly, to be re-presented primarily in reference to the extent of medicine's ability to sustain life.

5.3 Medicine as a Limited Practice

There are limits to medicine's capacity to provide specialized care. But this could be taken simply to refer to the technological limitations of medicine. Perhaps, then, it would be better to say that medicine is properly confined by the limitations of human beings, despite their physiological need, in benefitting from its specialized care. With this

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[62] Jonas, *Mortality and Morality*, 93. Cf. Jonas, *The Phenomenon of Life*, 106.
[63] Hauerwas, *Vision and Virtue*, 180.

in mind, this section entails a re-emphasis of certain tenets of a philosophy of medicine that are often made recessive in medical practice by high medical efficacy and technological proficiency. Three primary affirmations come into focus. First, medicine is only one way of caring; there are other ways that work alongside and sometimes apart from medicine. Second, the specialized care provided by medicine is often of a tragic nature: not all apparently beneficent acts will actually result in benefit. In particular, when life preserving acts fail to provide the physiological foundation necessary for further human actualization, such acts should be avoided. Palliative or nonmedical care should be taken up instead. Finally, sometimes expressions of care are best limited to being present with the patient as friend.

It should be noted that this discussion of care should not be mistaken for a directed contribution to a feminist interpretation of medicine. Although there will doubtless be commonalities with accounts made by certain feminist advocates who regard care as central to morality, my own efforts concern the activity of care (and the related concept of honour) as it is conceived in broadly Christian thought.

5.3.1 Medicine as (Only) a Species of Care

Medicine, then, is a particular species of care. One corollary of this is that such specialization imposes particular obligations on the practitioner. But a counter-assertion must be made: the kind of specialized care offered by medicine is limited in a way that some other less specialized forms of care are not. I say this to make the important distinction between withdrawing life preserving means from a dying patient and what physicians and bioethicists have come to label "abandoning the patient," or the medical desertion of the patient. Discussions of patient abandonment tend to centre on the *medical* neglect of incurable patients. Bioethicists and physician codes of practice generally affirm that when death is imminent and inevitable, the patient must not be left to linger alone and in pain. This was the primary contention of *The Patient as Person*, in which Ramsey argued for (only) caring for the dying.[64] The obligation to continue to care for dying patients is often reinforced by connecting medical care with charity. One Catholic

[64] Ramsey, *The Patient as Person*, 1st ed., 114ff.

working group, for instance, lists two primary norms relevant to end-of-life care.[65] The first is "you shall not kill," and the second is "love your neighbour as yourself." According to each of these, dying patients are never to be abandoned either through direct killing or by simple neglect or desertion. They are instead to be provided with palliative and other resources that are beneficial to them in their dying.

It is equally important, however, to affirm the difference between abandoning life preserving means and abandoning a patient. Quite often, in Christian bioethics, the abandonment of ANH is likened to patient abandonment, since it is characterized as necessarily opening the door to death. Meilaender is one who makes this claim, arguing that the removal of ANH from the PVS patient takes aim at life, not useless treatment: "We have ceased to care for that person as best we can in the time and place he has been given."[66] It is true that a decision to withdraw life preserving means from a patient *can* be consonant with patient abandonment, but it is not true that it *must* be so. Indeed, it ought to be observed that patient abandonment frequently occurs when patients are left in a "care facility" with the basic necessities of life provided to them. Such a patient can be abandoned when the administration of these necessities—both those that are more specialized, such as ANH, and those that are unspecialized, such as clean bed linens—is the only human contact the patient receives. Hauerwas describes these measures as "forms of uncare" that serve as "our substitute for personal *presence*."[67] Concern for these patients fails to reach the heights of genuine charity, instead remaining at the level of legal or perfunctory obligation. For no one stands in solidarity with them. No one considers them as part of the human community.

If the practice of medicine is to be viewed as a species of care, its moral nature will be properly determined in the way of other kinds of care: by the intention and aims of its activity, not, first of all, by the specific types of equipment or interventions engaged. The critical point to consider is *why* interventions are applied or forgone. Whereas in some cases the withdrawal or withholding of life preserving means dishonours the dignity of a patient, to neglect a patient by failing to *care* for them is in every case patient

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[65] Working Group on Roman Catholic Approaches to Determining Appropriate Critical Care, "Consensus Statement, March 2000," *Christian Bioethics* 7, no. 2 (2001): 181. Also see Pontifical Council for Pastoral Assistance to Health Care Workers, "The Charter for Health Care Workers," (1995), no. 115.
[66] Meilaender, *Bioethics: A Primer for Christians*, 71.
[67] Hauerwas, *Vision and Virtue*, 181. Emphasis added.

abandonment. Always it must be remembered that the duty to care surpasses the subsidiary medical duty to treat. One treats the individual as patient, but one cares for the individual as human being.

As earlier explained (3.3.2), the Pontifical Academy of Sciences imposed a new distinction onto the moral examination of end-of-life situations. This is the distinction between "medical treatment" and "basic care," wherein the latter is defined as the "compassion and spiritual and affective support due to every human being in danger."[68] It is certainly the case that compassion and spiritual and affective support ought never to be disengaged from anyone. However, there is more than one way of interpreting this rendering of the distinction between medical and nonmedical care. The first way corresponds with the magisterium's interpretation—although this way is not, in my view, the most accurate estimation of the relationship between medical treatment and other forms of care. When *curative* efforts fail, according to the magisterium, measures that are effective only in *preserving* life remain legitimate expressions of basic care, barring physical impossibility or great pain. But is this interpretation of basic care consistent with the larger notion of the care due to others? The academy's document is acceptable insofar as the above quoted definition of basic care implies that medicine ought not to be viewed as a practice that somehow stands apart in authority and obligation from the overarching category of human activity called care. That medicine is a practice with an internal morality and its own standards of excellence must not be taken to contradict its intrinsic relationship to care. But the error comes in likening certain interventions (often described as "nursing care"), such as ANH, to the kind of care that is always "due" to patients, barring physical impossibility or great discomfort. It would be more accurate to say that, as the human body can benefit only so much from medicine's efforts, there is a point at which the medical means of caring for patients must fall by the wayside, allowing for other, more appropriate means of care to come to the fore—particularly nonmedical ways of expressing compassion and spiritual and affective support. It should go without saying that the directive to (only) care for the dying does not entail that caring begins only when death is inevitable. Rather, "it may well be that we should care for the injured or the ill,

[68] Pontifical Academy of Sciences, "The Artificial Prolongation of Life," (1985), 306.

but it is by no means clear that medicine offers the best or only way to care for them."[69] If the rejection of patient abandonment indicates that the medical duty to care surpasses the medical duty to cure, it must equally be affirmed that the genus of care is larger than the species of medical care expressed in preventative, preservative, curative, ameliorative, and even palliative means.

Medicine, as a species of care, is not determinative of the nature and extent of care itself, even care for the critically ill or imminently dying patient.[70] Moreover, as observed in the previous chapter, the totalizing of human health by medicine is reductive of human nature or a vision of the image of humanity. Medicine cannot provide humanity with its ultimate end; it only provides a service that is sometimes requisite for the pursuit of this end. However helpful the medicalization of certain physiological conditions has proven, medicine needs to be circumscribed according to a prior image of humanity and the characterization of care that this image supports. Medical ends are subordinate to human ends; that is, both their content and their limitations are constrained by the intrinsic value derived from human ontology and the value to be achieved in human actualization. Medicine exists for the relief of human pain and, moreover, to provide patients with the physiological capacities necessary for the pursuit of the ends of human life.[71] Bearing in mind that a patient's pursuit can, owing to various physiological and nonphysiological factors, be rich or diminished, what legitimates medical intervention at its base is that medicine contributes to the patient's wellbeing, which itself is required for such pursuits. If medical acts preserve human life yet fail to contribute to wellbeing, the auxiliary medical end of preserving life is no longer properly ordered. It is at this point that life preserving efforts should be allowed to cease, though various palliative and other nonmedical ways of caring—ones that more effectively contribute to the individual's wellbeing—continue.

In short, care is the outworking of charity. The practice of medicine is a particular, very specialized expression of this outworking. Both care in general and medical care in particular are mandated by affirmative obligations, which do not need to be acted out in

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[69] Hauerwas, "Care," in *On Moral Medicine*, 1st ed., ed. Lammers and Verhey, 263.
[70] Cf. Pellegrino and Thomasma, *For the Patient's Good*, 32.
[71] See Walter, "The Meaning and Validity of Quality of Life Judgments," 79-80; and Shannon and Walter, "The PVS Patient and the Foregoing/Withdrawing of Medical Nutrition and Hydration," 645.

every circumstance. The difference between the two is that the genus of care is worked out in a variety of ways, and it is rare that no demonstration of care ought to be expressed. Medicine, by contrast, has a much more limited domain—human physiology—and its activity in this domain is constricted by considerations beyond the limits of its own proximate efficacy. Thus, there will be many instances in which medicine need not be engaged to fulfill moral obligations to others, even those on the brink of death.

5.3.2 Medicine as a Tragic Practice

It has already been established that medicine is, at root, justified by a moral concern for the ill. But if it is the case that medicine is limited not only by its own internal standards of excellence but also by the thresholds of human mortality and finitude, this practice will also be a tragic one at root.[72] For the success of its efforts is never final. At some point, a lack of benefit or grave burdens will stand in the way of acting out the obligation to care for the patient's health and the auxiliary obligation to preserve life. The kind of care medicine offers is one directed toward those who are "destined to die."[73] It will always end in a loss of the ontological goodness of the human patient. What is more, medical practitioners are perhaps more acutely aware of human mortality than the rest of us. It must be said, however, that this tragedy is different from reducing medical practice to a futile endeavour. Medicine is made no more futile by its tragic limitations than human life is made futile in its finitude. On the contrary, the obligation to care stands; as an enterprise, medicine is morally necessary and its efforts toward human health must never end. Hauerwas puts it this way: "Medicine is a moral art because it must be guided by convictions that sustain the effort to care in the face of death."[74]

Reminiscent of MacIntyre's observations of virtuous practices descending into vice, Ricœur observes that tragedy often results when constructs at the moral level, which are, in the first place, erected as means for pursuing the ethical aim, confound the ability to reach that aim by failing to measure up to the complexities of life.[75] The development of medical tragedy comes into play here. Being oriented toward the ethical aim, or the pursuit of the ends of human life, one will understand the derivative obligation to care for

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[72] This is an idea that both MacIntyre and Hauerwas have traced. See MacIntyre, "How Virtues Become Vices," 97-111; and Hauerwas, "Medicine as a Tragic Profession," in *Truthfulness and Tragedy*, 184-202.
[73] Hauerwas, *Truthfulness and Tragedy*, 178 and 182.
[74] Ibid., 186. Cf. Hauerwas, *Suffering Presence*, 107.
[75] Ricœur, *Oneself as Another*, 249.

the wellbeing and flourishing of oneself and others. One expression of this is the amelioration of physiological impairments through the specialized practice of medicine. Thus, medicine exists as a moral response to the natural evils of human suffering, ailment, decline, and untimely death. But medicine has proven itself incapable of eradicating the effects of physiological impairment on flourishing. Recall the medieval assertion that, whereas particular ailments are only conditionally necessary, illness itself is absolutely necessary. No variety of technical or moral expertise will change this fact.

But moral constructs such as medicine need not be internally unsuccessful to fail to correspond with the ethical aim. As Jonas indicates in his exploration of the dynamics of technology, the achievement of the end can be frustrated by the very success of the means. The very technical and moral standards of excellence that govern medicine's activity today can themselves compound the tragedy of medicine. Today, medicine's tragic character often does not correspond to the utter inability to provide medical care. When faced with certain classes of patients, medicine is confronted by the tragedy built into its own apparently virtuous operations: despite the development of multiple options for acting, despite the variety of effects that can be produced on a human body, there is yet no way to contribute to the larger good of the patient. Here, the condition of persistent vegetation is recognized in its full force as a medical tragedy. That is, it not only exemplifies the intractable fragility and mortality of the human condition; it proves that the ameliorative efforts of medicine can add insult to injury in a very real sense. Lacking the foresight Jonas so greatly covets as a complement to human technological power, medicine has applied ANH to a new class of patients (the unconscious), resulting in a new and tragic condition. In this situation, ANH separates the proximate ends of the nutritive capacity from their larger ends at the rational and sentient levels. The promise of medicine in preserving a basic capacity does nothing to enable the working out of the potential of higher capacities. Now caregivers for vegetative patients have two choices: either allow for imminent death (a natural evil), or save life by imposing an existence apart from any potential for actualization beyond the physiological level. Granted, it is the underlying medical condition of the patient that prevents the soul's expression at the sensitive and rational levels. But it is the medical intervention that is responsible for

stabilizing and sustaining this condition. This being the case, is it not possible that the latter option promotes, however inadvertently, a moral evil?

It might be that the traditional medical-moral obligation to preserve life is upheld by the continuance of ANH. The obligation is upheld, though, in a way that makes it primary and not auxiliary to human benefit. This is to neglect the ethical aim that gives character to the content of moral norms. It is to forget the narrative of human life, a narrative in which human value, though intrinsic, is contingent and limited. Moreover, it does this by taking up technology as the silent partner of medical ethics at the end of life. This has the unintended effect of allowing technology—that is, the human will to power exercised through the now uncontrollable, unpredictable medium of the artefactual—to impose its own agenda on the ends of medicine and the image of humanity. Now human lives are reclaimed and sustained in PVS with no further aim. They are not sustained in order to allow for or encourage the flourishing for which the patients are meant. No human ends can be reached by patients whose inability to operate at the perceptive and sentient levels prevents them from actualization through relationship. Absent, even, is the meaning that is found in struggling through adversity, whether the one who struggles succeeds or not. The fact that the intrinsic dignity of PVS patients remains, that no ontological change is manifest, does not mean that these patients are immune to the effects of the liminality imposed on them by this medically created and sustained condition.

Although Jonas and Ricœur share a sense of the inevitability of tragedy, this does not mean there are no moral lessons to be learned from tragedy. In this regard, Jonas commends the heuristics of fear and a return to the normative concept of the image of humanity to ground further technological action. Ricœur makes the connection between practical wisdom or prudence and tragic wisdom by mandating a return to the ethical aim.[76] The genus of care responds to normative indications of a theological or philosophical anthropology. Prudence in end-of-life medicine comes in recognizing how to reconstruct moral activity in a way that avoids the digression from medical virtue to medical vice. In the case of PVS, that no constructive good is accomplished in allowing the patient to die does not mean that this is not a better option than preserving the

[76] Ricœur, *Oneself as Another*, 247.

patient's life. Physiological conditions sometimes inevitably prevent human flourishing, something that can only be relieved in death. Although not to be pursued, death can be accepted by the Christian as the gateway to immediate friendship with God. This is as true for the one who is dying in intractable pain, whose life can be medically extended, as it is for the PVS patient. The preservation of life, though generally respectful of the value of the individual, ought to be remembered as an activity aimed at serving larger ends of the human being. When it fails to do so, its own purpose is exhausted, and life preserving means should be recognized for their lack of proportionate benefit rather than used to "upgrade" a terminal condition to one of unparalleled inability.

Thus, it is possible that many decisions to remove life preserving means are not based on a dualist view of the human being but rather on a reaction against the kind of medicalization that, in its efficiency, only ministers to one part of the patient at the expense of the whole patient. In fact, it might be said that it would be dualism to protect only the patient's physiology (since this is all that ANH can do for a PVS patient) when the functional integrity of the individual cannot be restored. By contrast, it would honour the patient's dignity to allow for the removal of preservative means and engage in other activities of care.

In an address delivered only months after his 2004 allocution on vegetative state, Pope John Paul II observed something similar. It is important to note that in this later address he spoke in terms of aggressive medical treatment and not ANH *per se*. He also allowed that sustaining human life beyond any further result is of legitimate medical benefit to a patient. Thus, this address did not overturn his earlier comments on the obligation to preserve vegetative human life. However, if it is correct to say that what is "aggressive" is to be determined according to the patient's condition, in light of the benefits and burdens the means presents to that patient, and not according to a predetermined moral bifurcation of basic care and medical treatment, the pope's comments become of great interest in a discussion of the legitimacy of removing disproportionate medical means:

> True compassion…encourages every reasonable effort for the patient's recovery. At the same time, it helps draw the line when it is clear that no further treatment will serve this purpose. The refusal of *aggressive treatment* is neither a rejection of the patient nor of his or her life. Indeed, the object of the decision on whether to begin or to continue a treatment has nothing to do with the value of the patient's

> life, but rather with whether such medical intervention is beneficial for the patient….Consequently, the decision to forego aggressive treatment is an expression of the respect that is due to the patient at every moment.[77]

As I have already shown, the same description can be applied to the withdrawal or withholding of life preserving but disproportionate medical means. The removal of means that prevent an otherwise imminent and inevitable death does not, in many circumstances, indicate a devaluing of the patient's life. Instead, it speaks to the disvalue of the medical means themselves in light of the patient's condition. It is, in fact, an expression of honour toward the patient's life.

The endurance of tragedy shows that it is not the job of ethics to make moral agents feel better about themselves or about the human condition. As Jonas has it, death remains at once friend and enemy, blessing and curse. It is the task of ethics to open the eyes of responsible agents to the reality of the moral situation and the limits it imposes for action—neither to relieve one of obligation nor to oblige beyond the boundaries of proportionate moral action. In wresting out a fitting action from such circumstances, there will inevitably be "unhappy trade-offs."[78] Tragedy lies in a borderline state. Medicine will never be relieved of this position. But a trade-off, when it is the only response to the constrictions of natural evil, is not a moral compromise.

5.3.3 Beyond Medical Intervention: The Care of Friends

Medical ends, such as the restoration of health and the preservation of life, are important but nonabsolute pursuits. Indeed, sometimes medical interventions are rightly neglected for the sake of a prevailing value. Although this idea requires special emphasis today, it is not a new idea or one alien to the considerations of the early proponents of the OEMD. When curative or ameliorative efforts are successful in producing effects on a patient but unsuccessful in serving the larger human ends at the sentient and rational levels, the respect medicine shows to the image of humanity in a particular patient is demonstrated in its own cessation, or in the application of purely palliative, non-life preserving efforts. The patient is allowed to succumb to the effects of the physiological condition, but this need not entail abandonment of the patient by family and friends, as

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[77] John Paul II, "To the Participants in the 19th International Conference of the Pontifical Council for Health Pastoral Care," (November 12, 2004), §4, http://www.vatican.va/holy_father/john_paul_ii/speeches/2004/november/documents/hf_jp-ii_spe_20041112_pc-hlthwork_en.html. Emphasis in original.

[78] This is Hauerwas' term. *Truthfulness and Tragedy*, 201.

those who advocate the maintenance of treatment in cases of PVS often suppose. Rather, patients ought to be attended to as friends, not as subjects of medical interventions. In fact, at this point in the analysis, it might be appropriate to cease using the language of patient and instead take up the language of friend. In the withdrawal of treatment, care of friends is not sacrificed, nor is their dignity or value degraded; at the same time, the tendency of novel technological capacities to expand ethical responsibilities and impose new ends is avoided.

Those who care for the patient (now friend) can do so based on a variety of roles: child, parent, family member, health care professional (in the case of palliative and nursing administrations), clergy member, and friend. I would like to subsume all of these roles under the role of friend as considered philosophically: the basic characterization of the one engaged in social relationship. Friendship, it will be recalled, is among the final ends of humanity according to Aristotle. In chapter two I made mention of the function of friendship in actualizing human beings. Ricœur calls this the "*mediating* role of others between capacities and realization."[79] Medicine serves the role of mediating between physiological capacities and their actualization. Friendship does the same for the higher capacities of a human. Serving this purpose, friendship is rightly considered a virtue. It is the friend who is required to bring one from the state of lack that results from only inward movements to the state of actualization that results from outward and reciprocated movements: "But your friend, since he is another yourself, supplies what your own efforts cannot supply."[80] Among other things, friendship supplies one with the perception of one's own actualization and regard for the actualization of others.[81] It is this kind of mutual recognition, according to Aristotle, that fosters affection for others and concern for their wellbeing. This is one explanation of the origins of care.

When specialized ways of caring fail, what is left is to care for the ill one as friend, as member of the human community, as a being moving toward actualization, despite illness. Sometimes, acting out this friendship is as simple as remaining present with the other. In fact, Ramsey considered the OEMD to help determine when there arises "the duty only to care for the dying, simply to comfort and company with them, to be

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[79] Ricœur, *Oneself as Another*, 181.
[80] Aristotle, *Nicomachean Ethics*, 9.9.1169b6-7.
[81] Ibid., 9.9.1170b1-14.

present to them."[82] This role of being present with or for others is critical, especially during the isolating experience of pain, suffering, and decline. Baptist theologian James McClendon has described presence itself as a virtue, "the quality of *being there* for and with the other," which exists between the extremes of "nosiness" and "avoidance or alienation."[83]

Of course, this role becomes problematic when the ailing friend is in a vegetative state. If it is decided that life preserving means may legitimately be withdrawn from this individual, what is to say that nonspecialized forms of care may not also be withdrawn? What is to say that such patients must not be left alone in their dying? As already discussed, there is no possibility for the vegetative patient's higher actualization, which is a function of friendship. After all, Aristotle defined friendship as reciprocated goodwill.[84] How is one to remain in friendship with such a being? Without reciprocity, can this relationship properly be called a friendship? Ramsey expressed this idea differently. Like medicine, care itself has inherent limits. Patients should be cared for as long as they can receive that care; but when they are "irretrievably inaccessible" to care, it may cease.[85] If the vegetative patient is in a condition of, as Ramsey puts it, "impenetrable solitude," what good does being present with the dying patient offer? Even the value of compassion, the act of "suffering with," is compromised in this instance: there is no "shared" suffering to be had with a patient who cannot experience the constraints of this physiological condition.

But there is another expression of care to consider. Aristotle also says that friendship consists more in loving than being loved.[86] I believe, then, that there is room to explore the virtue of *presence* as a legitimate expression by the friends of the unconscious, imminently dying patient. And if natural friendship is perfected by the theological virtue of charity, infused through the friendship of God, caregivers are freed up to care for the friend in the radically isolated moment of death.[87] Remaining "with" patients in their dying signals their enduring membership in the human community. Brice

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[82] Ramsey, *The Patient as Person*, 1st ed., 125.
[83] James William McClendon, Jr., *Systematic Theology: Ethics* (Nashville: Abingdon Press, 1986), 106.
[84] Aristotle, *Nicomachean Ethics*, 8.3.1155b34.
[85] Ramsey, *The Patient as Person*, 1st ed., 160. Cf. Hauerwas, *Truthfulness and Tragedy*, 177.
[86] Aristotle, *Nicomachean Ethics*, 8.8.1159a28-35.
[87] Aquinas, *Summa Theologica*, II-II, q.23 a.1.

de Malherbe upholds the values of accompanying and not abandoning PVS patients, affirming presence even though such patients are beyond the reach of this presence.[88] In fact, if it is to be affirmed that intrinsic dignity is not lost to the PVS patient, but only the possibility for actualizing the higher human capacities and flourishing as a human being is gone, remaining present with the patient in death will serve to acknowledge this. Although the friendship is not mutually active, what is conferred in the presence of the friend is the recognition that the patient is a human being—often, a human being to whom one has been related in a particular and meaningful way. Although there is no *appreciable* benefit to patients themselves through this action, their abandonment through avoidance ought to be regarded as an affront to their dignity.

There is, perhaps, a connection to be made between being present with another and bearing witness. Bearing witness is, of course, prefigured in martyrdom. But although caregivers often suffer as a result of the affliction of a loved one with PVS, martyrdom carries additional connotations that are unhelpful here. Bearing witness expresses the act of being present with and for someone else, though no appreciable benefit can come of it. It is most forcefully exemplified by those who choose to bear witness to atrocity, although they are incapable of stopping it, and although they could themselves escape the situation. Lt.-Gen. Roméo Dallaire is a contemporary example of this. The commander of the United Nations peacekeeping mission to Rwanda in 1994, Dallaire struggled to watch as a ceasefire unravelled and the country descended into genocide. Initially, the United Nations forbade the contingent from intervening in the violence. Slowly, Dallaire's forces were withdrawn from him until he was left with an ineffective contingent. Eventually, he was all but ordered to vacate the country. Dallaire refused to abandon his post and the Rwandan people, insisting that there was some value in remaining as a witness to the atrocities for the sake of the people experiencing them.[89] Bearing witness was the only activity left to Dallaire when all constructive efforts toward the avoidance or amelioration of harm were exhausted. This is an extreme and dramatic example, and the natural evils of illness and death are not to be compared with the moral evil of genocide. But the

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[88] de Malherbe, *Le respect de la vie humaine*, 115-16. de Malherbe also, however, upholds the value of maintaining treatment, even though the patient cannot experience its benefit.

[89] Dallaire documents the account in *Shake Hands with the Devil: The Failure of Humanity in Rwanda* (Toronto: Vintage Canada, 2003). See esp. 295.

example captures the essence of what it is to choose freely to remain present with another in disaster. For caregivers of the unconscious, dying patient, it is to insist on bearing witness to their existence, to their decline, to their humanity. It is a crucial act for recognizing that human nature can be as fragile as it is capable. When no benefit can be offered to a patient, even in the form of very "basic" kinds of care, there remains an obligation to accompany the dying patient, to be present at the end, however futile the action might appear.

Allowing for a patient to die in the company of friends does not relieve the sense of tragedy about the situation. The roles of the medical practitioner, elsewhere so powerful, and of medical technology, elsewhere so encompassing, have limits that betray a sense of irony. I am suggesting that the inability to fulfill an affirmative duty of the law, the preservation of life and health, is tragic. Moreover, the ineffectiveness of friends in caring for a patient in a vegetative state compounds the tragedy—for here the efficacy of one's action is entirely out of one's hands, even in an age of pervasive technology. All that is left is to be present. But it is this action that reveals that caregivers have learned to respond appropriately to tragedy. Now, the most basic definition of care surfaces:

> Caring is not to be identified with curing but with our willingness to be with another even though he is dying. Care is the insistence that human community is not destroyed at the first sign of death, but extends to and through the moment of death.[90]

Medical practice must remain a clearly defined enterprise, one whose value is nonabsolute and whose practice is sometimes unavoidably tragic. The good of medicine is associated with the kind of activity in which its practitioners are experts. But the good it accomplishes is not an ultimate end but an end that is also a means to a larger end. Medicine will be regarded as a practice consisting of virtuous activity with internal goods, including relieving human pain and protecting, preserving, and restoring human health. By extension, it also protects, preserves, and restores human life insofar as this supports the ends of the human being. This will mean that the preservation of life is a prerequisite for meeting this goal of health, but it is not a morally obligatory task if health is impossible to attain. Medicine, pertaining directly to physiological health, finds its moral

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[90] Hauerwas, *Vision and Virtue*, 181.

justification in its contributing role to the total life of the human being in community, and not first of all in its efficacy with regard to physiological functioning.

Together with this, the long-held understanding of caring for the sick must be upheld. Determining whether imposing or refraining from life preserving means at a given time is appropriate requires some practical wisdom. By placing the role of friend alongside that of medical practitioner, the importance of the ethical activity of being present with vulnerable or dying patients, bearing witness to their existence, is brought to light. The duties of medicine do not extend to preserving life beneath a very basic standard of health. The duty to care endures.

Chapter 6
The OEMD and the Persistent Vegetative State

Following the theoretical and ethical examination of medicine taken up in the previous chapter, what remains is to assert clearly the role of the OEMD in negotiating treatment decisions for vegetative patients whose condition is permanent. It has been expressed throughout this thesis that questionable benefit is offered by ANH when the latter is applied to the patient who is not expected to regain consciousness. ANH offers medical success in the sense of life preservation apart from the concept of patient recovery or significant improvement. Thus, treatment withdrawal must be seen as a potentially valid outcome of the OEMD analysis in this case. In order to support this argument fully, some loose ends must be tied up.

In the first place, it is important to address issues that tend to arise in the debate over PVS and treatment withdrawal. The initial section of this chapter will take account of certain diagnostic and prognostic issues when it comes to the vegetative state. The second section will address two other issues about caring for the PVS patient that lead some to maintain treatment: the likening of the vegetative state to a disability and the fulfillment of the Christian command to feed the hungry. Finally, this thesis has rightly concentrated on the lack of proportionate benefit PVS patients receive from ANH. In the concluding section I will address how the burdens of the OEMD pertain to PVS patients, and succinctly define the role of the OEMD in the case of PVS.

6.1 The Vegetative State

Prior to taking up the role of medical treatment for a PVS patient, it is important to account for certain disputes about the broader medical approach to PVS. One is a dispute over the accuracy of the diagnosis of vegetative state and, subsequently, that of the prognostic indications associated with persistent and permanent vegetation. The second is a dispute regarding the very validity of the diagnosis in the first place.

At the commencement of this thesis, the distinctions of the vegetative state, the persistent vegetative state (PVS), and permanent vegetation were presented. To recapitulate, the vegetative state indicates wakefulness without awareness of oneself or one's environment, and is due to severe brain damage that largely spares the brainstem (and attending cardiorespiratory and autonomic functions) but greatly affects the cerebral

hemispheres, the portions of the brain responsible for cognition. A vegetative state is deemed persistent or chronic after being stabilized and sustained for several weeks, and the prognostic judgement of permanence or irreversibility is made after several months. There is no treatment that induces recovery from this condition, and the brain continues to atrophy as the condition persists. But the provision of ANH, along with nursing care, can sustain the patient until a complication of the vegetative state ends the patient's life.

6.1.1 Diagnostic and Prognostic Difficulties

Neuroimaging and neurodiagnostic tests can help determine the anatomical nature of the brain damage sustained in vegetation. They can also observe the "sleep-wake cycle" of the vegetative patient and detect the progressive decrease in brain metabolism. However, a diagnosis based solely or primarily on neuroanatomical features and neuroactivity—the kind that might be considered medically objective—is insufficient to diagnose a patient as being in a vegetative state. Different types and severities of brain injury can result in a vegetative state, and sometimes the anatomical features of a patient in a vegetative state can correspond with those of a patient with advanced dementia who retains cognitive features.[1] Even so, there are certain anatomical features, notably severe brain lesions, that can help confirm a diagnosis. For instance, following global hypoxia and ischemia (a lack of oxygen and blood to the brain) the brain typically suffers from diffuse damage to cortical neurons (grey matter), often affecting the thalami but sparing the brainstem and hypothalamus.[2] Alternatively, following acute traumatic brain injury, the brain tends to undergo diffuse axonal injury, in which there is both damage to neurons and loss of neuronal connections (white matter) between the cortex and the thalami, and even the possibility of minor brainstem damage.

However, the diagnosis of vegetative state relies largely on clinical observation, which takes much time and attention on the part of physicians and nurses. If comatose patients have not expired after several weeks, their eyes will open, signalling the end of coma and the beginning of a new condition. (The timing of emergence is much earlier if

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[1] Jennett, *The Vegetative State*, 25-26.
[2] Joseph T. Giacino and Richard Malone, "The Vegetative and Minimally Conscious States," in *Disorders of Consciousness*, ed. G. Bryan Young and Eelco F. M. Wijdicks (Edinburgh: Elsevier Health Sciences, 2008), 103.

the coma is the result of nontraumatic injury.)[3] The determination of this condition, be it a vegetative state, minimal consciousness, or something else, depends on careful surveillance. Bryan Jennett, a pioneer in work on the vegetative state, reports that the opening of the eyes is the condition's only positive identifier. The remaining signals are negative: there is an absence of indication of awareness or purposeful activity.[4] In 1994, the Multi-Society Task Force on PVS identified a more comprehensive list of indicators of a vegetative state: 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 behavioural 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 and spinal reflexes.[5] These signs together make up the clinical diagnosis of the vegetative state, and different medical authorities have developed different tests of verification for each. However, determining the diagnosis is notoriously complicated; in some cases, the diagnosis has been applied incorrectly.[6] It is easy, for instance, to mistake reflex responses for purposeful activity.[7] Family members and caregivers are often susceptible to this misperception. On the other hand, purposeful responses are sometimes missed because of the infrequency of observation or the limitations of particular patients in exercising motor skills. Thus, regular assessment by nurses and physicians is required, and the assessment must take into account any concurrent injuries or conditions as well as the observations of other personnel and even family members or friends who spend significantly more time with the patient. A diagnosis cannot be made on the basis of one or two bedside visits. This is now well recognized in the literature.

The prognostic judgement—the predicted outcome for the vegetative patient—is made several months after the diagnosis. It varies according to the cause of injury, the age

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[3] Jennett, *The Vegetative State*, 9.
[4] Ibid., 10.
[5] Multi-Society Task Force on PVS, "Medical Aspects of the Persistent Vegetative State," part 1.
[6] For instance, see Nancy L. Childs, Walt N. Mercer, and Helen W. Childs, "Accuracy of Diagnosis of Persistent Vegetative State," *Neurology* 43 (1993): 1465-67.
[7] Jennett, *The Vegetative State*, 10.

of the patient, and the duration of the vegetative state up to this point. Prognosis is determined in relation to statistical probability, and, as I have indicated from the outset, the probability for recovery from the vegetative state is statistically miniscule at the time when permanence is established by the medical practitioner. However, probability statistics have indeed been known to conflict with the reality of a particular case. The papal allocution on the vegetative state points out that there are "well documented cases" of emergence following the prognostic indication of permanence.[8] The allocution does not cite any of these cases, so it is unclear which it takes to be convincing. Other documents proceeding from the Pontifical Academy for Life do cite relevant sources.[9] The majority of these "late recoveries" that defied prognosis were recorded prior to the 1994 Multi-Society Task Force report on the vegetative state. Various explanations can be applied to such cases. For instance, up to that point, the diagnostic and prognostic criteria had varied widely, and both instances of misdiagnosis or of early recovery that was only discovered much later might have been mistaken for a late recovery. Indeed, much of the uncertainty on the matter of recovery has been the result of semantics, namely confusion between what it means to be persistently vegetative (having a chronic condition) and to be permanently vegetative (having an irreversible condition). Since the more recent establishment of diagnostic and prognostic criteria, significantly fewer late recoveries have been reported.[10] Given circumspection and vigilance, accurate diagnoses—those in conformity with clinical standards—and prognoses—those that are statistically reliable—are possible. However, it must be accepted that, as Pope John Paul II said, "science, up until now, is still unable to predict with certainty who among patients in this condition will recover and who will not."[11] There are unpredictable exceptions.

6.1.2 Consciousness and Unconsciousness

Throughout this thesis I have asserted the importance of the capacity for consciousness or, as Aristotle has it, perception. An individual must be awake and aware

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[8] John Paul II, "Life Sustaining Treatments and Vegetative State," (2004), §2.
[9] In particular, see Gian Luigi Gigli and Mariarosario Valente, "Quality of Life and the Persistant Vegetative State," paper presented at the Eleventh Assembly of the Pontifical Academy for Life, (February 21-23, 2005), http://www.academiavita.org/template.jsp?sez=Pubblicazioni&pag=testo/qual_vita/gigli/gigli&lang=english.
[10] Jennett, *The Vegetative State*, 64.
[11] John Paul II, "Life Sustaining Treatments and Vegetative State," (2004), §2.

to carry on beyond the nutritive level. However compromised the efforts of those with severe neurological or psychological afflictions toward various kinds of actualization may be, their basic openness to human actualization at the sensory and rational levels ought not be put into question. This is the case even when their efforts are limited by susceptibility to distress or a lack of memory that disrupts their own sense of biographical identity—two qualities that are common to many with degenerative mental conditions. It is also the case when conscious awareness is intermittent and fleeting, as is the situation for the minimally conscious patient or one receiving palliative sedation. Other patients, however, are persistently unconsciousness, lacking even the minimal capacity to perceive the self and what is other than the self. As I set out in chapter two, for such patients, *friendship* with oneself and with what is other than the self is impossible.

Some, however, have challenged the critical importance of consciousness to an individual's capacity to achieve human ends, particularly the engagement with spiritual pursuits that do not directly involve interaction with other people. It must be asked, then, is consciousness truly critical to properly human acts, in the Thomistic sense of the term? The question can be treated as a scientific one, the answer to which needs to be determined by observable and verifiable means. This, I think, is the wrong approach. Consciousness was understood as the foundation for human sensory and rational activity long before neuroimaging techniques were made available. It has been assumed in the Christian bioethical tradition to be a critical function for the activity of the rational soul, including human subjectivity and relationship, and this ought to be highlighted. The importance of consciousness is often made apparent in Protestant and Catholic discussions of palliative or terminal sedation—the partial, intermittent, or full relief from consciousness that is medically achieved for a patient dying in intractable pain. Although no consensus exists in the Protestant community on the acceptability of sedation before death, bioethicists tend to be cautious on the matter of full or unremitting sedation. One ethicist, Howard Ducharme, has called permanent terminal sedation "existential euthanasia," commenting: "the embodied person (soul) is pharmacologically imprisoned, kept in embodied silence and solitary confinement from all consciousness and personal

interaction with others and the world."[12] Another, Robert Orr, who accepts terminal sedation for cases of unremitting pain, has also expressed reservations about attempts to treat psychological suffering with sedation.[13] Similar concerns about dying in an unconscious state are articulated in philosophy. One need look no further than Hans Jonas, who argues for the importance of coming to terms with death, something with which medical interventions should not interfere: "there is also the right to 'own' one's death in conscious anticipation—really the seal on the right to life as one's own, which must include the right to one's own death."[14] Pope Pius XII, in addressing sedation, noted the critical connection between consciousness and relationship with God. He indicated that sedation before death is acceptable if it is the only way to remove very burdensome and intractable pain. However, he also commented that, by fully or partially depriving a patient of consciousness, treatment dulls "the higher faculties in such a way as to paralyze the psychic control mechanisms which a man constantly uses for self mastery and self direction."[15] Self mastery and self direction were also discussed in relation to the potential burdensomeness of unconsciousness—even temporary unconsciousness—earlier in the works of Catholic manualists.[16]

Consciousness before death has thus taken on a spiritual significance in Christianity, most notably in Catholicism. Self mastery and self direction are considered important for prayer and communication with God; therefore, the deprivation of consciousness, especially before death, should be avoided only for a serious reason.[17] The Catholic *Declaration on Euthanasia* holds that "a person not only has to be able to satisfy his or her moral duties and family obligations; he or she also has to prepare himself or

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[12] Ducharme in Robert J. Kingsbury and Howard M. Ducharme, "The Debate Over Total/Terminal/ Palliative Sedation," Center for Bioethics and Human Dignity (January 24, 2002), http://www.cbhd.org/resources/endoflife/kingsbury-ducharme_2002-01-24.htm.
[13] Robert D. Orr, "Just Put Me to Sleep…Please! Ethical Issues in Palliative and 'Terminal Sedation,'" *Update* 18, no. 2 (2002): 1-4, 8. Orr justifies his conclusions on the basis of double effect.
[14] Jonas, "The Right to Die," 34.
[15] Pius XII, "The Morality of Pain Prevention," *Catholic Mind* 55 (May-June 1957): 270. Also see Pius XII, "Tranquilizers and Christian Morals," (1958), 438.
[16] J. Gury, A. Ballerini and D. Palmieri, *Compendium Theologiae Moralis*, I, n.391; C67-68. Although the temporary loss of consciousness that is necessary for surgical operations has today been dismissed as a prevalent burden, the fact that in the early days of anaesthesia it was considered at all shows the importance of the "higher faculties" of the human being.
[17] Pius XII, "The Morality of Pain Prevention," (1957), 275.

herself with full consciousness for meeting Christ."[18] This idea of needing to meet God consciously is repeated in *Evangelium Vitae*.[19] The *Ethical and Religious Directives* similarly claims that patients have the *right* to prepare for death while conscious.[20] Imposing unconsciousness for the purpose of pain relief is only acceptable, then, if the patient has already repented of sin and prepared for judgement. The value of consciousness to these activities is again underscored in the *Charter for Health Care Workers*. This document employs the doctrine of double effect, indicating the importance of the intention behind the use of palliative sedation: it is only acceptable to aim at pain relief, not at unconsciousness itself. Sedation imposed for the relief of existential suffering—essentially, to relieve one of conscious awareness itself—is not acceptable.[21] The loss of consciousness is here equated with a loss of freedom. Later, the *Charter* goes on to describe the illicit imposition of unconsciousness in the following way:

> The dying person is deprived of the possibility of "living his own life," by reducing him to a state of unconsciousness unworthy of a human being. This is why the administration of narcotics for the sole purpose of depriving the dying person of a conscious end is "a truly deplorable practice."[22]

If conscious awareness is critical to preparation for death, then relationship with God is presumed to be conducted in conscious ways.

If one is to take this much as evidence for the place of significance granted to human consciousness in Christian theology and ethics, still another question must be addressed. Are vegetative patients truly unconscious? It is the prevailing medical opinion that conscious awareness, along with the capacity to feel pain, is impossible for those in a vegetative state. Although there are remaining reflexes and brainstem activity, such activity is not felt or translated into experience. This opinion is widespread in the United

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[18] Congregation for the Doctrine of the Faith, *Declaration on Euthanasia*, (1980), Part III.
[19] John Paul II, *Evangelium Vitae*, (1995), §65.
[20] United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, Directive 61.
[21] Pontifical Council for Pastoral Assistance to Health Care Workers, "The Charter for Health Care Workers," (1995), §71.
[22] Ibid., §124.

States,[23] the United Kingdom,[24] parts of Europe,[25] and Australia.[26] It is justified by the observation that PVS patients demonstrate no detectable signs of consciousness. That is, there is a lack of clinically observable, purposive responses to environmental stimuli and no evidence of mental activity.[27] However, there are some medical practitioners and philosophers who depart from this view.[28] Those who do not accept that vegetative patients are by definition unconscious or unaware call attention to the fact that consciousness is not subject to empirical observation. They sometimes argue that even the comatose or those under general anaesthesia might be partially aware of what goes on around them,[29] although this is hardly well documented and not a widely held opinion. Many medical bodies do admit the philosophical elusiveness of a definition for consciousness, but it is problematic, according to their critics, that these bodies proceed to state categorically that consciousness, whatever it is, is absent from the vegetative patient: "It is paradoxical that clinical certainty about recognition of loss of consciousness can coexist with an overwhelming uncertainty about *what* has been lost."[30]

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[23] See American Academy of Neurology, "Position of the American Academy of Neurology on Certain Aspects of the Care and Management of the Persistent Vegetative State Patient," *Neurology* 39, no. 1 (1989): 125-26; American Medical Association, Council on Scientific Affairs and Council on Ethical and Judicial Affairs, "Persistent Vegetative State and the Decision to Withdraw or Withhold Life Support," *Journal of the American Medical Association* 263, no. 3 (1990): 426-30; American Neurological Association Committee on Ethical Affairs, "Persistent Vegetative State: Report of the A.N.A. Committee on Ethical Affairs," *Annals of Neurology* 33, no. 4 (1993): 386-91; and Multi-Society Task Force on PVS, "Medical Aspects of the Persistent Vegetative State," parts 1 and 2.

[24] K. Andrews, "International Working Party on the Management of the Vegetative State," *Brain Injury* 10, no. 11 (1996): 797-806; and British Medical Association, Ethics Department, *Treatment of Patients in Persistent Vegetative State: Guidelines from the BMA's Medical Ethics Department* (London: British Medical Association, 2007).

[25] See, for instance, France's Comité Consultatif National d'Ethique, *Opinion on Experimentation on Patients in a Chronic Vegetative State*, (1986), http://www.ccne-ethique.fr/docs/en/avis007.pdf; U. Veronesi, "Italy: Ad Hoc Committee on Artificial Nutrition and Hydration of Individuals in a Permanent Vegetative State," *Journal International de Bioéthique* 4, no. 12 (2001): 75-80; and Dutch Health Council, *Patients in a Vegetative State* (The Hague, 1994).

[26] National Health and Research Council of Australia, "Post-Coma Unresponsiveness (Vegetative State)."

[27] President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Deciding to Forego Life-Sustaining Treatment: Ethical, Medical, and Legal Issues in Treatment Decisions* (Washington, D.C.: U.S. Government Printing Office, 1983), 174.

[28] See François Tasseau et al., *États végétatifs chroniques: répercussions humaines; aspects médicaux, juridiques et éthiques* (Rennes, France: Éditions École Nationale de la Santé Publique, 1991); Peter McCullagh, *Conscious in a Vegetative State? A Critique of the PVS Concept* (Dordrecht: Kluwer, 2004); Paolo Cattorini and Massimo Reichlin, "Persistent Vegetative State: A Presumption to Treat," *Theoretical Medicine* 18, no. 3 (1997): 263-81; and D. Alan Shewmon, "A Critical Analysis of Conceptual Domains of the Vegetative State: Sorting Fact from Fancy," *NeuroRehabilitation* 19 (2004): 343-47.

[29] See D. Alan Shewmon, "The ABC of PVS: Problems of Definition," in *Brain Death and Disorders of Consciousness*, ed. Calixto Machado and D. Alan Shewmon (New York: Springer, 2004), 220.

[30] McCullagh, *Conscious in a Vegetative State?* 83.

The papal allocution on the vegetative state also indicates sympathy for the possibility that vegetative patients do experience suffering. In affirming the morally ordinary status of all kinds of nutrition and hydration, Pope John Paul II specified that the proper finality of ANH for a vegetative patient is "in providing nourishment to the patient *and alleviation of his suffering*."[31] He went on to say:

> It is not possible to rule out *a priori* that the withdrawal of nutrition and hydration, as reported by authoritative studies, is the source of considerable suffering for the sick person, even if we can see only the reactions at the level of the autonomic nervous system or of gestures. Modern clinical neurophysiology and neuro-imaging techniques, in fact, seem to point to the lasting quality in these patients of elementary forms of communication and analysis of stimuli.[32]

The allocution does not cite any sources for this latter observation, which contradicts the majority medical opinion.[33] In fact, a lack of consciousness in vegetation is often defended on the basis of the neurological damage sustained, corroborated by neuroimaging techniques. Positron-emission tomography scans can reveal a lack of neocortical activity in a PVS patient, similar to the condition of the brain under surgical anaesthesia.[34] Moreover, autopsies of PVS patients indicate a decisive anatomical fact: bilateral damage to the cerebral hemispheres is extensive enough to make consciousness impossible according to the medical understanding of brain functioning.[35] "It is a fundamental fact of neuroanatomy and neurophysiology," say Ronald Cranford and David Smith, "that consciousness and the capacity to experience pain and suffering are functions of the neocortex."[36] In the PVS patient, the structural features required to support consciousness are gone. Still, others have begun to question the reliability of leaving consciousness exclusively to the domain of the neocortex. As the argument goes, the fact that, for a healthy brain, a given structure is involved in a given function does not mean this relationship is a necessary one, and certain shifts in function may be made by

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[31] John Paul II, "Life-Sustaining Treatments and Vegetative State," (2004), §4. Emphasis added.
[32] Ibid., §5.
[33] Cf. Multi-Society Task Force on PVS, "Medical Aspects of the Persistent Vegetative State," parts 1 and 2.
[34] Ibid., part 1.
[35] Ibid. Cf. American Academy of Neurology, "Position of the American Academy of Neurology," 125.
[36] Ronald E. Cranford and David Randolph Smith, "Consciousness: The Most Critical Moral (Constitutional) Standard for Human Personhood," *American Journal of Law & Medicine* 13, nos. 2-3 (1987): 237.

the compromised brain in order to compensate for a damaged neocortex.[37] Indeed, studies in neuroplasticity are novel and groundbreaking, although no breakthroughs relevant to the vegetative state have been made. Still, it must be admitted that consciousness, in the end, is not subject to evidence-based medicine. No one has direct access to the consciousness of another; one may only infer consciousness based on certain signals.[38]

6.1.3 Kinds of Certitude

Despite the apparent doubts about diagnosis and prognosis, and about the nature of consciousness itself, some facts must be recognized. Coma, the vegetative state, and the minimally conscious state are all disorders of consciousness that are technologically sustained. Over time, the vegetative state has come to be recognized in distinction from coma, the former being signalled by activity limited to the brainstem and the attending "sleep-wake cycle." Likewise, the minimally conscious state has come to be recognized in distinction from the vegetative state, indicating awareness that consciousness is a spectrum and can persist even at very low, yet detectable, levels. The significance of this is that medical practitioners are not unaware of the troubled relationship between brain injury and consciousness. If the vegetative state cannot be definitively verified by objective standards of measurement at this time (or ever), the step of defining the criteria for its diagnosis and prognosis represents a movement toward greater accuracy in judgements about particular classes of patients, not a regression. The standards for medical judgements about vegetation are in conformity with current medical knowledge as it has developed in the past several decades. (It must not be forgotten that these judgements are also made in conjunction with the new technological capacity to introduce and sustain vegetative human life.)

It is possible to ameliorate the uncertainty that comes with the difficulties of defining and judging the presence of consciousness, and of imposing a standard for clinical diagnosis and statistical probability for prognosis, if the difference between medical and moral certitude is understood.[39] Medical or scientific certitude, sometimes

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[37] Shewmon, "A Critical Analysis of Conceptual Domains of the Vegetative State." Also see McCullagh, *Conscious in a Vegetative State?* 44.
[38] Patrick Verspieren, "Un terme à la recherche d'une signification. Que dire des patients en état végétatif?" in Tasseau et al., *États végétatifs chroniques*, 40.
[39] The terms are common in Catholicism. See Michael James Ryan, "Certitude," in *The Catholic Encyclopedia*, vol. 3 (New York: Robert Appleton Company, 1908), 540.

considered in conjunction with physical certitude, is the kind of certitude that is fact-based, achievable through an application of the scientific method. It is testable; its results are reproducible or consistent over time, and so it is taken to rest upon the "laws of nature" as perceived through experience.[40] The general medical consensus is that the vegetative state can be diagnosed with a reasonable degree of medical certitude through clinical observation and examination of the brain.[41] At the same time, it must be recognized that, as a science, medicine's search for knowledge is ongoing. The "abstract universals" on which certitude depends receive further qualification with time and experience. Although medical practice accurately reflects the medical knowledge of a given point in time, medical knowledge may not be completely reflective of the reality of the objects known to it.[42] Scientific epistemology typically yields a partial view of reality, even if its observations of that part are taken to be accurate. Medical certitude indicates what can be presumed, or what is persuasive or compelling, given the medical evidence. It bears the paradoxical nature of combining an *a posteriori* method with the demand of predictive reliability. Medical-technological tools of measurement are designed to detect what is supposed, based on experience, to be indicative for a condition. Likewise, prognostic judgements will often depend on what has happened in the past given similar circumstances. As Charles Curran has said, this is not absolute certitude, but a working certitude that holds so long as nothing better comes along.[43] It has been shown that for the OEMD, a standard of *reasonable* hope of benefit is applied. Now it is seen that even medical certitude itself is based on what is reasonable to suppose. Medical practitioners, though not closed to anomalies, must in practice rely on what is medically certain (that is, certain given medical knowledge), basing their diagnostic, treatment, and prognostic judgements on it. For those philosophers who doubt that a particular diagnosis carries medical certitude, it is important to recall that not even medical certitude is absolute certitude, but a partial view of reality.

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[40] The term "medical certitude" is also invoked in court through the expert testimony of medical practitioners. But on its inconsistent meaning in the legal arena see Robert D. Miller, "Reasonable Medical Certainty: A Rose by Any Other Name," *Journal of Psychiatry and Law* 34, no. 3 (2006): 273-90.
[41] Gastone G. Celesia, "Persistent Vegetative State: Clinical and Ethical Issues," *Theoretical Medicine* 18, no. 3 (1997): 223.
[42] Raphael Sassower and Michael A. Grodin, "Scientific Uncertainty and Medical Responsibility," *Theoretical Medicine* 8, no. 2 (1987): 228-29.
[43] Charles Curran, "Absolute Norms in Moral Theology," in *Norm and Context in Christian Ethics*, ed. Gene H. Outka and Paul Ramsey (New York: Charles Scribner's Sons, 1968), 169.

Thus, although the two are often opposed, medical certitude interacts with moral certitude, even in a dependent way. Moral certitude is often used in a legal sense ("beyond a reasonable doubt") but it is first of all an ethical notion. The concept is dependent on the oft quoted but seldom heeded observation of Aristotle: "we do not look for the same degree of exactness in all areas, but the degree that accords with a given subject matter and is proper to a given line of inquiry."[44] Moral certitude is based on prudential judgement, one that deals with both abstract universals and practical variables, and openly accepts the need to go with what is most plausible, notwithstanding the fact that this may not be scientifically demonstrable. It accepts that some things can be known with confidence though not subject to proof. Although there may be some supporting evidence for these things that are known, moral certitude does not attempt to elevate the credible to the absolute. Rather, it allows that confidence about a prudential decision may be had despite a knowledge that is less than absolute: "the certitude of probability suffices, such as may reach the truth in the greater number of cases, although it fail in the minority."[45] I have provided examples of moral certitude already in the manualist discussions of the OMED. For instance, de Lugo insisted that the prisoner, condemned to starve and not expecting a regular supply of food, is not obliged to eat the single meal that is smuggled in to him. This was based on moral certitude regarding what would happen in the future. Of course, for the prisoner there would still remain a remote possibility that a regular food supply could be obtained, but this does not change the level of obligation associated with eating the solitary smuggled-in meal; the prisoner has made a reasoned, prudential judgement about what is most likely to occur.

In more recent times, the notion of moral certitude has been brought in to defend the validity of the brain death definition. Pope Pius XII admitted there was a chance the brain dead patient might not actually be dead, but he indicated that there was enough moral certitude to allow for ventilator removal from a brain dead patient.[46] Why this is the case was further explained by Pope John Paul II.[47] No empirical indicator, he claimed,

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[44] Aristotle, *Nicomachean Ethics*, 1.7.1094b28-29.
[45] Aquinas, *Summa Theologica*, II-II q.70 a.2. Cf. I-II q.96 a.1 ad.3 and I q.12 a.7 ad.3.
[46] Pius XII, "The Prolongation of Life," (1958), 396-97.
[47] John Paul II, "To the 18th International Congress of the Transplantation Society," (August 29, 2000), §4, http://www.vatican.va/holy_father/john_paul_ii/speeches/2000/jul-sep/documents/hf_jp-ii_spe_20000829_transplants_en.html.

can directly identify the event or moment of human death, and thus the brain death definition lacks the kind of medical certitude that certain other diagnoses offer. There are, however, biological signs that experience has shown to be indicative of the fact that death has occurred, including the entire loss of brain activity. On the basis of moral certitude that a brain dead patient is dead, the pope was able to speak positively about vital organ transplantation following death. Other Christian theologians have spoken to the same bioethical problem. John Wesley, for instance, discussed the classical notion that the cessation of cardiorespiratory function indicated the event of the soul's separation from the body—the only "medical" standard of which he knew. Yet Wesley was aware of occurrences in which one whose breathing and blood circulation had ceased was later revived.[48] For Wesley, these anomalies did not compromise the moral certitude that could be had in pronouncing a given patient dead when cardiorespiratory function ceases.

It must be admitted that there will be certain medical questions that will go unanswered in diagnosing a patient as vegetative, or in determining this condition to be permanent. It is possible that, even with careful attention to statistical patterns, a patient might incorrectly be determined to be permanently vegetative. Also, the absence of consciousness cannot be definitively measured by medical-technological means. The medical model offers no way to determine that activity specific to a particular region of the brain is absolutely necessary for any kind of conscious experience. Moreover, there is no way to demonstrate that self-awareness and friendship with God are absolutely dependent on certain states of the brain. In the case of friendship with God, theologians are right to say that one must take account of the element of grace at work in this relationship, which is true even for the fully conscious individual. That is, friendship with God is not achieved only or primarily by human capacities but requires first of all the loving action of God. Who is to say, then, whether God sustains mutual friendship with the PVS patient in a way that circumvents conscious awareness? This is a possibility that, for the Christian, cannot absolutely be ruled out. However, the practice of moral certitude is one that relies on what is most credible, not what is marginally possible or conceivable. Thus, if absolute medical certitude is lacking, acting on the diagnostic and prognostic judgements pertaining to the vegetative state can be thought to be dependent on moral

[48] Wesley, "What is Man?" Sermon 109, §12.

certitude.[49] A correlation of clinical factors, brain activity, and neuroanatomy points to a particular diagnosis and prognosis, although these depend on certain non-verifiable presumptions. Medical practitioners and bioethicists alike must operate on the understanding of consciousness as the human way to perceive the self and what is other than the self, since they know of no other mechanism by which to achieve this perception. They must assume that certain kinds and levels of brain activity are foundational for consciousness and that, when present, consciousness can be observable to others, legitimizing clinical diagnosis. They must also accept that a wrong prognosis, even when determined with due diligence, does not necessarily overturn the validity of the prognostic procedure itself.

Although some medical judgements appear to rely on fewer objective standards of measurement than others, at base, medical certitude is subject to moral certitude: it is conditioned by the belief that it is acceptable to act on the knowledge of what is most credible. What moral certainty allows is for prudential action that is authentically moral—that is, action in which there is no self-deception, which is aimed toward the goodness of life, yet which may well admit of doubt. It does not, then, demand that action be infallible. Prudential action, like the practice of medicine itself, is necessarily open to tragedy.

6.2 Other Arguments

Even if moral certainty is accepted as justifying a diagnosis of PVS, the maintenance of ANH continues to be advocated on the basis of two primary arguments. The first is that PVS patients are not dying, but disabled, and deserve to be valued like any other disabled individual. The second is that ANH fulfills the command to feed the hungry. It should be noted that both of these arguments are made possible by technological advances. Without ANH, there would be no perceived obligation to sustain patients who are unable to take in sufficient nutrition orally. Without ANH, and other intensive care measures, what is perceived as a disability would never come to pass, but instead end in earlier death. As I will go on to show, these two arguments are also

[49] See, for instance, the second question put by the United States Conference of Catholic Bishops to the Congregation for the Doctrine of the Faith, in the 2007 document "Responses to Certain Questions": "When nutrition and hydration are being supplied by artificial means to a patient in a 'permanent vegetative state,' may they be discontinued when competent physicians judge with moral certainty that the patient will never recover consciousness?"

compromised by the very technology that produces them. For this reason, they do not threaten the judgement that treatment withdrawal ought to be permissible for the permanently vegetative patient.

6.2.1 The PVS Patient: Disabled?

It should go without saying, contrary to Evangelical bioethicists Emmett and Rakestraw, and contrary to those in the secular bioethical sphere who advocate for a higher brain standard of death, that the PVS patient is not dead. The soul is expressed at the vegetative level. This actualization, namely the nutritive function, though aided and sustained through medical intervention, is not artificially-directed. Nutrients are, rather, metabolized spontaneously by the body. There is, nonetheless, a pathological feature present. The cerebral damage is fatal insofar as it disconnects the capacity to take in sufficient nourishment from the capacity to metabolize it. That is, the swallowing reflex is not engaged proficiently and insufficient, if any, nourishment can be obtained orally. Even caregivers dedicated to hand feeding these patients must supplement their efforts with artificially delivered nutrition and hydration.

However, this pathology does not make death imminent and inevitable, thanks to medical technology. Some would therefore consider it to be indicative of disability. In fact, many defend the intrinsic goodness of the PVS patient in the same manner that they defend the goodness of a mentally or physically disabled individual. Those with PVS are shown to be "persons" like the rest of us, only severely incapacitated.[50] Their disability is a lack of consciousness, along with the incapacity to complete self-nourishment. An attack against the lives of PVS patients, in their view, is an attack on the disability community.

Along these lines it is interesting to note a similar argument made by de Malherbe.[51] From his perspective, the vegetative state, once stabilized, is not an illness but a "state" or condition of human life (as might be said of disability). Granted, it is a condition of radical dependence, but it is a human condition nonetheless. What is owed to the patient are palliative means (including ANH) or means that address the state of

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[50] See Grisez, "Should Nutrition and Hydration Be Provided," 171-86; Meilaender, "Living Life's End," 19; O'Mathúna, "Responding to Patients in the Persistent Vegetative State"; and McCullagh, *Conscious in a Vegetative State?* 175-92.

[51] de Malherbe, *Le respect de la vie humaine*, 129ff.

dependence without necessarily attempting to improve the condition or "combat" an illness. As such, applying ANH is merely caring for a patient, not, in the manner of ventilators or other medical means, aiming to preserve the patient's life unduly. Removing ANH is refusing to carry on supporting the goodness of the life of the one with diminished capacity. It is to deliberately intend their death.

Although it should be evident by now that I accept the intrinsic goodness of the PVS patient, I would argue that the distinction between the disabled and the PVS patient is a qualitative one, although the capacities of technology sometimes cloud this fact. This can be explained by referring to the anthropology laid out in the second chapter and supplemented with concepts provided in Jonas' philosophical biology. Self-actualization has been articulated as requiring a movement outward. Jonas speaks of this movement as present at all levels of life, from the function of metabolism onward, indicating a kind of purposiveness pervasive in life. More recently, others have articulated something similar in supporting the brain death standard. The President's Council on Bioethics has felt the need to defend this standard in the face of occasions wherein a brain dead patient's body has continued to act in an integrated way, perhaps fighting infection or even gestating a fetus. The council rejected the "loss of somatic integration" criterion as definitive for this standard. Instead, it now favours of the criterion of the "cessation of fundamental vital work" of the organism. This is "the work of self-preservation, achieved through the organism's need-driven commerce with the surrounding world."[52] According to the council, this work depends on three capacities: 1) openness to the environment, or receptivity to stimuli and signals from the surrounding environment; 2) the ability to act upon the environment to obtain selectively what one needs; and 3) the basic felt need that drives one to act as one must, to obtain what one needs and what one's openness reveals to be available.[53] If these capacities cease and do not begin again, the human being is dead.

In recounting this description of a living organism, I do not intend to set up the PVS patient as lacking each of these characteristics. The PVS patient, unlike the brain dead patient, is not dead. The council itself does not view these patients as dead, even

[52] President's Council on Bioethics, *Controversies in the Determination of Death*, 60.
[53] Ibid., 61.

pointing to their characteristic activities, such as the "sleep-wake cycle" and reflexes, as indicative of life. All other things being equal, PVS patients retain the above three capacities to various degrees at the vegetative level, or the nutritive part of the soul. PVS patients continue to receive and metabolize the nutrients supplied to them, selecting what is useful and expelling waste. They do all this without external compulsion. The "will" of the body (in the Jonasian sense of the purposiveness present at all levels of life) to continue to live is apparent in such activity. It is this disposition toward life that indicates the enduring presence of the soul, even if the soul is expressed only through nutritive activity.[54] PVS patients are, however, unable to express the above three capacities at the sensitive and rational levels. Nowhere is this clearer than in the very process by which they are nourished and hydrated. Despite the fact that the body acts upon the sustenance delivered to it for survival, the patient cannot seek food in any self-directed way. Further, the involuntary reflex that enables swallowing cannot be consciously controlled, with the result that, even if handfed, having food placed carefully at the back of the throat to trigger the swallowing reflex, the risk of aspiration and the inability to take in sufficient amounts of food threaten proper nourishment.[55] The act of nourishment is in no way voluntary, in no way the patient's "own" action, in the Thomistic sense.

It is significant that the PVS patient operates with an "inner drive" only at the nutritive level, since, according to Christian anthropology, human beings are supposed to have inner drives evident at all levels of the human soul. This indicates something qualitatively different from disability. It is a fundamental inability or a-abledness at the level of human acts, in the Thomistic sense. Permanent vegetation is a condition distinct from conditions of disability in that it absolutely and irreversibly inhibits active human engagement with the world and thus, also, with the self. According to both medical knowledge and the theological anthropology outlined here, there is no way to pursue human flourishing in this condition. PVS patients are entirely prevented from this,

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[54] de Malherbe points this out in *Le respect de la vie humaine*, 149.

[55] Ronald E. Cranford, "The Persistent Vegetative State: The Medical Reality (Getting the Facts Straight)," *Hastings Center Report* 18, no. 1 (1988): 31; and Jennett, *The Vegetative State*, 18. It should be noted that there is not universal agreement on the retention of the swallowing reflex. The Multi-Society Task Force on PVS concluded that both chewing and swallowing reflexes are retained. "Medical Aspects of the Persistent Vegetative State," part 1. However, others have noted that the swallowing reflex is absent. See James L. Bernat, "The Boundaries of the Persistent Vegetative State," *Journal of Clinical Ethics* 3, no. 3 (1992): 176-80.

whereas the disabled are not. The latter have at least minimal consciousness and thus potential for actualization beyond the nutritive level. For instance, Stephen Post shows that those in a state of extreme mental degradation, such as advanced dementia, often still have capacities for things like emotion. He describes their care in the following way:

> The moral task is always to enhance the person with dementia. What cues seem to elicit memory? What music or activity seems to add to well-being? How can capacities still intact be creatively drawn out? How can modalities of touch and voice convey love to the person? Rather than think of people with dementia as out of reach because of forgetfulness, or as unworthy because of cognitive disability, the moral task is to bring them into discourse in creative ways.[56]

But this kind of interaction is not possible for PVS patients. There is nothing sentient to be drawn out of them. The soul depends upon the body for its expression and the body of the PVS patient, incapable of expressing sentience, is damaged beyond repair. Experimental rehabilitation programs such as sensory stimulation or "coma arousal programs" have not proven effective in arousing the patient from unconsciousness.[57] This being the case, it is inappropriate in my view to align PVS patients with the disabled. Intensive care medicine, it seems, has produced a class of declining patients that fit under none of the conventional labels.

6.2.2 ANH: Feeding the Hungry?

In the first days of unconsciousness for those who ultimately will be stabilized in a vegetative state, patients are often given a nasogastric tube for the delivery of nutrition and hydration. This tube is only a temporary measure, unsuited to long term use. It can induce vomiting and aspiration, placing the patient at risk of aspiration pneumonia.[58] Often irritating, it can cause bleeding. Only after the vegetative state is determined to be chronic is a percutaneous endoscopic gastrostomy (PEG) tube inserted through the abdominal wall. Fewer medical complications are associated with this method of ANH.

The giving of food and water, which I have already outlined in relation to the Christian tradition, is a symbolic expression of care. It also, of course, expresses the preservation of life. Because food and water are basically necessary to life, their provision

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[56] Stephen G. Post, "A Moral Case for Nonreductive Physicalism," in *Whatever Happened to the Soul?* 201.
[57] Jennett, *The Vegetative State*, 90; John P. Pierce et al., "The Effectiveness of Coma Arousal Intervention," *Brain Injury* 4, no. 2 (1990): 191-97.
[58] David Major, "The Medical Procedures for Providing Food and Water: Indications and Effects," in *By No Extraordinary Means: The Choice to Forgo Life-sustaining Food and Water*, ed. Joanne Lynn (Bloomington: Indiana University Press, 1989), 25.

is often viewed as a sacred obligation. The pastoral constitution *Gaudium et Spes* quotes the aphorism: "Feed the man dying of hunger, because if you have not fed him, you have killed him."[59] But as I have dealt with the issue of life preservation in discussions of the development of the OEMD, it can be put aside here. Charity, generosity, and community are often claimed to be forfeited when ANH is withdrawn from a PVS patient.[60] One of the most elemental ways to express care for the helpless is to feed them, to relieve hunger pangs, so the withdrawal of feeding mechanisms can be troubling.[61] Such notions fuel the argument to maintain ANH for PVS patients. They are foundational to a view that ANH is "basic care" or "comfort care."

Others have pointed out, however, that providing artificial nutrition and hydration is much different, even on a symbolic level, from eating or hand feeding. Elizabeth McMillan notes that providing ANH is reductive of the task of feeding, being void of any sensory, social, or cultural experience that is associated with eating or eating together.[62] The reason this is so is because PVS prevents conscious experience of any of these elements; ANH itself bypasses the functions of mastication and swallowing, and no one else need be present for the duration of its administration. The benefit of providing this symbol of "care" is vacant if the patient is incapable of experiencing its comfort, which is one of the substantive senses of its symbolic meaning. A further point that must be noted is that, even if one were to doubt the unconsciousness of PVS patients or their inability to experience pain and suffering, it would still be unlikely that ANH would be perceived by the patient as being of much comfort. Sensations of hunger might be relieved, but muscle atrophy and other conditions concomitant with persistent vegetation would impose further pain and discomfort that would not be relieved by ANH. Indeed, ANH would be prolonging a very painful and uncomfortable condition. It would appear that the one who

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[59] Paul VI, *Gaudium et Spes*, (1965), §69.
[60] See Canadian Catholic Bioethics Institute, "Reflections on Artificial Nutrition and Hydration"; Anthony Fisher, "On Not Starving the Unconscious," *New Blackfriars* 74, no. 869 (1993): 130-45; O'Mathúna, "Responding to Patients in the Persistent Vegetative State," 72.
[61] Daniel Callahan once argued that the importance of the symbolic meaning of feeding is in its manifestation of basic social instincts and their concomitant emotions. For instance, there can be deep-seated revulsion at the cessation of ANH. Daniel Callahan, "On Feeding the Dying," *Hastings Center Report* 13, no. 5 (1983): 20. For a number of reasons, he has since revised his position and now allows for the removal of ANH.
[62] Elizabeth McMillan, "The Catholic Moral Tradition on Providing Food and Fluids," *Linacre Quarterly* 54, no. 4 (1987): 59-60.

offers ANH to the PVS patient as a means of comfort must also be compelled to offer measures of pain relief, although this is something not often admitted.

In claiming the sensory, social and cultural benefits of eating or sharing a meal, I do not deny that feeding and eating are morally obligatory even when, for comparatively healthy people, food is consumed alone or by artificial means, or when it is not enjoyed. I do argue, rather, that the symbolic importance alone of food and water is not enough to justify the maintenance of artificial feeding. Although I do differentiate the administration of ANH from "feeding" and from the reciprocal relationship involved in sitting at table, what separates typical cases of eating from those of PVS patients is primarily that the latter do not hunger for food. Even if electrolyte imbalance is the proximate cause of death when ANH is removed, this does not mean the patient dies of hunger any more than it means that the patient is "starved to death." In this case, there is no consciously felt need for food or water, no seeking after sustenance. Although the possibility to swallow may remain, patients whose swallowing reflex is triggered will not be discriminating about what is offered to them, whether the substance is nutritious or toxic. The body itself declines without sustenance for metabolism, but hunger is an experiential phenomenon, a cognitive response to a physiological stimulus, a sensation that must be suffered. This requires the expression of an "inner drive" at the sensitive level of the tripartite soul. If the PVS patient is not hungry it is questionable that the symbolic importance of feeding as care, and of the command to feed the hungry, is relevant.

One practical way the symbolic importance of feeding is already being amended in contemporary bioethics is in the feeding of the imminently dying. It has now become widely recognized that a loss of hunger often accompanies the dying process, and eating can become more of a burden than a benefit.[63] This is something that was recognized long ago by Vitoria in his observation that eating can be torturous for the dying one without appetite.[64] Although sensations of thirst can attend the withdrawal of nourishment, these are readily alleviated when ice chips are placed on the patient's lips. The lack of desire to eat can be seen as a recognition by the whole patient, nutritive, sensory, and rational

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[63] Mark Yarborough, "Why Physicians Must Not Give Food and Water to Every Patient," *Journal of Family Practice* 29, no. 6 (1989): 683-84; Daniel Callahan, *The Troubled Dream of Life*, 81-82; and Stephen M. Winter, "Terminal Nutrition: Framing the Debate for the Withdrawal of Nutritional Support in Terminally Ill Patients," *American Journal of Medicine* 109, no. 9 (2000): 723-26.
[64] Vitoria, *Relectio de Temperantia*, n.1; C35.

functions alike, that one's good is no longer served by the provision of nutrients to the body. It is questionable that "feeding the hungry" is a good way to describe the imposition of food and water on such a patient. It would be more appropriate to call this "force feeding." Without hunger, the symbolism of feeding as care is lost.

For many imminently dying patients, a lack of hunger can be manifest at the conscious level. For the PVS patient, a lack of hunger can be manifest in the fact of permanent unconsciousness. The technological impact of ANH on such patients is that it reduces the act of feeding to the provision of bodily nourishment; it reduces hunger to the capacity for metabolism. It is this consignment to a liminal state that is decidedly apart from experience of one's condition—including the experience of suffering hunger—that makes the imposition of ANH quite contrary to the benefit of the patient.

6.3 Applying the OEMD

Much has been discussed in the way of transposing the OEMD and its original response to the medical-technological culture of the sixteenth century to that of today. However, this discussion has taken place largely with reference to the concept of benefit and how benefit is to be considered in light of new medical possibilities for life extension in unprecedented conditions. If benefit is absent, the life preserving means has already failed the test of the OEMD. Although it is appropriate that the analysis of benefit comes first, this is not to say that there are no grave burdens associated with providing ANH to PVS patients. An examination of these burdens bridges the gap between the philosophical investigation of medicine undertaken earlier and the practical application of this philosophy to the case of PVS.

6.3.1 The Burdens of the PVS

Each of the burdens to be described here relates to the traditionally articulated burdens of excessive effort or difficulty, extreme pain, intense abhorrence, and great expense as they apply to the patient in question. One burden that has already received treatment is that of excessive effort or difficulty. The authoritative commentary on the 2004 papal allocution addressed this burden as being a possible consideration when it pointed out that in certain remote locations, the caregiver might not have access to

ANH.[65] I need not discuss this further at this point. Also among the burdens that can be passed over here is the burden of undue pain. Although Pope John Paul II was not convinced the patient's experience of pain could be precluded, it is safe to say, according to the best medical knowledge, that PVS patients feel no pain, and so this cannot be a relevant burden for them. (As noted, if they did feel pain, it would be incumbent upon those who sustained their lives to provide them with a continuous form of pain relief. However, the measure of relief required would be very difficult to discern, since the correct dosage is determined in conjunction with the patient's feedback as to the level of alleviation achieved.)

This leaves two remaining burdens to consider. The burden of intense abhorrence is relevant to discussions of PVS for one stark reason: the vegetative state is commonly described in medical editorials and surveys as "a fate worse than death."[66] This sort of sentiment is not limited to the secular medical community but is present in the Christian context as well. It is no wonder that this is the case, given the significance of consciousness for the human being. The 2004 papal allocution refers to this condition as a prison.[67] Grisez allows that vegetation can be perceived as a "miserable state."[68] In the *Cor Unum* document, one cardinal speaks of vegetative "reanimation," calling it "useless torture."[69] Of course, the cardinal cannot be referring to a subjective *experience* of torture. It is more likely that he considers this act *objectively* to be torture. Here it can be affirmed that some burdens are not only subjective but open to the external viewer, and thus they remain even when subjective experience of them is absent. For instance, an individual can be inflicted with an indignity without ever being aware of it. If the PVS patient was left ungroomed, this would be considered an indignity despite the patient's lack of self-awareness. Indignities can even be imposed on a human corpse, though no soul remains. Even those in favour of maintaining ANH for PVS patients agree with this.[70] I have

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[65] Congregation for the Doctrine of the Faith, "Commentary," (2007).
[66] See Bryan Jennett, "Resource Allocation for the Severely Brain Damaged," *Archives of Neurology* 33, no. 9 (1976): 595-97; William M. Feinberg, and Peggy C. Ferry, "A Fate Worse Than Death: The Persistent Vegetative State in Childhood," *American Journal of Diseases of Children* 138, no. 2 (1984): 128-30; and E. A. Freeman, "The Persistent Vegetative State: A 'Fate Worse Than Death,'" *Clinical Rehabilitation* 6, no. 2 (1992): 159-65.
[67] John Paul II, "Life-Sustaining Treatments and Vegetative State," (2004), §2.
[68] Grisez, "Should Nutrition and Hydration Be Provided to Permanently Unconscious Persons?" 176.
[69] Pontifical Council *Cor Unum*, "Questions of Ethics Regarding the Fatally Ill and the Dying," (1981), 291.
[70] See Grisez, "Should Nutrition and Hydration Be Provided to Permanently Unconscious Persons?" 176.

located in the Catholic literature no single opinion that the vegetative state is not an undesirable condition.[71] Intense abhorrence is the consistent reaction to the thought of existing in this condition.

It has already been noted that later manualists argued that the burden of intense abhorrence was legitimate as an anticipated fear of a future condition, as is the case, for instance, with the prospect of mutilating surgery. But others contest the relevance of this burden. Boyle claims that to reject life in a repugnant condition would be suicide.[72] Indeed, in an age in which much human life can be supported in compromised conditions, it is important to be discriminating in the consideration of the burden of intense abhorrence. Many have pointed out that those who come to endure disability at a later stage in life often learn to accept their disability and value their lives in unanticipated ways.[73] However, here the distinction between disability and PVS must be recalled. It is one thing to reject a life of disability, perhaps because one does not want to be encumbered or unattractive, even though potential for higher actualization remains. It is another thing altogether to reject the prospect of a life of complete inability because one understands that this is not what human beings are made for.

Of course, the burden of intense abhorrence will not be determined in relation to the PVS patient's current subjective apprehension of the condition since there is none to be had. It may, however, be determined by means of an advance directive in which the patient requests ANH be withdrawn if the prognosis of permanent vegetation is given. I will return to the matter of advance directives (see 6.3.2).

Finally, the burden of great expense must be considered. This is perhaps the most controversial burden of all. It is often deemed quite crass to consider the money spent on a single patient, or a class of patients, in a calculating way because the assumed object of calculation is to judge whether a kind of patient is worth the expense. Yet financial considerations have never been held outside of consideration in the tradition of the OEMD. From Vitoria on, whether health was to be purchased through delicate food or a

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[71] A lone philosophical argument—albeit an unconvincing one—departing from this opinion has been made by two Protestants. Nathan Carlin and Donald Capps, "Consciousness, the Vegetative State, and the Intrinsic Value of Life," *Pastoral Psychology* 57, nos. 5-6 (2009): 223-34.
[72] Boyle, "Towards Ethical Guidelines for the Use of Artificial Nutrition and Hydration," 120.
[73] See, for instance, Gary L. Albrecht and Patrick J. Devlieger, "The Disability Paradox: High Quality of Life against All Odds," *Social Science & Medicine* 48, no. 8 (1999): 977-88.

costly medication, expense—even expense incurred over the long term—was recognized as a valid consideration. Recall that the financial scale used was, at its base, relative to the resources of the patient: whatever expense was too great for a given individual was admitted as too burdensome. However, there was a ceiling imposed that discouraged everyone, no matter how wealthy, from spending money on health care beyond what the average individual could afford. According to Cronin's survey of the manualists, great expense is the most frequently cited burden.[74]

Financial decisions are no less relevant in the context of public health care systems in which resource allocation is a pressing concern than they are for individual patients or caregivers who must shoulder the burden of paying for treatments independently. Resource allocation is an important matter when it comes to public health care systems because these calculations will affect what the physician can reasonably offer patients in terms of treatment options. Medicine is a pursuit hedged by competing social pursuits that also serve larger human ends, and so it is not the recipient of all our social resources. A second reason for the limitation of medicine's resources is that medicine is a nonabsolute and essentially tragic endeavour. Although the needs medicine serves may be basic, it is not always financially possible to meet them all, and hard decisions must often be made about which needs are more pressing. There is more than one way to shape the allocation of health care funds. Some of these ways are troubling in their removal of patients and proxies from treatment decisions. According to medical policy in one Canadian province, there is no obligation on the part of the health care practitioner to provide life preserving means to one who can no longer experience oneself, one's environment, or one's existence.[75] Treatment can be removed despite the proxy's insistence that it be maintained, and there may be insufficient time to find an alternate physician and a health care facility to care for the patient. To be sure, this kind of mandate is too rigid for a pluralistic culture in which the anthropologies and ethical systems of certain groups would continue to require that life preserving means be applied to unconscious patients. It is insensitive to the perspectives of proxies on what "futile"

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[74] Cronin, "The Moral Law," 86-87.

[75] College of Physicians and Surgeons of Manitoba, *Withholding and Withdrawing Life-Sustaining Treatment*, Statement no. 1602 (February 1, 2008), http://www.cpsm.mb.ca/statements/1602.pdf. To be clear, this statement has as much to do with differing conceptions of human anthropology and what is valuable about being human as it does with resource allocation.

care is. However, saying that a rule against treating PVS patients ought not to be applied does not entail that the financial resources needed to support a PVS patient over the long term should be excluded from the benefit-burden analysis. Although my argument for treatment withdrawal from PVS patients has not been based on financial interests, it is not inappropriate to bring in this consideration here.

Expenses in preserving the life of a PVS patient include not only the insertion of the feeding tube, the attending equipment, and the nutritional solution. They also include nursing care, which involves the maintenance and supervision of ANH but also turning the patient to prevent bed sores, caring for the patient's hygiene, and moving limbs to ease muscle atrophy, among other tasks. If the patient is housed in a hospital or care facility rather than at home, there are additional expenses to consider. The actual cost of this ongoing care will differ according to time and place. Although the following figures are somewhat dated, it helps to be aware of the estimations accepted by the Multi-Society Task Force on PVS in 1994 on the annual cost of caring for a PVS patient in the United States.[76] The estimated funds dedicated to a single adult patient in a long-term care facility were $350-500 per day or $126,000-180,000 per year. The total annual cost for care of children and adults in PVS in the United States was estimated as being anywhere between $1 billion and $7 billion. Although it is unlikely that these figures would be controversial were some incontrovertible proportionate benefit achieved through the ongoing application of ANH to the permanently vegetative patient, one has to ask if these costs are incurred in order to fulfill the ends of medicine—to provide relief from pain or to lead a patient to a condition of physical actualization that supports other kinds of human actualization. If this question is not asked, the swell of medical possibilities for preserving life will lead to increasing expenditures that may be justified by a technological imperative but not by the nature of medicine itself. In the case of PVS, the costs incurred result simply in maintaining the life of an unconscious individual who is very unlikely to regain consciousness.

6.3.2 Advanced Directives and Proxy Judgements

It is of considerable significance to the moral evaluation that the burden of great cost is one that is borne by the caregivers and health care system rather than the patient.

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[76] Multi-Society Task Force, "Medical Aspects of the Persistent Vegetative State," part 2.

As already mentioned (3.3.4), Meilaender and others argue that proxy decisions made about life preserving treatments should avoid any hint of intention toward euthanasia by considering only "objectifiable" factors that relate directly to the patient. Therefore, the burden of expense placed on the family and other caregivers would not, in their view, overturn an ordinary judgement. Here we come up against an inherent difficulty of applying the OEMD to today's context: the OEMD was not designed with proxy judgements in mind. Although there is precedent in marginal cases for physicians and religious leaders to overrule patient decision,[77] the decision has always been described first of all as the patient's own. But in a situation in which patients have no decision-making capacity, the need to weigh benefits and burdens endures.

It was noted in chapter three that in a patient's decision about treatment, the burdens that treatment would pose for *caregivers* is a valid consideration. There is, of course, the danger that this may allow an intention toward euthanasia to be covered up. However, this is not a new risk being imposed on the use of the OEMD, but, rather, an old risk in a new context. It was always possible that a benefit-burden analysis might come out in favour of treatment withdrawal, with the patient's own motives for withdrawal being suicide and not merely the intention to withdraw extraordinary means. Now this risk is being extended to decisions made on behalf of others. It remains a risk that must be tolerated. Validating the role of the OEMD in proxy decisions is one amendment to the OEMD that must be made in a modern context, especially for cases in which the patient is not fully or even partially cognizant of the burdens imposed on others by the treatment.

Although this transferral of burden is not easily accepted when it comes to financial matters, it should be pointed out that burdens on caregivers in the case of proxy decisions have already been validated by Catholic sources. The burden of extreme difficulty in obtaining or applying a means, whether because of extreme poverty or remote location, was one of the only burdens considered to be relevant to the proxy decision by the Congregation for the Doctrine of the Faith.[78] The difference between this assessment and that of the manualists is that for the latter, the accepted standard of

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[77] Cronin, "The Moral Law," 56 and 115.
[78] Congregation for the Doctrine of the Faith, "Commentary," (2007).

expense was, at its height, what was within the means of the typical individual and, at its base, what was affordable for the individual in question. The Congregation for the Doctrine of the Faith seems to put a more extreme restriction on cost and difficulty, limiting these burdens to those individuals who face financial difficulties even apart from the treatment of illness. In order to remain consistent with the traditional articulation of the OEMD, it should be accepted that grave financial *burden*, and not merely financial impossibility, makes a treatment extraordinary.

Although in publicly funded health care systems some of the financial burden will be lifted from the caregiver, this does not mean that the financial burden is entirely absent. It is appropriate to limit the decision-making capacity to the proxy and not allow hospital policy or legislation to override caregivers' decisions on this matter. However, it is also appropriate that the proxy conduct the moral evaluation with the awareness that the financial burden of the treatment is not lifted altogether, but only lifted from the family. This is not to say that the proxies must thoroughly apprise themselves of the current state of health care allocation. Rather, it is important to be aware in a general sense that there are more technological opportunities to preserve life than there are economic resources to support such opportunities. Having a possibility to preserve life does not always mean it is financially reasonable to do so. Again, this consideration is often not the deciding factor in the course of applying the OEMD, but it remains a valid one. So, for instance, sick and elderly patients who sign a "Do Not Resuscitate" order might do so because they do not wish to suffer the prolonged agonies imposed by cardio-pulmonary resuscitation. But in making this prudential decision, they also positively affect the supply of health care resources, freeing more for medical interventions that will be beneficial in relieving pain and enabling physical functioning that supports further actualization.

Many matters related to proxy judgement could be avoided if patients issued advance directives specifying treatment decisions in the case of permanent vegetation. The validity of advance directives that specify against ANH is largely accepted in Protestantism. The subject has not, however, been definitively addressed by the Catholic magisterium. Indeed, the legitimacy of advance directives *per se* has come under scrutiny. The Canadian Catholic Bioethics Institute accepts the legitimacy of advance directives, also claiming that their validity depends on their conformity to respect for human life and

dignity, and the continuance of ordinary means.[79] The *Ethical and Religious Directives* also specify that advance directives that contradict Catholic teaching will not be honoured in Catholic institutions.[80] How these statements are interpreted in relation to PVS is, of course, dependent on whether one views ANH as ordinary for the particular patient.[81] Little more need be said about the dueling perspectives on this subject.

Despite the Catholic acceptance of noncontroversial advance directives, some voices have expressed concern about such documents in themselves. At the 2008 Pontifical Academy for Life congress, the president of the academy, Msgr. Elio Sgreccia, questioned the validity of a document on treatment decisions drawn up in anticipation of a future reality, opposing this to treatment decisions that are made as a present reality is being faced.[82] Doubt about whether one can accurately project one's will into situations not yet experienced has been raised by other thinkers outside the academy. Legal experts Jacqueline Laing and Laura Palazzini each argue that decisions made in anticipation of a condition are made in ignorance of how one would develop resources to cope with the actual condition, which can only be determined in the situation itself.[83] One Protestant voice, Meilaender, echoes this, claiming that advance directives are a delusion of autonomy, and that many people learn to accept disabilities they previously thought would be unliveable.[84] The problem with this line of reasoning is that people make decisions pertaining to their future conditions all the time, and these are encouraged in the Christian tradition. Both the decisions to marry and have children have lasting effects on one's future condition despite the fact that one cannot predict one's suitability to either the marital or parental role in the distant future. These decisions are made because Christians are supposed to be able to have some influence over their character, the kind of

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[79] Canadian Catholic Bioethics Institute, "Reflections on Artificial Nutrition and Hydration," no. 10.
[80] United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, Directive 24.
[81] However, Grisez renders valid advance directives that indicate against the application of ANH in conditions of permanent unconsciousness. He justifies respect for such a directive as an expression of the bond of human communion. See his "Should Nutrition and Hydration Be Provided to Permanently Unconscious and Other Mentally Disabled Persons?" 175 and 182.
[82] Elio Sgreccia, "Communicating Information to the Incurably Sick," paper presented at the Fourteenth Assembly of the Pontifical Academy for Life, (February 25-26, 2008), 18, http://www.academiavita.org/english/AssembleaGenerale/2008/rel2008/sgreccia/sgreccia_eng2008.pdf.
[83] Jacqueline Laing, "Food and Fluids: Human Law, Human Rights and Human Interests," in *Artificial Nutrition and Hydration: The New Catholic Debate*, ed. Tollefsen, 86; Laura Palazzini, "Advance Directives and Living Wills," *Neurorehabilitation* 19, no. 4 (2004): 305-13.
[84] Meilaender, *Bioethics: A Primer for Christians*, 81.

individual they will themselves to be. For the patient in PVS, character and will have no expression, so it would appear acceptable to refuse to participate in the kind of existence that offers no resources for coping with burden. Although it is never appropriate to reject life simply because it offers disability, according to the OEMD it remains acceptable in some cases to make the decision to withdraw life preserving means.

Furthermore, as limited as human foresight may be, one is typically much better than other parties at estimating one's own desires in regard to a future reality. The vegetative state imposes a condition in which one is entirely unable to make such treatment decisions for oneself in the present, leaving the matter to proxies and medical practitioners. It is questionable that one in so critical a situation should be forced, by virtue of the denial of the legitimacy of advance directives, to yield this kind of power to someone else.

6.3.3 The Practical Judgement

The vegetative patient, a human being, must always be treated as one. But human beings in different conditions, though bearing the same dignity, require different expressions of honour, and those expressions required by the vegetative patient will be few in number. As indications of the dignity of the patient's being, caregivers will care for patient hygiene and grooming, reduce muscle atrophy and bedsores, and provide human presence. ANH is not included amongst these kinds of care because it is not merely a sign of respect for dignity but a means that actively preserves life.

Rather than view ANH in a purely positive light as a life saving ministration, it is important to evaluate critically the application of this technology to vegetative patients. ANH interferes with the comatose patient who enters into PVS by deforming the process of death. Prior to the advent of ANH, such patients would die quickly, never having the possibility to enter into a vegetative state. The "blessing" of medical feeding, along with other forms of intensive medical treatment, is that it now allows some comatose patients and vegetative patients to recover from their condition. The "curse" of these technologies is that they also impose interminable unconsciousness for others. Jonas offers the following comment:

> The novel problem is this: medical technology, even when it cannot cure or relieve or purchase a further, if short-term, lease on a worthwhile life, can still put off the terminal event of death beyond the point where the patient himself may

> value the life thus prolonged, or even is still capable of any valuing at all. This often marks a therapeutic stage where the line between life and death wholly coincides with that between continuance and discontinuance of treatment—in other words, where the treatment does nothing but keep the organism going, without in any sense being ameliorative, let alone curative.[85]

Technology has changed medicine by attempting to divorce the necessity of death from extreme illness. Bioethics must now respond to this new context for medical decision making, not by expanding rules to maximize use of technology and allow withdrawal only when death is imminent and inevitable, but by continuing to minimize the burdens of technology imposed on human life and avoiding interventions that produce no proportionate benefit.

With new medical capacities for preserving life that allow medical personnel enough time to determine likelihood of recovery, there is now a felt obligation to allow for several months of vegetation, since to do otherwise might be to allow for death when death could be prevented and some level of health restored. No longer is it clear when a patient is legitimately "dying"—unless, like the Catholic magisterium, one uses the criteria of imminence and inevitability. This is a situation that is likely unavoidable. If the comatose patient is physically robust, it is appropriate to maintain the patient's life through ANH and other interventions in order to determine proper diagnosis and prognosis. However, once a prognosis of permanence is established, it should be admitted that the OEMD comes into play again. Moral reassessment is required when the variables change.

If the OEMD judgement measures no significant benefit or a disproportionate burden, it follows that the means may be withdrawn and the patient may be allowed to die. In the case of PVS, although there are burdens to bring to the account, it is likely that the determination of benefit will be the decisive factor in the judgement: the treatment postpones death without allowing the patient to pursue human flourishing. If the functional relation between body and soul has been so severely damaged that the individual can no longer actively engage in relations with God, oneself, or others, the patient may be allowed to succumb to the effects of his or her condition, rather than be maintained in such a state. One must hold together the two dimensions of dignity

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[85] Jonas "The Right to Die," 31.

discussed earlier—the ontological and the actual, or that given with human nature and that actualized by human beings—to respect the human being and sieve out disoriented attempts to reach human ends. Preserving life without enabling patients to live their lives actively, but instead threatening them with an interminable condition of unconsciousness, would appear a misguided interpretation of medicine's aim. It is not charged with the task of maintaining physical lives when the individual is no longer able to self-actualize, or when actualization would be so burdensome as to present a moral impossibility. The preservation of life provides no proportionate benefit to the patient as an individual since it fails to heal the incapacity of the body to express the soul at the sensory and rational levels. In cases of clear diagnostic and prognostic indications, it is likely that an extraordinary judgement will be rendered toward ANH.

Here the admission must be made that PVS is best seen as iatrogenic, that is, an adverse side-effect of the medical treatment applied to determine whether a patient will be aroused from coma or vegetative state. Further, it warps the ends of medicine, encouraging the technological imperative that would change the understanding of the value of life preserving means from promoting human actualization to extending biological life. But does this mean that the best way to respond to those who would create a hard-and-fast rule around "basic care" for PVS patient is to create a counter-rule? Some ethicists have done just this. Jonas, it has been mentioned, is in favour of such a rule. Kelly also claimed that life preserving means should not be used in cases of lingering coma because of the lack of benefit.[86] Even Ramsey at one time argued in favour of a rule to withdraw, introducing an additional justifying reason: "Just as it would be negligence to the sick to treat them as if they were about to die, so it is another sort of 'negligence' to treat the dying as if they are going to get well or might get well."[87]

A rule, though, is problematic. The manualist tradition allowed only for *generalizations* about certain extraordinary means (and *no* generalizations about ordinary means, in distinction from the 2004 papal allocution). Although it is the case that treatment withdrawal from the PVS patient is an adequate reflection of the OEMD judgement made in good conscience, room must always be left for nonmedical factors

[86] Kelly, "The Duty of Using Artificial Means," 220.
[87] Ramsey, *The Patient as Person*, 1st ed., 133.

that can affect the moral decision. The OEMD judgement remains contextual in nature, which admits that there may be exceptions even to reasoned presumptions about particular classes of patients. One important contextual element that has raised its head in certain high profile cases of PVS is the desire of caregivers to maintain the life of the patient, whether this is justified by irrational hopes for the patient's recovery or an impression that the caring thing to do is to continuing to feed the patient. Although I am persuaded that the most appropriate expression of care is simply to remain present with the patient in death, rather than sustaining the PVS condition, there are others who perceive the situation differently. My own conclusions are drawn from a close look at Christian anthropology and a history of responses to life preserving means. It is not common for caregivers to undertake this kind of study; and those who do might come to different conclusions than my own. Instead of creating a hard-and-fast rule to withdraw ANH from PVS patients that could cause undue strife and hardship to some caregivers, I prefer to advocate that, in cases in which prognosis is clear to medical practitioners and there are no other overriding considerations, the proxy who refuses to "let the patient go" ought to be allowed to choose to maintain ANH. However, I also advocate that it is important for others concerned in the moral decision making process, perhaps the health care team and spiritual advisor, to exercise sensitive persuasion and attempt to offer the proxy a different perspective. Persuasion is consistent with the manualist tradition, evidenced in cases of irrational judgements. Vitoria allowed that one might persuade another to adopt medical treatments that might be helpful in an age when the dubious quality of many medicines prevented people from taking advantage of those that were expected to be beneficial. Additional manualists allowed for irrational fear or shame at the prospect of treatment or examination to be counted as a legitimate burden, also advocating that others persuade the patient of the irrationality of such a reaction. In the case of confounding conditions and troubling treatment decisions, it is clear that community consultation is a great asset to the moral decision making process.

Finally, the *presumption* that a particular intervention will be ordinary or extraordinary for a particular class of patients has been made legitimately by Catholic authorities before. Thus, eating is presumed to be ordinary for the healthy individual, although *per accidens* it may be extraordinary. To be sure, it is difficult to envision an

instance in which ANH would be merely ordinary for a permanently vegetative patient. However, it can be allowed that, in consideration of other moral factors, only a presumption for withdrawal, and not a rule toward it, can be made. In extreme cases, there might be reason to permit the imposition of this presumably extraordinary means (as the extraordinary is not forbidden but only nonobligatory), if only to allow caregivers to come to terms with the patient's prognosis.

6.4 Conclusion

This thesis has shown how an unprecedented medical condition—the persistent vegetative state—is made confounding by an old difficulty, that is, how one is to distinguish between illicit suicide or euthanasia and licit refusals of life preserving means. In other words, how can respect for the individual human being be demonstrated in ways that neither absolutize human life nor make too little of life in a compromised condition? The root of this problem is in anthropological confusion and inconsistency, which have granted technology too great a hand in moral decision making at the end of life. As the debate over PVS indicates, technological means of sustaining life can blind one's perception of how best to observe the moral obligation to preserve life.

In the Protestant context, a lack of cogent anthropological reflection allows for multiple conclusions regarding the value of the PVS patient and attending ethical responses, offering no way forward for a rational and persuasive Protestant position on the issue. Some Catholics, on the other hand, often led by new natural law theorists, have deviated from the traditional interpretation of Aristotelian-Thomistic anthropology, disallowing a single, final end for humanity and refusing to allow for a hierarchy of human goods. This has moved the Vatican and other magisterial representatives closer to an absolutist position on the value of human life. In consequence, the role of medicine is drastically altered in both communities from a species of care that aims to circumvent physiological barriers to human actualization, to an overriding practice that focuses first of all on preserving the human patient's life even apart from possibilities for actualization at the sensory and rational levels. In the case of PVS, this causes two expressions of value—human nature and human ends—to appear to clash.

Yet this dissonance is indeed only apparent, although its appearance is underscored by the polarities that have formed in the PVS debate. New technological

possibilities require that Catholics and Protestants better understand the intrinsic *relationship* of these expressions of value—nature and ends—a relationship that has been accepted as long as theological anthropology has been undertaken. It is the proper understanding of this relationship that guided the manualists in the gradual formulation of the OEMD that resulted. It is this relationship that must continue to guide treatment decisions and keep medicine in its proper place. In insisting that the human being, an ensouled body or embodied soul, remains intrinsically good, one must always make room for the fact that, in a particular circumstance, preserving the life of the human being might not be a decision pursuant to human ends. If one takes the duality (not dualism) of the human constitution seriously, one sees, as Aristotle, Aquinas, and Jonas each affirm, that the human end is not simply to live. One is also made to live well. This entails activity beyond mere metabolism. Such a position aims not to be elitist or to devalue the lives of those who fail to live well, whether by choice or by circumstance. Instead, this view of the human being indicates why medicine is important in the first place. A theological anthropology prescribes limits to medicine's role in human lives, granting it some responsibility for bringing patients to the point at which they have the capacity not only to live but to pursue living well, even if this is a matter of living well in the dying hours. In this light, the following statement of Pope John Paul II can be brought to bear:

> It is evident that every medical procedure performed on the human person is subject to limits: not just the limits of what it is technically possible, but also limits determined by respect for human nature itself, *understood in its fullness*: "what is technically possible is not for that reason alone morally admissible."[88]

And so this anthropological position also shows that care goes beyond medical and nonmedical ways of preserving life. It enters into the realm of human solidarity, of the recognition by one individual of another's humanity. It is not primarily moral rules of conduct but this recognition of humanity's being in the love of God that guards against euthanasist and suicidal tendencies.

An interpretation of the Christian narrative shows why Christians would be tempted to keep a PVS patient alive. Concern for the vulnerable, manifested in the feeding of the hungry and other ways, is a central virtue. But the same tradition also

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[88] John Paul II, "To the 18th International Congress of the Transplantation Society," (2000), §2. Emphasis added.

indicates why caregivers must be able to let permanently vegetative patients go. The preservation of life, whether by medical means, nonmedical means, or means that blur such distinctions, is a limited endeavour. Preserving life is only one manifestation of care for life, one that sometimes fails, as Saint Basil put it, to assure the soul's benefit. The limits of the moral obligation to preserve life must be measured in relation to human ends, the ethical aim, not primarily in reference to technological capacities to keep patients alive. Thus, despite a changed context for action that contemporary medical technology imposes—indeed, *because* of this change—there is a great need within Christian bioethics to recover the tradition of the OEMD and its original propositions, including the observation that both natural and artificial means are always subject to an evaluation of burden and benefit made in context. Although some things continue to be naturally ordered to life and health, the OEMD remains the safeguard when technology changes benefit into mere effect. The OEMD remains the safeguard of individual human beings and a limiter of our medical reach. Most of all, however, it continues to act as a safeguard of what Christians understand humans beings to be and to be made for.

Bibliography

1. Works on the Ordinary-Extraordinary Means Distinction

Amundsen, Darrel W. "The Physician's Duty to Prolong Life: A Medical Duty Without Classical Roots." *Hastings Center Report* 8, no. 4 (1978): 23-30.

Atkinson, Gary M. "Theological History of Catholic Teaching on Prolonging Life." In *Moral Responsibility in Prolonging Life Decisions*, edited by Donald G. McCarthy and Albert S. Moraczewski, 95-115. St. Louis: Pope John Center, 1981.

Bretzke, James T. "A Burden of Means: Interpreting Recent Catholic Magisterial Teaching on End-of-Life Issues." *Journal of the Society of Christian Ethics* 26, no. 2 (2006): 183-200.

Calipari, Maurizio. "The Principle of Proportionality in Therapy: Foundations and Applications Criteria." *Neurorehabilitation* 19, no. 4 (2004): 391-97.

Cataldo, Peter J. "Pope John Paul II on Nutrition and Hydration: A Change of Catholic Teaching?" *National Catholic Bioethics Quarterly* 4, no. 3 (2004): 513-36.

------. "To Conserve Human Life." *Ethics & Medics* 17, no. 12 (1992): 2-4.

Connery, John R. "Prolonging Life: The Duty and Its Limits." *Linacre Quarterly* 47, no. 2 (1980): 151-65.

------. "Quality of Life." *Linacre Quarterly* 53, no. 1 (1986): 26-33.

Daly, Daniel J. "Prudence and the Debate on Death and Dying." *Health Progress* 88, no. 5 (2007), http://www.chausa.org/Pub/MainNav/News/HP/Archive/2007/09Sept-Oct/Articles/Features/hp0709i.htm.

Eberl, Jason T. "Extraordinary Care and the Spiritual Goal of Life: A Defense of the View of Kevin O'Rourke, O.P." *National Catholic Bioethics Quarterly* 5, no. 3 (2005): 491-501.

Fleming, Julia. "When 'Meats are Like Medicines': Vitoria and Lessius on the Role of Food in the Duty to Preserve Life." *Theological Studies* 69, no. 1 (2008): 99-115.

Hill, T. Patrick. "Changing Roman Catholic Attitudes toward Termination of Life-Sustaining Treatments." *Linacre Quarterly* 58, no. 2 (1991): 51-59.

Kelly, Gerald. "The Duty of Using Artificial Means of Preserving Life." *Theological Studies* 11, no. 2 (1950): 203-20.

------. "The Duty to Preserve Life." *Theological Studies* 12, no. 4 (1951): 550-56.

Keown, John. "Medical Murder by Omission? The Law and Ethics of Withholding and Withdrawing Treatment and Tube Feeding." *Clinical Medicine* 3, no. 4 (2003): 460-63.

Kopfensteiner, Thomas R. "Developing Directive 58: A Look at the History of the Directive on Nutrition and Hydration." *Health Progress* 81, no. 3 (2000), http://www.chausa.org/Pub/MainNav/News/HP/Archive/2000/05MayJun/Articles/Features/hp0005e.htm.

May, William E. “Criteria for Withholding or Withdrawing Treatment.” *Linacre Quarterly* 57, no. 3 (1990): 81-90.

McCartney, James J. “The Development of the Doctrine of Ordinary and Extraordinary Means of Preserving Life in Catholic Moral Theology before the Karen Quinlan Case.” *Linacre Quarterly* 47, no. 3 (1980): 215-24.

McCormick, Richard A. “The Quality of Life, the Sanctity of Life.” *Hastings Center Report* 8, no. 1 (1978): 30-36.

Meilaender, Gilbert. “Ordinary and Extraordinary Treatments: When Does Quality of Life Count?” *Theological Studies* 58, no. 3 (1997): 527-31.

------. “*Terra es animata*: On Having a Life.” *Hastings Center Report* 23, no. 4 (1993): 25-32.

Mulligan, James J. “The Catholic Tradition on Means of Sustaining Life.” In *Scarce Medical Resources and Justice*, edited by Donald McCarthy, 74-87. Braintree: Pope John Center, 1987.

Oraison, Marc. “Euthanasie et mystére de l’homme.” *Cahiers Laënnec* 23 (1963): 5-19.

O’Rourke, Kevin D. “The Catholic Tradition on Forgoing Life Support.” *National Catholic Bioethics Quarterly* 5, no. 3 (2005): 537-53.

------. “Evolution of Church Teaching on Prolonging Life.” *Health Progress* (Jan-Feb 1988): 28-35.

------. “Father O’Rourke Responds.” *National Catholic Bioethics Quarterly* 3, no. 1 (2003): 15-18.

Pellegrino, Edmund D. “Decision at the End of Life: The Use and Abuse of the Concept of Futility.” *Life and Learning* 10 (2000): 85-110.

Pius XII. “The Prolongation of Life.” *The Pope Speaks* 4, no. 4 (1958): 393-98.

Ramsey, Paul. “Prolonged Dying: Not Medically Indicated.” *Hastings Center Report* 6, no. 1. (1976): 14-17.

Schneiderman, Lawrence J., and Nancy S. Jecker. *Wrong Medicine: Doctors, Patients, and Futile Treatment*. Baltimore: Johns Hopkins University Press, 1995.

Schneiderman, Lawrence J., Nancy S. Jecker, and Albert R. Jonsen. “Medical Futility: Its Meaning and Ethical Implications.” *Annals of Internal Medicine* 112, no. 12 (1990): 949-54.

Shannon, Thomas A., and James J. Walter. “Assisted Nutrition and Hydration and the Catholic Tradition.” *Theological Studies* 66, no.3 (2005): 651-62.

Smith, Russell E., ed. *Conserving Human Life*. Braintree: Pope John Center, 1989.

Stempsey, William E. “End-of-Life Decisions: Christian Perspectives.” *Christian Bioethics* 3, no. 3 (1997): 249-61.

Sullivan, Scott M. “The Development and Nature of the Ordinary/Extraordinary Means Distinction in the Roman Catholic Tradition.” *Bioethics* 21, no. 7 (2007): 386-97.

Sulmasy, Daniel P. "Preserving Life? The Vatican & PVS." *Commonweal* 134, no. 21 (2007): 16-18.

Walter, James J., and Thomas A. Shannon, eds. *Quality of Life: The New Medical Dilemma*. New York: Paulist Press, 1990.

Welie, Jos V. M. "When Medical Treatment is No Longer in Order: Toward a New Interpretation of the Ordinary-Extraordinary Distinction." *National Catholic Bioethics Quarterly* 5, no. 3 (2005): 517-36.

Wildes, Kevin W. "Ordinary and Extraordinary Means and the Quality of Life." *Theological Studies* 57, no. 3 (1996): 500-12.

------. "When Does Quality of Life Count? A Response to Gilbert Meilaender." *Theological Studies* 59, no. 3 (1998): 505-08.

2. Works on the Provision of Nutrition and Hydration

American Academy of Hospice and Palliative Medicine. "Statement on Artificial Nutrition and Hydration Near the End of Life." December 8, 2006, http://www.aahpm.org/positions/nutrition.html.

Bishops of Pennsylvania. "Nutrition and Hydration: Moral Considerations." Rev. ed., 1999, http://www.pacatholic.org/bishops-statements/nutrition-and-hydration-moral-considerations.

Cahill, Lisa Sowle. "Catholic Consensus on Critical Care, Patient Welfare and the Common Good." *Christian Bioethics* 7, no. 2 (2001): 185-92.

Callahan, Daniel. "Feeding the Dying Elderly." *Generations* 10, no. 2 (1985): 15-17.

------. "On Feeding the Dying." *Hastings Center Report* 13, no. 5 (1983): 20.

Canadian Catholic Bioethics Institute. "Reflections on Artificial Nutrition and Hydration: Colloquium of the Canadian Catholic Bioethics Institute." July 22, 2004, http://www.iacbweb.org/ANHstatement.html#_ftnref1.

Casarett, David, Jennifer Kapo, and Arthur Caplan. "Appropriate Use of Artificial Nutrition and Hydration—Fundamental Principles and Recommendations." *New England Journal of Medicine* 353, no. 24 (2005): 2607-12.

Clark, Peter. "Tube Feedings and Persistent Vegetative State Patients: Ordinary or Extraordinary Means?" *Christian Bioethics* 12, no. 1 (2006): 43-64.

Congregation for the Doctrine of the Faith. "Responses to Certain Questions of the United States Conference of Catholic Bishops Concerning Artificial Nutrition and Hydration." August 1 2007, http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20070801_risposte-usa_en.html.

------. "Responses to Certain Question of the United States Conference of Catholic Bishops Concerning Artificial Nutrition and Hydration: Commentary." August 1, 2007, http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20070801_notacommento_en.html.

Connery, John R. "The Ethical Standards for Withholding/Withdrawing Nutrition and Hydration." *Issues in Law and Medicine* 2, no. 2 (1986): 87-97.

Cranston, Robert E. "Withholding or Withdrawing of Artificial Nutrition and Hydration." Center for Bioethics and Human Dignity, November 19, 2001, http://www.cbhd. org/resources/endoflife/cranston_2001-11-19.htm.

Drane, James F. "Stopping Nutrition and Hydration Technologies: A Conflict between Traditional Catholic Ethics and Church Authority." *Christian Bioethics* 12, no. 1 (2006): 11-28.

Dunlop, John T. "The Feeding Tube Dilemma: Key Questions." Center for Bioethics and Human Dignity, January 27, 2006, http://www.cbhd.org/resources/endoflife/ dunlop_2006-01-27.htm.

Fisher, Anthony. "On Not Starving the Unconscious." *New Blackfriars* 74, no. 869 (1993): 130-45.

Glatz, Carol. "Ambiguities Cloud Moral, Medical Issues as End of Life Nears." *Catholic News Service* (February 29, 2008), http://www.catholicnews.com/data/stories/cns/ 0801177.htm.

Grant, Mark D., Mark A. Rudberg, and Jacob A. Brody. "Gastronomy Placement and Mortality among Hospitalized Medicare Beneficiaries." *Journal of the American Medical Association* 279, no. 24 (1998): 1973-76.

Hamel, Ronald P., and James J. Walter, eds. *Artificial Nutrition and Hydration and the Permanently Unconscious Patient: The Catholic Debate*. Washington, D.C.: Georgetown University Press, 2007.

Hardt, John J., and Kevin D. O'Rourke. "Nutrition and Hydration: The CDF Response, In Perspective." *Health Progress* 88, no. 6 (2007), http://www.chausa.org/Pub/ MainNav/News/HP/Archive/2007/11Nov-Dec/Articles/Features/hp0711g.htm.

Hauerwas, Stanley. "Response to the 'Consensus Statement of the Working Group on Roman Catholic Approaches to Determining Appropriate Critical Care.'" *Christian Bioethics* 7, no. 2 (2001): 239-42.

Keating, Bernard. "L'alimentation et l'hydration artificielles des patients en état végétatif permanent: la discussion américaine et les interventions romaines récentes." *Laval théologique et philosophique* 64, no. 2 (2008): 485-525.

Leff, Bruce, Nina Cheuvront, and William Russell. "Discontinuing Feeding Tubes in a Community Nursing Home." *Gerontologist* 34, no. 1 (1994): 130-33.

Lynn, Joanne, ed. *By No Extraordinary Means: The Choice to Forgo Life-sustaining Food and Water*. Bloomington: Indiana University Press, 1989.

May, William E. "Tube Feeding and the 'Vegetative' State." Pts. 1 and 2. *Ethics & Medics* 23, no. 12 (1998): 1-2; 24, no. 1 (1999): 3-4.

May, William E., Robert Barry, Orville Griese, Germain Grisez, Brian Johnstone, Thomas J. Marzen, James T. McHugh, Gilbert Meilaender, Mark Siegler, and William Smith. "Feeding and Hydrating the Permanently Unconscious and Other Vulnerable Persons." *Issues in Law and Medicine* 3, no. 3 (1987): 203-18.

McMillan, Elizabeth. "The Catholic Moral Tradition on Providing Food and Fluids." *Linacre Quarterly* 54, no. 4 (1987): 55-66.

Meilaender, Gilbert. "The Confused, the Voiceless, the Perverse: Shall We Give Them Food and Drink?" *Issues in Law and Medicine* 2, no. 2 (1986): 133-48.

------. "On Removing Food and Water: Against the Stream." *Hastings Center Report* 14, no. 6 (1984): 11-13.

National Council for Hospice and Specialist Palliative Care Services. "Ethical Decision-Making in Palliative Care: Artificial Hydration for People who are Terminally Ill." *Catholic Medical Quarterly* (May 2001): 23-24.

O'Rourke, Kevin D. "Artificial Nutrition and Hydration and the Catholic Tradition." *Health Progress* 88, no. 3 (2007), http://www.chausa.org/Pub/MainNav/News/HP/Archive/2007/05MayJune/Articles/Features/hp0705i.htm.

------. "Should Nutrition and Hydration Be Provided to Permanently Unconscious and Other Mentally Disabled Persons?" *Issues in Law and Medicine* 5, no. 2 (1989): 181-96.

O'Rourke, Kevin D., Philip Boyle, and Larry King. "The Brophy Case: The Use of Artificial Hydration and Nutrition." *Linacre Quarterly* 54, no. 2 (1987): 63-72.

O'Rourke, Kevin D., and Jean deBlois. "Removing Life Support: Motivations, Obligations. An Opinion on NCCB Committee for Pro-Life Activities' Statement on Artificial Nutrition and Hydration." *Health Progress* 73 (July-August 1992): 20-27.

Post, Stephen G. "Tube Feeding and Advanced Progressive Dementia." *Hastings Center Report* 31, no. 1 (2001): 36-42.

President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. *Deciding to Forego Life-Sustaining Treatment: Ethical, Medical, and Legal Issues in Treatment Decisions*. Washington, D.C.: U.S. Government Printing Office, 1983.

Shannon, Thomas A. "Nutrition and Hydration: An Analysis of the Recent Papal Statement in the Light of the Roman Catholic Bioethical Tradition." *Christian Bioethics* 12, no. 1 (2006): 29-41.

Shannon, Thomas A., and James J. Walter. "Implications of the Papal Allocution on Feeding Tubes." *Hastings Center Report* 34, no. 4. (2004): 18-20.

Sullivan, William. *The Role of Artificial Nutrition and Hydration in the Care of the Frail Elderly: Empirical Issues and Disputed Questions*. Toronto: Canadian Catholic Bioethics Institute, 2004, http://www.iacbweb.org/ANHsullivan.html#_edn1.

Tobin, Bernadette M. "Hydration in a Dying Patient." *Journal of Paediatrics and Child Health* 36, no. 4 (2000): 395-96.

Tollefsen, Christopher, ed. *Artificial Nutrition and Hydration: The New Catholic Debate*. Dordrecht: Springer, 2008.

Torchia, Joseph. "Artificial Hydration and Nutrition for the PVS Patient: Ordinary Care

or Extraordinary Intervention?" *National Catholic Bioethics Quarterly* 3, no. 4 (2003): 719-30.

United States Bishops' Committee for Pro-Life Activities. "Nutrition and Hydration: Moral and Pastoral Reflections." *Catholic International* 3, no. 13 (1992): 620-32.

Winter, Stephen M. "Terminal Nutrition: Framing the Debate for the Withdrawal of Nutritional Support in Terminally Ill Patients." *American Journal of Medicine* 109, no. 9 (2000): 723-26.

Working Group on Roman Catholic Approaches to Determining Appropriate Critical Care. "Consensus Statement, March 2000." *Christian Bioethics* 7, no. 2 (2001): 179-84.

Yarborough, Mark. "Why Physicians Must Not Give Food and Water to Every Patient." *Journal of Family Practice* 29, no. 6 (1989): 683-84.

3. Works on End of Life and Disorders of Consciousness

Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death. "A Definition of Irreversible Coma." *Journal of the American Medical Association* 205, no. 6 (1968): 337-40.

American Academy of Neurology. "Position of the American Academy of Neurology on Certain Aspects of the Care and Management of the Persistent Vegetative State Patient." *Neurology* 39, no. 1 (1989): 125-26.

American Medical Association, Council on Scientific Affairs and Council on Ethical and Judicial Affairs. "Persistent Vegetative State and the Decision to Withdraw or Withhold Life Support." *Journal of the American Medical Association* 263, no. 3 (1990): 426-30.

American Neurological Association Committee on Ethical Affairs. "Persistent Vegetative State: Report of the A.N.A. Committee on Ethical Affairs." *Annals of Neurology* 33, no. 4 (1993): 386-91.

Andrews, K. "International Working Party on the Management of the Vegetative State." *Brain Injury* 10, no. 11 (1996): 797-806.

Ashby, Michael. "The Fallacies of Death Causation in Palliative Care." *Medical Journal of Australia* 166, no. 4 (1997), http://www.mja.com.au/public/issues/feb17/ashby/ashby.html.

Ashley, Benedict. "Integrative Unity and the Human Soul." *National Catholic Bioethics Quarterly* 1, no. 1 (2001): 7-9.

Austriaco, Nicanor, Basil Cole, and William E. May. "Reply to Fr. Ashley." *National Catholic Bioethics Quarterly* 1, no. 1 (2001): 9-11.

Bernat, James L. "The Boundaries of the Persistent Vegetative State." *Journal of Clinical Ethics* 3, no. 3 (1992): 176-80.

------. "Chronic Disorders of Consciousness." *Lancet* 367, no. 9517 (2006): 1181-92.

Bishops of Maryland. "Comfort and Consolation: Care of the Sick and Dying." June, 2007, http://www.mdcathcon.org/library/resources/Documents/Publications/COMFCONSInsideFinal.pdf.

British Medical Association, Ethics Department. *Treatment of Patients in Persistent Vegetative State: Guidelines from the BMA's Medical Ethics Department*. London: British Medical Association, 2007.

Byrne, Peter. "'Brain Death' is Not Death." *Catholic World Report* (March 2005): 54-58, http://www.catholicculture.org/library/view.cfm?recnum=6647.

Callahan, Daniel. "On Defining a 'Natural Death.'" *Hastings Center Report* 7, no. 3 (1977): 32-37.

------. "Pursuing a Peaceful Death." *Hastings Center Report* 23, no. 4 (1993): 33-38.

------. "Terminating Life-Sustaining Treatment of the Demented." *Hastings Center Report* 25, no. 6 (1995): 25-31.

------. *The Troubled Dream of Life: Living with Mortality*. New York: Simon and Schuster, 1993.

Callahan, Daniel, Gilbert Meilaender, William B. Smith, M. Therese Lysaught, Caroline Whitbeck, William E. May, and Eric Cassell. "The Sanctity of Life Seduced: A Symposium on Medical Ethics." *First Things* 42 (April 1994): 13-27, http://www.firstthings.com/article.php3?id_article=4439.

Campbell, A. G. M. "Children in a Persistent Vegetative State." *British Medical Journal* 289 (October 20, 1984): 1022-23.

Carlin, Nathan, and Donald Capps. "Consciousness, the Vegetative State, and the Intrinsic Value of Life." *Pastoral Psychology* 57, nos. 5-6 (2009): 223-34.

Catholic Education Resource Center. "Definitions on Euthanasia: International Task Force on Euthanasia and Assisted Suicide." http://catholiceducation.org/articles/euthanasia/eu0018.html.

Cattorini, Paolo, and Massimo Reichlin. "Persistent Vegetative State: A Presumption to Treat." *Theoretical Medicine* 18, no. 3 (1997): 263-81.

Celesia, Gastone G. "Persistent Vegetative State: Clinical and Ethical Issues." *Theoretical Medicine* 18, no. 3 (1997): 221-36.

Cherry, Mark J. "How Should Christians Make Judgments at the Edge of Life and Death?" *Christian Bioethics* 12, no. 1 (2006): 1-10.

Childs, Nancy L., Walt N. Mercer, and Helen W. Childs. "Accuracy of Diagnosis of Persistent Vegetative State." *Neurology* 43 (1993): 1465-67.

Christian Medical and Dental Associations. "Vegetative State." May 2, 1998, http://www.cmda.org/AM/Template.cfm?Section=Assisted_Suicide_Euthanasia&CONTENTID=3990&TEMPLATE=/CM/ContentDisplay.cfm.

Cohen, Eric. "In Whose Image Shall We Die?" *New Atlantis* 15 (Winter 2007): 21-39.

Cohen, Lewis, Linda Ganzini, Christine Mitchell, Stephen Arons, Elizabeth Goy, and

James Cleary. "Accusations of Murder and Euthanasia in End-of-Life Care." *Journal of Palliative Medicine* 8, no. 6 (2005): 1096-1104.

College of Physicians and Surgeons of Manitoba. *Withholding and Withdrawing Life-Sustaining Treatment*. Statement no. 1602. February 1, 2008, http://www.cpsm.mb.ca/statements/1602.pdf.

Comité Consultatif National d'Ethique. *Opinion on Experimentation on Patients in a Chronic Vegetative State*. 1986, http://www.ccne-ethique.fr/docs/en/avis007.pdf.

Commission on Faith and Witness of the Canadian Council of Churches. "Statement of Convergence on Euthanasia and Assisted Suicide." December, 1996, http://www.ccc-cce.ca/english/faith/euthanasia.htm.

Committee on Medical Ethics, Episcopal Diocese of Washington. *Assisted Suicide and Euthanasia: Christian Moral Perspectives: The Washington Report*. Harrisburg: Morehouse Publishing, 1997.

-----. *Toward a Good Christian Death: Crucial Treatment Choices*. Harrisburg: Morehouse, 1999.

Congregation for the Doctrine of the Faith. *Declaration on Euthanasia*. May 5, 1980, http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc _19800505_euthanasia_en.html.

Council for Health and Human Service Ministries, United Church of Christ. *Making End-of-Life Decisions: United Church of Christ Perspectives*. Cleveland: United Church of Christ, 1993.

Cranford, Ronald E. "The Persistent Vegetative State: The Medical Reality (Getting the Facts Straight)." *Hastings Center Report* 18, no. 1 (1988): 27-32.

Cranford, Ronald E., and David Randolph Smith. "Consciousness: The Most Critical Moral (Constitutional) Standard for Human Personhood." *American Journal of Law & Medicine* 13, nos. 2-3 (1987): 233-48.

de Malherbe, Brice. *Le respect de la vie humaine dans une éthique de communion: Une alternative à la bioéthique à partir de l'attention aux personnes en étét végétatif chronique.* France: Parole et Silence, 2006.

Department for Studies, Division for Church in Society, Evangelical Lutheran Church in America. "End of Life Decisions." November 9, 1992, http://www.elca.org/What-We-Believe/Social-Issues/Messages/End-of-Life-Decisions.aspx.

Diocese of Erie. "End of Life Issues." http://www.eriercd.org/charities4g.asp.

Doyle, Derek, Geoffrey Hanks, Nathan I. Cherny, and Kenneth Calman, eds. *Oxford Textbook of Palliative Medicine*. 3rd ed. Oxford: Oxford University Press, 2004.

Dutch Health Council. *Patients in a Vegetative State*. The Hague, 1994.

Eberl, Jason T. "A Thomistic Understanding of Human Death." *Bioethics* 19, no. 1 (2005): 29-48.

Emanuel, Linda L. "Reexamining Death: The Asymptotic Model and a Bounded Zone Definition." *Hastings Center Report* 25, no. 4 (1995): 27-35.

Emmett, Peter Alan. "The Image of God and the Ending of Life." *Asbury Theological Journal* 47, no. 1 (1992): 53-62.

End of Life Task Force, General Convention of the Episcopal Church. *Faithful Living, Faithful Dying: Anglican Reflections on End of Life Care*. Harrisburg: Morehouse Publishing, 2000.

Evangelical Fellowship of Canada. "Euthanasia and Assisted Suicide: Defining Terms." http://www.evangelicalfellowship.ca/NetCommunity/Page.aspx?pid=624.

Feinberg, William M., and Peggy C. Ferry. "A Fate Worse than Death: The Persistent Vegetative State in Childhood." *American Journal of Diseases of Children* 138, no. 2 (1984): 128-30.

Fins, Joseph J. "Across the Divide: Religious Objections to Brain Death." *Journal of Religion and Health* 34, no. 1 (1995): 33-39.

------. "Rethinking Disorders of Consciousness: New Research and Its Implications." *Hastings Center Report* 35, no. 2 (2005): 22-24.

Freedman, Benjamin. "Death: The Final Stage of Confusion." *Journal of Clinical Ethics* 2, no. 2 (1991): 125-6.

------. "The Titration of Death: A New Sin." *Journal of Clinical Ethics* 1, no. 4 (1990): 275-77.

Freeman, E. A. "The Persistent Vegetative State: A 'Fate Worse Than Death.'" *Clinical Rehabilitation* 6, no. 2 (1992): 159-65.

Giacino Joseph T., and Richard Malone. "The Vegetative and Minimally Conscious States." In *Disorders of Consciousness*, edited by G. Bryan Young and Eelco F. M. Wijdicks, 99-114. Edinburgh: Elsevier Health Sciences, 2008.

Gigli, Gian Luigi, and Mariarosario Valente. "Quality of Life and the Persistant Vegetative State." Paper presented at the Eleventh Assembly of the Pontifical Academy for Life, February 21-23, 2005, http://www.academiavita.org/template.jsp?sez=Pubblicazioni&pag=testo/ qual_vita/gigli/gigli&lang=english.

Gigli, Gian Luigi, and Nathan David Zasler. "Foreword." *NeuroRehabilitation* 19, no. 4 (2004): 271-72.

Gormally, Luke. "Definitions of Personhood: Implications for the Care of PVS Patients." *Ethics & Medicine* 9, no. 3 (1993): 44-48.

Hamel, Ronald P. "The Catholic Health Association's Response to the Papal Allocution on Artificial Nutrition and Hydration." *Virtual Mentor: American Medical Association Journal of Ethics* 9, no. 5 (2007): 388-92.

Harris, Curtis E., John O'Keefe, Robert D. Orr, and Gilbert Meilaender. "The End of Care." *First Things* 148 (December 2004): 6-8.

Howsepian, A. A. "The 1994 Multi-Society Task Force Consensus Statement on the Persistent Vegetative State: A Critical Analysis." *Issues in Law and Medicine* 12, no. 1 (1996): 3-29.

------. "Philosophical Reflections on Coma." *Review of Metaphysics* 47, no. 4 (1994):

735-56.

International Task Force on Euthanasia and Assisted Suicide. "Euthanasia Definitions." http://euthanasia.com/definitions.html.

Jennett, Bryan. "Resource Allocation for the Severely Brain Damaged." *Archives of Neurology* 33, no. 9 (1976): 595-97.

------. *The Vegetative State: Medical Facts, Ethical and Legal Dilemmas*. Cambridge: Cambridge University Press, 2002.

Jennett, Bryan, and Fred Plum. "Persistent Vegetative State after Brain Damage: A Syndrome in Search of a Name." *Lancet* 1, no. 7753 (1972): 734-37.

John Paul II. "To the Participants in the 19th International Conference of the Pontifical Council for Health Pastoral Care." November 12, 2004, http://www.vatican.va/holy_fatherjohn_paul_ii/speeches/2004/november/documents/hf_jp-ii_spe_20041112_pc-hlthwork_en.html.

------. "To the Participants in the International Congress on 'Life-Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas.'" March 20, 2004, http://www.vatican.va/holy_father/john_paul_ii/speeches/2004/march/index_en.htm.

Kaufman, Sharon R. "In the Shadow of 'Death with Dignity': Medicine and Cultural Quandaries of the Vegetative State." *American Anthropologist* 102, no. 1 (2000): 69-83.

Kingsbury, Robert J., and Howard M. Ducharme. "The Debate Over Total/Terminal/Palliative Sedation." Center for Bioethics and Human Dignity, January 24, 2002, http://www.cbhd.org/resources/endoflife/kingsbury-ducharme_2002-01-24.htm.

Krimchansky, Ben-Zion, Leon Sazbon, Leon Heller, Hanan Kosteff, and Zvi Luttwak. "Bladder Tone in Patients in Post-traumatic Vegetative State." *Brain Injury* 13, no. 11 (1999): 899-903.

Kushner, Thomasine. "Having a Life versus Being Alive." *Journal of Medical Ethics* 10, no. 1 (1984): 5-8.

Lamau, M.-L., B. Cadore, and P. Boitte. "From 'The Ethical Treatment of Patients in a Persistent Vegetative State' to a Philosophical Reflection on Contemporary Medicine." *Theoretical Medicine* 18, no. 3 (1997): 237-62.

Laureys, Steven. "Eyes Open, Brain Shut: The Vegetative State." *Scientific American* (May 2007): 32-37.

Laureys, Steven, Fabien Perrind, Caroline Schnakers, Melanie Boly, and Steve Majerus. "Residual Cognitive Function in Comatose, Vegetative and Minimally Conscious States." *Current Opinion in Neurology* 18 (December 2005): 726-33.

Leowy, Erich H. "Terminal Sedation, Self-Starvation, and Orchestrating the End of Life." *Archives of Internal Medicine* 161, no. 3 (2001): 329-32.

McCormick, Richard A. *Corrective Vision: Explorations in Moral Theology*. Kansas City: Sheed & Ward, 1994.

------. "Technology, the Consistent Ethic and Physician-Assisted Suicide." *Origins* 25, no. 27 (1995), http://originsplus.catholicnews.com.

------. "To Save or Let Die: The Dilemma of Modern Medicine." *America* (July 7, 1974): 6-10.

McCullagh, Peter. *Brain Dead, Brain Absent, Brain Donors: Human Subjects or Human Objects?* New York: John Wiley & Sons, 1993.

------. *Conscious in a Vegetative State? A Critique of the PVS Concept.* Dordrecht: Kluwer, 2004.

Meilaender, Gilbert. "The Distinction between Killing and Allowing to Die." *Theological Studies* 37, no. 3 (1976): 467-70.

------. "Living Life's End." *First Things* 153 (May 2005): 17-21.

Muller, Jessica H., and Barbara A. Koenig. "On the Boundary of Life and Death: The Definition of Dying by Medical Residents." In *Biomedicine Examined*, edited by Margaret Lock and Deborah Gordon, 351-74. Dordrecht: Kluwer, 1988.

Multi-Society Task Force on PVS. "Medical Aspects of the Persistent Vegetative State." Pts. 1 and 2. *New England Journal of Medicine* 330, no. 21 (1994): 1499-1508; 330, no. 22 (1994): 1572-79, http://content.nejm.org/cgi/content/full/330/21/1499 and http://content.nejm.org/cgi/content/full/330/21/1499.

National Health and Research Council of Australia. "Post-Coma Unresponsiveness (Vegetative State): A Clinical Framework for Diagnosis." 2004, http://www.nhmrc.gov.au/publications/synopses/_files/hpr23.pdf.

O'Brien, Dan, John Paul Slosar, and Anthony R. Tersigni. "Utilitarian Pessimism, Human Dignity, and the Vegetative State: A Practical Analysis of the Papal Allocution." *National Catholic Bioethics Quarterly* 4, no. 3 (2004): 497-512.

O'Mathúna, Dónal P. "Responding to Patients in the Persistent Vegetative State." *Philosophia Christi* 19, no. 2 (1996): 55-83.

O'Rourke, Kevin D. "On the Care of 'Vegetative' Patients." Pts. 1 and 2. *Ethics & Medics* 24, no. 4 (1999): 3-4; 24, no. 5 (1999): 3-4.

O'Rourke, Kevin D., and Patrick Norris. "Care of PVS Patients: Catholic Opinion in the United States." *Linacre Quarterly* 68, no. 3 (2001): 201-17.

Orr, Robert D. "Just Put Me to Sleep…Please! Ethical Issues in Palliative and 'Terminal Sedation.'" *Update* 18, no. 2 (2002): 1-4, 8.

Orr, Robert D., and Gilbert Meilaender. "Ethics and Life's Ending: An Exchange." *First Things* 145 (August-September 2004): 31-38.

Pierce, John P., David M. Lyle, Susan Quine, Nicola J. Evans, John Morris, and Michael R. Fearnside. "The Effectiveness of Coma Arousal Intervention." *Brain Injury* 4, no. 2 (1990): 191-97.

Pontifical Academy for Life and World Federation of Catholic Medical Associations.

"Joint Statement on the Vegetative State." March 17, 2004, http://www.vatican.va/roman_curia/pontifical_academies/acdlife/documents/rc_pont-acd_life_doc _20040320_joint-statement-veget-state_en.html.

President's Council on Bioethics. *Controversies in the Determination of Death: A White Paper*. Washington, D. C.: President's Council on Bioethics, 2008.

Rakestraw, Robert V. "The Persistent Vegetative State and the Withdrawal of Nutrition and Hydration." *Journal of the Evangelical Theological Society* 35, no. 3 (1992): 389-405

Ravelingien, A., F. Mortier, E. Mortier, I. Kerremans, and J. Braeckman. "Proceeding with Clinical Trials of Animal to Human Organ Transplantation: A Way Out of the Dilemma." *Journal of Medical Ethics* 30, no. 1 (2004): 92-98.

Rousseau, M. C., S. Confort-Gouny, A. Catala, J. Graperon, J. Blaya, E. Soulier, P. Viout, D. Galanaud, Y. Le Fur, P. J. Cozzone, and J. P. Ranjeva. "A MRS-MRI-fMRI Exploration of the Brain: Impact of Long-lasting Persistent Vegetative State." *Brain Injury* 22, no. 2 (2008): 123-34.

Schneiderman, Lawrence J. "Exile and PVS." *Hastings Center Report* 20, no. 3. (1990): 5.

Schotsmans, Paul. "The Patient in a Persistent Vegetative State: An Ethical Re-appraisal." *Bijdragen, tijdschrift voor filosofie en theologie* 54 (1993): 2-18.

Sgreccia, Elio. "Communicating Information to the Incurably Sick." Paper presented at the Fourteenth Assembly of the Pontifical Academy for Life, February 25-26, 2008, http://www.academiavita.org/english/AssembleaGenerale/2008/rel2008/sgreccia/sgreccia_eng2008.pdf.

------. "Vegetative State and Brain Death: Philosophical and Ethical Issues from a Personalistic View." *Neurorehabilitation* 19, no. 4 (2004): 361-66.

Shewmon, D. Alan. "The ABC of PVS: Problems of Definition." In *Brain Death and Disorders of Consciousness*, edited by Calixto Machado and D. Alan Shewmon, 215-28. New York: Springer, 2004.

------. "A Critical Analysis of Conceptual Domains of the Vegetative State: Sorting Fact from Fancy." *NeuroRehabilitation* 19 (2004): 343-47.

------. "Recovery from 'Brain Death': A Neurologist's Apologia." *Linacre Quarterly* 64, no. 1 (1997): 30-96.

Singer, Peter. "Is the Sanctity of Life Ethic Terminally Ill?" *Bioethics* 9, nos. 3-4 (1995): 327-43.

Social Action Commission of the Evangelical Fellowship of Canada. *A Matter of Life and Death: A Discussion Paper on Euthanasia*. March 1994, http://files.efc-canada.net/si/Euthanasia/Euth-Matter_Life_Death.pdf.

Southern Baptist Convention. "Resolution on Euthanasia and Assisted Suicide." June 9-11, 1992, http://www.sbc.net/resolutions/amResolution.asp?ID=493.

Spinsanti, Sandro, and Angela Schneider O'Connell. "The French Vegetative State."

Review of *Etats vegetatifs chroniques: répercussions humaines; aspects medicaux, juridiques et éthiques*, by François Tasseau, Marie-Hélène Boucand, Jean-Roger LeGall, and Patrick Verspieren. *Hastings Center Report* 22, no. 4. (1992): 36-37.

Sullivan, Joseph V. *The Morality of Mercy Killing*. Foreword by Francis J. Connell. Westminster: Newman Press, 1950.

Tännsjö, Torbjörn, ed. *Terminal Sedation: Euthanasia in Disguise?* Dordrecht: Kluwer, 2004.

Task Force on Assisted Suicide, Episcopal Diocese of Newark. *Report of the Task Force on Assisted Suicide to the 122nd Convention of the Episcopal Diocese of Newark*. January 27, 1996, http://www.dioceseofnewark.org/report.html.

Task Group of the Faith, Worship and Ministry Committee, Anglican Church of Canada. *Care in Dying: A Consideration of the Practices of Euthanasia and Physician Assisted Suicide*. Toronto: Anglican Church of Canada, 1998.

Tasseau, François, Marie-Hélène Boucand, Jean-Roger LeGall, and Patrick Verspieren. *États végétatifs chroniques: répercussions humaines; aspects médicaux, juridiques et éthiques*. Rennes, France: Éditions École Nationale de la Santé Publique, 1991.

Teasdale, Graham, and Bryan Jennett. "Assessment of Coma and Impaired Consciousness: A Practical Scale." *Lancet* 304, no. 7872 (1974): 81-84.

Thobaben, James R. "A United Methodist Approach to End-of-Life Decisions: Intentional Ambiguity or Ambiguous Intentions." *Christian Bioethics* 3, no. 3 (1997): 222-48.

Thomasma, David C. "The Range of Euthanasia." *Bulletin of the American College of Surgeons* 73, no. 8 (1988): 4-13

Torchia, Joseph. "Postmodernism and the Persistent Vegetative State." *National Catholic Bioethics Quarterly* 2, no. 2 (2002): 257-75.

Tudor, Maureen. "Persistent Vegetative State: Some Clinical Observations." *Ethics & Medicine* 9, no. 3 (1993): 37-39.

Veatch, Robert M. *Death, Dying, and the Biological Revolution: Our Last Quest for Responsibility*. New Haven: Yale University Press, 1976.

------. "The Impending Collapse of the Whole Brain Definition of Death." *Hastings Center Report* 23, no. 4 (1993): 18-24.

Veronesi, U. "Italy: Ad Hoc Committee on Artificial Nutrition and Hydration of Individuals in a Permanent Vegetative State." *Journal International de Bioéthique* 4, no. 12 (2001): 75-80.

Wechter, David. "The Soul and the Persistent Vegetative State." *National Catholic Bioethics Quarterly* 3, no. 2 (2003): 243.

Zimmerman, Anthony. "Allowing the Unconscious to Depart." *Linacre Quarterly* 58, no. 1 (1991): 17-24.

4. Works on Christian Bioethics

Advisory Council on Church and Society of the Presbyterian Church. *The Covenant of Life and the Caring Community, and Covenant and Creation: Theological Reflections on Contraception and Abortion*. New York: Office of the General Assembly, 1983.

Anitei, I. Julian. "Beyond a Culture of Life: Why Philosophy Cannot Restore Christendom." *Christian Bioethics* 8, no. 1 (2002): 91-98.

Ashley, Benedict M., Jean K. deBlois, and Kevin D. O'Rourke. *Health Care Ethics: A Catholic Theological Analysis*. 5th ed. Washington, D.C.: Georgetown University Press, 2006.

Bernardin, Joseph. "Call for a Consistent Ethic of Life." *Origins* (December 29, 1983): 492-93.

Berry, R. J. "Fabricated Nature: Where are the Boundaries?" *Ecotheology* 11, no. 1 (2006): 9-31.

Braine, David. *Medical Ethics and Human Life*. 2nd ed. Great Britain: Palladio, 1983.

Cahill, Lisa Sowle. "Moral Notes 2006: Bioethics." *Theological Studies* 67, no. 1 (2006): 120-42.

Cataldo, Peter J., and Albert S. Moraczewski, eds. *Catholic Health Care Ethics: A Manual for Ethics Committees*. Foreword by Edmund D. Pellegrino. Boston: National Catholic Bioethics Center, 2001.

Congregation for the Doctrine of the Faith. "Instruction *Dignitas Personae* on Certain Bioethical Questions." September 8, 2008, http://ncronline.org/mainpage/specialdocuments/Dignitas_Personae_Inglese.pdf.

------. "Instruction on Respect for Human Life in Its Origin and on the Dignity of Procreation." March 10, 1987, http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19870222_respect-for-human-life_en.html.

Cranston, Robert E. "Is It Permissible to Forego Life-Saving Dialysis?" *Ethics & Medicine* 24, no. 2 (2008): 83-85

Curran, Charles E. "The Catholic Moral Tradition in Bioethics." In *The Story of Bioethics: From Seminal Works to Contemporary Explorations*, edited by Jennifer K. Walter and Eran P. Klein, 113-30. Washington: Georgetown University Press, 2003.

du Toit, D. A. "Anthropology and Bioethics." *Ethics & Medicine* 10, no. 2 (1994): 35-42.

Engelhardt, H. Tristram, Jr. *The Foundations of Christian Bioethics*. Lisse: Swets & Zeitlinger Publishers, 2000.

Engelhardt, H. Tristram, Jr., and Mark Cherry, eds. *Allocating Scarce Medical Resources: Roman Catholic Perspectives*. Washington, D.C.: Georgetown University Press, 2002.

Engelhardt, H. Tristram, Jr., and Ana Smith Iltis, "End-of-Life: The Traditional Christian

View." *Lancet* 366, no. 9490 (2005): 1045-49.

George, Francis. "The Need for Bioethical Vision." In *Cutting-Edge Bioethics: A Christian Exploration of Technologies and Trends*, edited by John F. Kilner, C. Christopher Hook, and Diann B. Uustal, 90-100. Grand Rapids: William B. Eerdmans, 2002.

Gilkey, Langdon. "Theological Frontiers: Implications for Bioethics." In *Theology and Bioethics: Exploring the Foundations and Frontiers*, edited by Earl E. Shelp, 115-33. Dordrecht: D. Reidel Publishing Company, 1985.

Gill, Robin. *Health Care and Christian Ethics*. Cambridge: Cambridge University Press, 2006.

Glannon, Walter. "Tracing the Soul: Medical Decisions at the Margins of Life." *Christian Bioethics* 6, no. 1 (2000): 49-69.

Gormally, Luke. "Human Dignity: The Christian View and the Secularist View." Paper presented at the Seventh Assembly of the Pontifical Academy for Life, March 1-4, 2001, http://www.academiavita.org/template.jsp?sez= Pubblicazioni&pag=testo/cultvita/gormally/gormally&lang=english.

------, ed. *Issues for a Catholic Bioethic: Proceedings of the International Conference to Celebrate the Twentieth Anniversary of the Foundation of The Linacre Centre, 28-31 July 1997*. The Linacre Centre: London, 1999.

Graham, Elaine. "In Whose Image? Representations of Technology and the 'Ends' of Humanity." *Ecotheology* 11, no. 2 (2006): 159-82.

Grisez, Germain. "Bioethics and Christian Anthropology." *National Catholic Bioethics Quarterly* 1, no. 1 (2001): 33-38.

Grisez, Germain, Joseph Boyle, and John Finnis. "Practical Principles, Moral Truth, and Ultimate Ends." *American Journal of Jurisprudence* 32 (1987): 99-151.

Hauerwas, Stanley. *Naming the Silences: God, Medicine, and the Problem of Suffering*. Grand Rapids: William B. Eermans Publishing Company, 1990.

------. *Suffering Presence: Theological Reflections on Medicine, the Mentally Handicapped, and the Church*. Notre Dame: University of Notre Dame Press, 1986.

John Paul II. "To the 18th International Congress of the Transplantation Society." August 29, 2000, http://www.vatican.va/holy_father/john_paul_ii/speeches/ 2000/jul-sep/documents/hf_jp-ii_spe_20000829_transplants_en.html.

------. "To the President of the Pontifical Academy for Life on the Occasion of a Study Congress on 'Quality of Life and Ethics of Health.'" February 19, 2005, http://www.vatican.va/holy_father/john_paul_ii/letters/2005/documents/hf_jp-ii_let_20050219_pont-acad-life_en.html.

------. "To the Scientists of the Pontifical Academy of Sciences." October 21, 1985, http://www.vatican.va/holy_father/john_paul_ii/speeches/1985/october/documents/hf_jp-ii_spe_19851021_pontificia-accademia-scienze_en.html.

Jones, D. Gareth. "Making Human Life Captive to Biomedical Technology: Christianity and the Demise of Human Values." *Update* 11, no. 4 (1995): 1-7.

Keenan, James F. "Dualism in Medicine, Christian Theology, and the Aging." *Journal of Religion and Health* 35, no. 1 (1996): 33-45.

Kelly, David F. *Contemporary Catholic Health Care Ethics*. Washington, D.C.: Georgetown University Press, 2004.

Kelly, Gerald. *Medico-Moral Problems*. St. Louis: Catholic Hospital Association. 1958.

Kilner, John F. *Life on the Line: Ethics, Aging, Ending Patients' Lives, and Allocating Vital Resources*. Grand Rapids: William B. Eerdmans, 1992.

Lammers, Stephen E., and Allen Verhey, eds. *On Moral Medicine: Theological Perspectives in Medical Ethics*. Grand Rapids: William B. Eerdmans, 1987. And 2nd ed. Grand Rapids: William B. Eerdmans, 1998.

Latkovic, Mark S. "The Role of Morality and Personhood in Health Care and Its Dilemmas: A Catholic Natural Law Perspective." Paper presented at the Bioethics Seminar Series of the Lansing Guild of the Catholic Medical Association, St. John's Center for Youth and Family, October 11, 2003.

May, William E. "What is a Human Person and Who Counts as a Human Person? A Crucial Question for Bioethics." http://www.christendom-awake.org/pages/may/humanperson.htm.

McCormick, Richard A. *Health and Medicine in the Catholic Tradition: Tradition in Transition*. New York: Crossroad, 1985.

------. *How Brave a New World: Dilemmas in Bioethics*. Washington, D.C.: Georgetown University Press, 1981.

McKenny, Gerald P. "Technology." In *The Blackwell Companion to Religious Ethics*, edited by William Schweiker, 459-68. Oxford: Blackwell Publishing, 2005.

------. *To Relieve the Human Condition: Bioethics, Technology, and the Body*. Albany: State University of New York Press, 1997.

Meilaender, Gilbert. *Bioethics: A Primer for Christians*. 2nd ed. Grand Rapids: William B. Eerdmans, 2005.

------. "Bioethics and the Character of Human Life." *New Atlantis* 1 (Spring 2003): 67-78.

------. *Body, Soul, and Bioethics*. Notre Dame: University of Notre Dame Press, 1995.

------. "Love's Casuistry': Paul Ramsey on Caring for the Terminally Ill." *Journal of Religious Ethics* 19, no. 2 (1991): 133-56.

Monks of Solesmes, eds. *The Human Body*. Boston: St. Paul Editions, 1979.

O'Donovan, Oliver. Review of *Evangelium Vitae*, by John Paul II. *Studies in Christian Ethics* 9, no. 1 (1996): 89-94.

O'Rourke, Kevin D. "As Time Goes By: Twenty-Five Years of Bioethics." *Cambridge Quarterly of Healthcare Ethics* 11, no. 4 (2002): 380-87.

O'Rourke, Kevin D., and Philip Boyle, eds. *Medical Ethics: Sources of Catholic Teachings*. 2nd ed. Washington: Georgetown University Press, 1993.

O'Rourke, Kevin D., and Dennis Brodeur. *Medical Ethics: Common Ground for Understanding*. St. Louis: U. S. Catholic Health Association, 1986.

Pellegrino, Edmund D., John P. Langan, and John Collins Harvey, eds. *Catholic Perspectives on Medical Morals: Foundational Issues*. Dordrecht: Kluwer Academic Publishers, 1981.

Pellegrino, Edmund D., and David C. Thomasma. *The Christian Virtues in Medical Practice*. Edited by David G. Miller. Washington, D.C.: Georgetown University Press, 1996.

Pessina, Adriano. "The Culture of Life and the Technological Mentality." Paper presented at the Seventh Assembly of the Pontifical Academy for Life, March 1-4, 2001, http://www.academiavita.org/template.jsp?sez=Pubblicazioni&pag=testo/cultvita/pessina/pessina&lang=english.

Pius XII. "Applied Psychology." *The Pope Speaks* 5, nos. 8-9 (1958): 7-20.

------. "The Morality of Pain Prevention." *Catholic Mind* 55 (May-June 1957): 260-78.

------. "Tranquilizers and Christian Morals." *The Pope Speaks* 5, nos.8-9 (1958): 431-39.

Pontifical Council for Pastoral Assistance to Health Care Workers. "The Charter for Health Care Workers." 1995, http://www.healthpastoral.org/text.php?cid=256&sec=4&docid=26&lang=en.

Ramsey, Paul. *Basic Christian Ethics*. Louisville: Westminster/John Knox Press, 1993.

------. *Ethics at the Edges of Life: Medical and Legal Intersections*. New Haven: Yale University Press, 1978.

------. "The Indignity of 'Death with Dignity.'" *Hastings Center Report* 2, no. 2 (1974): 47-62.

------. "The Morality of Abortion." In *Moral Problems: A Collection of Philosophical Essays*, edited by James Rachels, 5-27. New York: Harper & Row, 1971.

------. *The Patient as Person: Explorations in Medical Ethics*. New Haven: Yale University Press, 1970. And 2nd ed. Foreword by Margaret Farley, essays by Albert R. Jonsen and William F. May. New Haven: Yale University Press, 2002.

Secretariat of Roman Catholic Church in Netherlands. *Euthanasia and Human Dignity: A Collection of Contributions by the Dutch Catholic Bishops' Conference to the Legislative Procedure 1983-2001*. Edited by P. Kohnen and G. Schumacher. Utrecht: Peeters, 2002.

Seifert, Joseph. "The Right to Life and the Fourfold Root of Human Dignity." Paper presented at the Eighth Assembly of the Pontifical Academy for Life, February 25-27, 2002, http://www.academiavita.org/template.jsp?sez=Pubblicazioni&pag=testo/nat_dig/seifert/seifert&lang=English.

Sgreccia, Elio, and Maria Luisa Di Pietro. "The Life of the Spirit in Corporeity: Person

and Personality." Paper presented at the Seventh Assembly of the Pontifical Academy for Life, March 1-4, 2001, http://www.academiavita.org/template.jsp?sez=Pubblicazioni&pag=testo/cultvita/sgreccia_di_pietro/sgreccia_di_pietro&lang=english.

Shannon, Thomas A. "Grounding Human Dignity." *Dialog* 43, no. 2 (2004): 113-17.

Shuman, Joel, and Brian Volck. *Reclaiming the Body: Christians and the Faithful Use of Modern Medicine*. Grand Rapids: Brazos Press, 2006.

Smith, George P, II. *The Christian Religion and Biotechnology: A Search for Principled Decision-making*. Dordrecht: Springer, 2005.

Sulmasy, Daniel P. "Death, Dignity, and the Theory of Value." *Ethical Perspectives* 9, nos. 2-3 (2002): 103-18.

Taylor, Carol, and Roberto Dell'Oro, eds. *Health and Human Flourishing: Religion, Medicine, and Moral Anthropology*. Washington, D.C.: Georgetown University Press, 2006.

United States Conference of Catholic Bishops. *Ethical and Religious Directives for Catholic Health Care Services*. 4th ed. Washington D.C.: United States Conference of Catholic Bishops, 2001. Also available online at http://www.usccb.org/bishops/directives.shtml.

Verhey, Allen. "What Makes Christian Bioethics Christian? Bible, Story, and Communal Discernment." *Christian Bioethics* 11, no. 3 (2005): 297-315.

Waters, Brent. "Freedom in Responsibility: A Response." *Christian Bioethics* 11, no. 2 (2005): 167-73.

Wildes, Kevin W., Francesc Abel, and John C. Harvey, eds. *Birth, Suffering, and Death: Catholic Perspectives at the Edges of Life*. Dordrecht: Kluwer, 1992.

5. Works on Bioethics in the Public Square

Albrecht, Gary L., and Patrick J. Devlieger. "The Disability Paradox: High Quality of Life against All Odds." *Social Science & Medicine* 48, no. 8 (1999), 977-88.

Beauchamp, Tom L. "The 'Four Principles' Approach." In *Principles of Health Care Ethics*, edited by Raanan Gillon, 3-12. New York: John Wiley & Sons, 1994.

Beauchamp, Tom L., and James F. Childress. *Principles of Biomedical Ethics*. New York: Oxford University Press, 1979.

Callahan, Daniel. "Conservatives, Liberals, and Medical Progress." *New Atlantis* 10 (Fall 2005): 3-16.

------. *Setting Limits: Medical Goals in an Aging Society*. Washington: Georgetown University Press, 1995.

------. *The Tyranny of Survival and Other Pathologies of Civilized Life*. New York: Macmillan, 1973.

------. *What Kind of Life: The Limits of Medical Progress*. New York: Simon & Schuster,

1990.

Callahan, Daniel, and Erik Parens. "The Ends of Medicine: Shaping New Goals." *Bulletin of the New York Academy of Medicine* 72, no. 1 (1995): 95-117.

Cassell, Eric J. *The Nature of Suffering and the Goals of Medicine*. 2nd ed. Oxford: Oxford University Press, 2004.

------. "The Sorcerer's Broom: Medicine's Rampant Technology." *Hastings Center Report* 23, no. 6 (1993): 32-39.

DeGrazia, David. "Enhancement Technologies and Human Identity." *Journal of Medicine and Philosophy* 30, no. 3 (2005): 261-83.

Emanuel, Ezekiel J. *The Ends of Human Life: Medical Ethics in a Liberal Polity*. Cambridge: Harvard University Press, 1991.

Engelhardt, H. Tristram, Jr., and Daniel Callahan, eds. *Knowing and Valuing: The Search for Common Roots*. New York: Institute for Society, Ethics and the Life Sciences (The Hastings Center), 1980.

Engelhardt, H. Tristram, Jr., and Stuart F. Spicker, eds. *Evaluation and Explanation in the Biomedical Sciences*. Dordrecht: D. Reidel Publishing, 1975.

Entralgo, P. Lain. *Doctor and Patient*. Translated by Frances Partridge. New York: McGraw-Hill, 1969.

Freedman, Benjamin. "Offering the Truth: One Ethical Approach to the Uninformed Cancer Patient." *Archives of Internal Medicine* 153, no. 5 (1993): 572-76.

Fuchs, Victor R. "The Growing Demand for Medical Care." In *Essays in the Economics of Health and Medical Care*, edited by Victor R. Fuchs, 61-68. New York: Columbia University Press, 1972.

Hanson, Mark J., and Daniel Callahan, eds. *The Goals of Medicine: The Forgotten Issue in Health Care Reform*. Washington, D.C.: Georgetown University Press, 1999.

Hofmann, Bjørn. "Is There a Technological Imperative in Health Care?" *International Journal of Technology Assessment in Health Care* 18, no. 3 (2002): 675-89.

Interagency Advisory Panel on Research Ethics, *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans*. 2nd ed. (draft). Ottawa: 2008.

Isaacs, David, Henry Kilham, Adrienne Gordon, Heather Jeffery, William Tarnow-Mordi, Janet Woolnough, Julie Hamblin, and Bernadette M. Tobin. "Withdrawal of Neonatal Mechanical Ventilation against the Parents' Wishes." *Journal of Paediatrics and Child Health* 42, no. 5 (2006): 311-15.

Kass, Leon. "Regarding the End of Medicine and the Pursuit of Health." *Public Interest* 40 (Summer 1975): 11-42.

Kaufman, Sharon R. "Intensive Care, Old Age, and the Problem of Death in America." *Gerontologist* 38, no. 6 (1998): 715-25.

Koch, Tom. "Bioethics as Ideology: Conditional and Unconditional Values." *Journal of Medicine and Philosophy* 31, no. 3 (2006): 251-67.

Koenig, Barbara A. "The Technological Imperative in Medical Practice: The Social Creation of a 'Routine' Treatment." In *Biomedicine Examined*, edited by Margaret Lock and Deborah Gordon, 465-96. Dordrecht: Kluwer, 1988.

Kuhse, Helge. "A Modern Myth: That Letting Die is Not the Intentional Causation of Death." In *Bioethics: An Anthology*. 2nd ed., edited by Peter Singer and Helge Kuhse, 315-28. Oxford: Blackwell, 2006.

Lizza, John P. *Persons, Humanity, and the Definition of Death*. Baltimore: Johns Hopkins University Press, 2006.

Lysaught, M. Therese. "Respect: Or, How Respect for Persons Became Respect for Autonomy." *Journal of Medicine and Philosophy* 29, no. 6 (2004): 665-80.

MacIntyre, Alasdair. "Can Medicine Dispense with a Theological Perspective on Human Nature?" In *The Roots of Ethics: Science, Religion, and Values*, edited by Daniel Callahan and H. Tristram Engelhardt, Jr., 119-37. New York: Plenum Press, 1981.

McKenny, Gerald. P. "The Integrity of the Body: Critical Remarks on a Persistent Theme in Bioethics." In *Persons and their Bodies: Rights, Responsibilities, Relationships,* edited by Mark J. Cherry, 353-61. Great Britain: Kluwer, 1999.

Meilaender, Gilbert. "Human Dignity and Public Bioethics." *New Atlantis* 17 (Summer 2007): 33-52.

Mitchell, C. Ben, Edmund D. Pellegrino, Jean Bethke Elshtain, John F. Kilner, and Scott B. Rae. *Biotechnology and the Human Good*. Washington, D.C.: Georgetown University Press, 2007.

Palazzini, Laura. "Advance Directives and Living Wills." *Neurorehabilitation* 19, no. 4 (2004): 305-13.

Pellegrino, Edmund D. "The Internal Morality of Clinical Medicine: A Paradigm for the Ethics of the Helping and Healing Professions." *Journal of Medicine and Philosophy* 26, no. 6 (2001): 559-79.

------. "Philosophy of Medicine: Should It Be Teleologically or Socially Construed?" *Kennedy Institute of Ethics Journal* 11, no. 2 (2001): 169-80.

------. *Physician and Philosopher: The Philosophical Foundation of Medicine: Essays by Dr. Edmund Pellegrino*. Foreword by Daniel P. Sulmasy. Charlottesville: Carden Jennings, 2001.

Pellegrino, Edmund D., and David C. Thomasma. *For the Patient's Good: The Restoration of Beneficence in Health Care*. New York: Oxford University Press, 1988.

------. *A Philosophical Basis of Medical Practice: Toward a Philosophy and Ethic of the Healing Professions.* New York: Oxford University Press, 1981.

Potter, Van Rensselaer. "Bioethics, the Science of Survival." *Perspectives in Biology and Medicine* 13 (1970): 127-53.

President's Council on Bioethics, ed. *Human Dignity and Bioethics: Essays*

Commissioned by the President's Council on Bioethics. Washington, D.C., President's Council on Bioethics: 2008.

Quill, Timothy E., Rebecca Dresser, and Dan W. Brock. "The Rule of Double Effect: A Critique of Its Role in End-of-life Decision Making." *New England Journal of Medicine* 337, no. 24 (1997): 1768-71.

Ramsey, Paul. "The Nature of Medical Ethics." In *The Teaching of Medical Ethics*, edited by Robert M. Veatch, Willard Gaylin, and Councilman Morgan, 14-28. Hastings-on-Hudson: Hastings Center Publications, 1973.

Sassower, Raphael, and Michael A. Grodin. "Scientific Uncertainty and Medical Responsibility." *Theoretical Medicine* 8, no. 2 (1987): 221-34.

Schaub, Diana. "Methuselah and Us." *New Atlantis* 4 (Winter 2004): 37-42.

Somerville, Margaret. *Death Talk: The Case against Euthanasia and Physician-assisted Suicide*. Montreal: McGill-Queen's University Press, 2001.

Squier, Susan Merrill. *Liminal Lives: Imagining the Human at the Frontiers of Biomedicine*. Durham: Duke University Press, 2004.

Thomasma, David C., David N. Weisstub, and Christian Hervé, eds. *Personhood and Health Care*. Dordrecht: Kluwer, 2001.

Trotter, Griffin. "Why Bioethics is Ill Equipped to Contribute to the Debate About Prolonging Lifespans." *Health Care Ethics Committee Forum* 16, no. 3 (2004): 197-213.

Vaux, Kenneth, ed. *Who Shall Live: Medicine, Technology, Ethics*. Philadelphia: Fortress Press, 1970.

Veatch, Robert M. "The Impossibility of a Morality Internal to Medicine." *Journal of Medicine and Philosophy* 26, no. 6 (2001): 621-42.

Walter Jennifer K., and Eran P. Klein, eds. *The Story of Bioethics: From Seminal Works to Contemporary Explorations*. Washington, D.C.: Georgetown University Press, 2003.

Whitehouse, Peter J. "The Rebirth of Bioethics: Extending the Original Formulations of Van Rensselaer Potter." *American Journal of Bioethics* 3, no. 4 (2003): W26-W31.

Wildes, Kevin W. "The Crisis of Medicine: Philosophy and the Social Construction of Medicine." *Kennedy Institute of Ethics Journal* 11, no. 1 (2001): 71-86.

Wolfensberger, Wolf. "The Growing Threat to the Lives of Handicapped People in the Context of Modernistic Values." *Disability and Society* 9, no. 3 (1994): 395-413.

World Health Organization. "Preamble to the Constitution of the World Health Organization as Adopted by the International Health Conference." Official Records of the World Health Organization, 1946.

Zaner, Richard M. "Body: Embodiment in the Phenomenological Tradition." In *Encyclopedia of Bioethics*, edited by Stephen G. Post, 320-26. New York: Macmillan Reference, 2004.

6. Works on Christian Ethics and Moral Theology

Ashley, Benedict. *Theologies of the Body: Humanist and Christian*. Braintree: Pope John Center, 1985.

------. "What is the End of the Human Person? The Vision of God and Integral Human Fulfilment." In *Moral Truth and Moral Tradition: Essays in Honour of Peter Geach and Elizabeth Anscombe*, edited by Luke Gormally, forward by Cahal B. Daly, 68-96. Portland: Four Courts Press, 1994.

Barbour, Ian G. *Ethics in an Age of Technology*. San Francisco: Harper Collins, 1993.

Berkman, John. "How Important is the Doctrine of Double Effect for Moral Theology? Contextualizing the Controversy." *Christian Bioethics* 3, no. 2 (1997): 95-96.

Berkouwer, G. C. *Man: The Image of God*, translated by Dirk W. Jellema. Grand Rapids: William B. Eerdmans, 1962.

Bonhoeffer, Dietrich. *Ethics*. Edited by Eberhardt Bethge. New York: Macmillan, 1955.

Boyle, Joseph. "Free Choice, Incomparably Valuable Options, and Incommensurable Categories of Good." *American Journal of Jurisprudence* 47 (2002): 123-41.

Cahill, Lisa Sowle. "The Practical and Social Significance of Double Effect." In *Method and Catholic Moral Theology: The Ongoing Reconstruction*, edited by Todd A. Salzman, 233-59. Omaha: Creighton University Press, 1999.

Cathrein, Victor. "Law." In *The Catholic Encyclopedia*. Vol. 9. New York: Robert Appleton Company, 1910: 53-56.

Clarke, W. Norris. "Technology and Man: A Christian Vision." *Technology and Culture* 3, no. 4 (1962): 422-42.

Curran, Charles. "Absolute Norms in Moral Theology." In *Norm and Context in Christian Ethics*, edited by Gene H. Outka and Paul Ramsey, 139-73. New York: Charles Scribner's Sons, 1968.

Finnis, John. *Natural Law and Natural Rights*. Oxford: Oxford University Press, 2001.

Fletcher, Joseph. *Situation Ethics: The New Morality*. Introduction by James F. Childress. Louisville: Westminster John Knox Press, 1966.

Gallagher, John A. *Time Past, Time Future: An Historical Study of Catholic Moral Theology*. New York: Paulist Press, 1990.

Gallagher, Raphael. "Catholic Medical Ethics: A Tradition which Progresses." In *Change in Official Catholic Moral Teachings*, no. 13 in *Readings in Moral Theology*, edited by Charles E. Curran, 306-18. New York: Paulist Press, 2003.

Grisez, Germain. *The Way of the Lord Jesus*. Vol. 1, *Christian Moral Principles*. Vol. 2, Living a Christian Life. Chicago: Franciscan Herald Press, 1983 and 1993.

Gustafson, James M. "Ethical Issues in the Human Future." In *How Humans Adapt: A Biocultural Odyssey*, edited by Donald J. Ortner, 491-515. Washington, D.C.: Smithsonian Press, 1983.

------. *Ethics from a Theocentric Perspective*. Vol. 1. Chicago: University of Chicago Press, 1981.

------. *Protestant and Roman Catholic Ethics: Prospects for Rapprochement*. Chicago: University of Chicago Press, 1978.

------. *Theology and Christian Ethics*. Philadelphia: United Church Press, 1974.

Hall, Douglas John. *Imaging God: Dominion as Stewardship*. Eugene: Wipf & Stock, 2004.

Harakas, Stanley S. "Eastern Orthodox Christian Ethics." In *The Westminster Dictionary of Christian Ethics*, edited by James F. Childress and John MacQuarrie, 166-77. Philadelphia: Westminster Press, 1986.

Hauerwas, Stanley. "The Importance of Being Catholic: A Protestant View." *First Things* 1 (March 1990): 23-30.

------. *Truthfulness and Tragedy: Further Investigations in Christian Ethics*, with Richard Bondi and David B. Burrell. Notre Dame: University of Notre Dame Press, 1977.

------. *Wilderness Wanderings: Probing Twentieth-Century Theology and Philosophy*. Boulder: Westview Press, 1997.

Hauerwas, Stanley, and John Berkman. "The Chief End of All Flesh." In *Good News for Animals?* edited by Jay McDaniel and Charles Pinches, 196-208. Maryknoll: Orbis Books, 1992.

Hopper, David H. *Technology, Theology, and the Idea of Progress*. Louisville, Kentucky: Westminster/John Knox Press, 1991.

Janssens, Louis. "Ontic Evil and Moral Evil." *Louvain Studies* 4 (1972): 115-56.

------. "Ontic Good and Evil: Premoral Values and Disvalues." *Louvain Studies* 12, no. 1 (1987): 62-82.

John Paul II. *Evangelium Vitae*. March 25, 1995, http://www.vatican.va/holy_father/john_paul_ii/encyclicals/documents/hf_jp-ii_enc_25031995_evangelium-vitae_en.html.

------. *Salvifici Doloris*. February 11, 1984, http://www.vatican.va/holy_father/john_paul_ii/apost_letters/documents/hf_jp-ii_apl_11021984_salvifici-doloris_en.html.

------. "To the Bishops of the Episcopal Conference of the United States of America (California, Nevada and Hawaii)." October 2, 1998, http://www.vatican.va/holy_father/john_paul_ii/speeches/1998/october/documents/hf_jp-ii_spe_19981002_ad-limina-usa_en.html.

Jonson, Albert, and Stephen Toulmin. *The Abuse of Casuistry*. Berkeley: University of California Press, 1987.

McClendon, James William, Jr. *Systematic Theology: Ethics*. Nashville: Abingdon Press, 1986.

McCormick, Richard A. "Ambiguity in Moral Choice." In *Doing Evil to Achieve Good:*

Moral Choice in Conflict Situations, edited by Richard McCormick and Paul Ramsey, 7-53. Chicago: Loyola University Press, 1978.

------. *The Critical Calling: Reflections on Moral Dilemmas since Vatican II*. Washington, D.C.: Georgetown University Press, 1989.

------. *Notes on Moral Theology, 1965 through 1980*. Washington, D.C.: University Press of America, 1981.

Meilaender, Gilbert. *The Freedom of a Christian: Grace, Vocation, and the Meaning of Our Humanity*. Grand Rapids: Brazos Press, 2006.

------. *The Limits of Love: Some Theological Explorations*. University Park: Pennsylvania State University Press, 1987.

Mohan, Robert Paul, ed. *Technology and Christian Culture*. Washington: Catholic University of America Press, 1960.

Moltmann, Jürgen. *God in Creation: A New Theology of Creation and the Spirit of God*. San Francisco: Haper & Row, 1985.

Moreland, J. P., and Scott B. Rae. *Body & Soul: Human Nature & the Crisis in Ethics*. Downers Grove: InterVarsity Press, 2000.

Muers, Rachel. "Pushing the Limit: Theology and Responsibility to Future Generations." *Studies in Christian Ethics* 16, no. 2 (2003): 36-51.

Niebuhr, H. Richard. *Radical Monotheism and Western Culture*. With Supplementary Essays. New York: Harper & Row: 1960.

O'Donovan, Oliver. *Resurrection and Moral Order: An Outline for Evangelical Ethics*. Leicester: InterVarsity Press, 1986.

Paul VI. *Gaudium et Spes*. December 7, 1965, http://www.vatican.va/archive/hist_councils/ii_vatican_council/documents/vat-ii_cons_19651207_gaudium-et-spes_en.html.

Pope, Stephen J. "Natural Law and Christian Ethics." In *The Cambridge Companion to Christian Ethics*, edited by Robin Gill, 77-95. Cambridge: Cambridge University Press, 2001.

Rigali, Norbert J. "Christian Morality and Universal Morality: The One and the Many." *Louvain Studies* 19, no. 1 (1994): 18-33.

Ryan Michael James. "Certitude." In *The Catholic Encyclopedia*. Vol. 3. New York: Robert Appleton Company, 1908: 540-43.

Sulmasy, Daniel P., and Edmund D. Pellegrino. "The Rule of Double Effect: Clearing Up the Double Talk." *Archives of Internal Medicine* 159, no. 6 (1999): 545-50.

Thielicke, Helmut. *The Ethics of Sex*. New York: Harper & Row, 1964.

------. *Foundations*. Vol. 1, *Theological Ethics*. Edited by William H. Lazareth. Philadelphia: Fortress Press, 1966.

Tonti-Filippini, Nicholas. "*Vel* and *ut*: A Puzzle in the Definition of Euthanasia." *New Blackfriars* 86, no. 1006 (2005): 598-603.

Tubbs, James B., Jr. "Richard McCormick: Ordered Values and Proportionate Reasons." In *Christian Theology and Medical Ethics: Four Contemporary Approaches*, 13-53. Dordrecht: Kluwer, 1996.

Verhey, Allen. "The Body and the Bible: Life in the Flesh According to the Spirit." In *Embodiment, Morality, and Medicine*, edited by Lisa Sowle Cahill and Margaret A. Farley, 3-22. Dordrecht: Kluwer, 1995.

Weaver, Darlene Fozard. "Death." In *The Oxford Handbook of Theological Ethics*, edited by Gilbert Meilaender and William Werpehowski, 254-269. Oxford: Oxford University Press, 2005.

7. Hans Jonas: Primary and Secondary Sources

Becchi, Paolo. "Technology, Medicine, and Ethics in Hans Jonas." *Graduate Faculty Philosophy Journal* 23, no. 2 (2002): 155-82.

Bernstein, Richard J. "Rethinking Responsibility." *Hastings Center Report* 25, no. 7 (1995): 13-20.

Callahan, Daniel. "Response to Hans Jonas." In *Knowledge, Value and Belief*, edited by H. Tristram Engelhardt, Jr. and Daniel Callahan, 199-206. New York: Institute of Society, Ethics and the Life Sciences (The Hastings Center), 1977.

Depré, Olivier. *Hans Jonas (1903-1993)*. Paris: Ellipses, 2003.

Donhoff, Marion, and Reinhard Merkel. "Not Compassion Alone: On Euthanasia and Ethics." (An Interview with Hans Jonas.) Translated by Hunter and Hilde Hannum. *Hastings Center Report* 25, no. 7 (1995): 44-50.

Donnelley, Strachan. "Bioethical Troubles: Animal Individuals and Human Organisms." *Hastings Center Report* 25, no. 7 (1995): 21-29.

------. "Natural Responsibilities: Philosophy, Biology, and Ethics in Ernst Mayr and Hans Jonas." *Hastings Center Report* 32, no. 4 (2002): 36-43.

Granados, José. "Love and the Organism: A Theological Contribution to the Study of Life." *Communio* 32 (Winter 2005): 1-37.

Hogue, Michael S. *The Tangled Bank: Toward an Ecological Ethics of Responsible Participation*. Eugene: Pickwick Publications, 2008.

------. "Theological Ethics and Technological Culture: A Biocultural Approach." *Zygon* 42, no. 1 (2007): 77-95.

Hösle, Vittorio. "Ontology and Ethics in Hans Jonas." *Graduate Faculty Philosophy Journal* 23, no. 1 (2001): 31-50.

Jonas, Hans. "Closer to the Bitter End." (An interview with Hans Jonas.) By Matthias Matussek and Wolfgang Kaden. Translated by Hunter and Hildegarde Hannum. *Graduate Faculty Philosophy Journal* 23, no. 1 (2001): 21-30.

------. *Le droit de mourir*. Translated by Philippe Ivernel. Paris: Editions Payot & Rivages, 1996.

------. “Ethics and Biogenetic Art.” *Social Research* 52, no. 3 (1985): 491-504.

------. *Une éthique pour la nature*. Edited by Wolfgang Schneider, translated by Sylvie Courtine-Denamy. Paris: Desclée de Brouwer, 2000.

------. “Freedom of Scientific Inquiry and the Public Interest.” *Hastings Center Report* 6, no. 4 (1976): 15-17.

------. *The Gnostic Religion: The Message of the Alien God and the Beginnings of Christianity*. Boston: Beacon Press, 1963.

------. *The Imperative of Responsibility: In Search of an Ethics for the Technological Age*. Translated by Hans Jonas and David Herr. Chicago: University of Chicago Press, 1984.

------. *Mortality and Morality: A Search for the Good after Auschwitz*. Edited with introduction by Lawrence Vogel. Evanston: Northwestern University Press, 1996.

------. “Parallelism and Complementarity: The Psycho-Physical Problem in the Succession of Niels Bohr.” In *The Philosophy of Baruch Spinoza*, edited by Richard Kennington, 121-30. Washington, D.C.: The Catholic University of America Press, 1980.

------. *The Phenomenon of Life: Toward a Philosophical Biology*. Evanston: Northwestern University Press, 1966.

------. *Philosophical Essays: From Ancient Creed to Technological Man*. New Jersey: Prentice-Hall, 1974.

------. “Philosophy at the End of the Century: A Survey of Its Past and Future.” *Social Research* 61, no. 4 (1994): 813-32.

------. “Responsibility Today: The Ethics of an Endangered Future.” *Social Research* 43 (Spring 1976): 77-97.

------. “The Right to Die.” *Hastings Center Report* 8, no. 4 (1978): 31-36.

------. *Technik, Medizin und Ethik. Zur Praxis des Prinzips Verantwortung*. Frankfurt: Suhrkamp Taschenbuch, 1987.

------. “Technology as a Subject for Ethics.” *Social Research* 49 (Winter 1982): 891-98.

------. “Toward a Philosophy of Technology.” *Hastings Center Report* 9, no. 1 (1979): 34-43.

------. “*Wissenschaft* as Personal Experience.” *Hastings Center Report* 32, no. 4 (2002): 27-35.

Kass, Leon R. “Appreciating *the Phenomenon of Life*.” *Hastings Center Report* 25, no. 7 (1995): 3-12.

Kopfensteiner, Thomas R. “Death with Dignity: A Roman Catholic Perspective.” *Linacre Quarterly* 63, no. 4 (1996): 64-75.

Kranzberg, Melvin, ed. *Ethics in an Age of Pervasive Technology*. Boulder: Westview Press, 1980.

Levy, David J. *Hans Jonas: The Integrity of Thinking*. Columbia: University of Missouri Press, 2002.

Nikulin, Dmitri. "Reconsidering Responsibility: Hans Jonas' Imperative for a New Ethics." *Graduate Faculty Philosophy Journal* 23, no. 1 (2001): 99-118.

O'Mathúna, Dónal P. "Bioethics and Biotechnology." *Cytotechnology* 53 (2007): 113-19.

Schutze, Christian. "The Political and Intellectual Influence of Hans Jonas." *Hastings Center Report* 25, no. 7 (1995): 40-44.

Schweiker, William. "Radical Interpretation and Moral Responsibility: A Proposal for Theological Ethics." *Journal of Religion* 73, no. 4 (1993): 613-37.

Scodel, Harvey. "An Interview with Professor Hans Jonas." *Social Research* 70, no. 2 (2003): 339-68.

Spicker, Stuart F., ed. *Organism, Medicine and Metaphysics: Essays in Honor of Hans Jonas*. Dordrecht: Reidel, 1978.

Stempsey, William E. "Emerging Medical Technologies and Emerging Conceptions of Health." *Theoretical Medicine and Bioethics* 27 (2006): 227-43.

Vogel, Lawrence. "Jewish Philosophies after Heidegger: Imagining a Dialogue Between Jonas and Levinas." *Graduate Faculty Philosophy Journal* 23, no. 1 (2001): 119-46.

------. "Natural Law Judaism? The Genesis of Bioethics in Hans Jonas, Leo Strauss, and Leon Kass." *Hastings Center Report* 36, no. 3 (2006): 32-48.

Wiese, Christian. *Life and Thought of Hans Jonas: Jewish Dimensions*. Waltham: Brandeis University Press, 2007.

Wolters, Gereon. "Hans Jonas' Philosophical Biology." *Graduate Faculty Philosophy Journal* 23, no. 1 (2001): 85-98.

8. Other Works

Anderson, Ray. "Theological Anthropology." In *The Blackwell Companion to Modern Theology*, edited by Gareth Jones, 82-94. Oxford: Blackwell Publishing, 2004.

Aristotle. *De Anima*. Translated by R. D. Hicks. New York: Prometheus Books, 1991.

------. *Metaphysics*. Translated by W. D. Ross. Australia: University of Adelaide, 2007.

------. *Nicomachean Ethics*. Translated by Terence Irwin. Indianapolis: Hackett, 1985.

Augustine. *The City of God against the Pagans*. Edited by R. W. Dyson. Cambridge: Cambridge University Press, 1998.

------. *Confessions*. 2nd ed. Edited by Michael P. Foley, translated by F. J. Sheed. Indianapolis: Hackett, 2006.

------. *The Greatness of the Soul, The Teacher*. Translated by Joseph M. Colleran. New York: Newman Press, 1978.

------. *On Genesis*. Vol. 13, *Works of St. Augustine*. Edited by John E. Rotelle, translated by Edmund Hill. New York: New City Press, 2002.

------. *The Trinity*. Translated by Edmund Hill. New York: New City Press, 1991.

Barth, Karl. *Church Dogmatics* II:2, III:2, and III:4. Edited by G. W. Bromily and T. F. Torrance, translated by H. Knight, G. W. Bromily, J. K. S. Reid, and R. H. Fuller. London: T & T Clark International, 2004.

Basil the Great, "The Long Rules." In *The Fathers of the Church: A New Translation*. Vol. 9, *St. Basil: Ascetical Works*, translated by M. Monica Wagner, 336-37. Washington: Catholic University of America Press, 1962.

The Bible. New Revised Standard Version.

Boyd, Jeffrey H. "The Soul as Seen through Evangelical Eyes, Part II: On the Use of the Term 'Soul.'" *Journal of Psychology and Theology* 23, no. 3 (1995): 161-70.

Bretzke, James T. *Consecrated Phrases: A Latin Theological Dictionary. Latin Expressions Commonly Found in Theological Writings*. 2nd ed. Collegeville: Liturgical Press, 1998.

Brown, Warren S., Nancey Murphy, and H. Newton Malony, eds. *Whatever Happened to the Soul? Scientific and Theological Portraits of Human Nature*. Minneapolis: Fortress Press, 1998.

Buckham, John Wright. "Dualism or Duality?" *Harvard Theological Review* 6, no. 2 (1913): 156-71.

Calvin, John. *Institutes of the Christian Religion*. Translated by Henry Beveridge. Grand Rapids: William. B. Eerdmans, 1989.

Commission on Faith and Witness of the Canadian Council of Churches. *Becoming Human: Theological Anthropology in an Age of Engineering Life. Christian Reflections for Further Discussion*. Toronto: Canadian Council of Churches, 2005.

Dahill, Lisa E. "Spirituality." In *The Encyclopedia of Christianity*, vol. 5, edited by Erwin Fahlbusch, 158-61. Grand Rapids: William B. Eerdmans, 2008.

Dallaire, Roméo. *Shake Hands with the Devil: The Failure of Humanity in Rwanda*. Toronto: Vintage Canada, 2003.

Descartes, René. "Discourse on Method; Letter to Henry More, 5 February 1649." In *Animal Rights and Human Obligations*, 2nd ed., edited by Tom Regan and Peter Singer, 13-19. Engelwood Cliffs: Prentice Hall, 1989.

------. *Meditations on First Philosophy*. Edited by Stanley Tweyman. London: Routledge, 1993.

Engel, Thomas and Ulrike Henckel. "Human Beings, Technology and the Idea of Man." *Poiesis & Praxis* 5, nos. 3-4 (2008): 249-63.

Engelhardt, H. Tristram, Jr. *Mind-Body: A Categorial Relation*. The Hague: Martinus Nijhoff, 1973.

Faith and Order Commission of the World Council of Churches. *Christian Perspectives on Theological Anthropology: A Faith and Order Study Document*. Faith and Order Paper No. 199. Geneva: World Council of Churches, 2005.

Fathers of the Sacred Council for Everlasting Memory. "Decree on Priestly Formation (*Optatam Totius*)." In *Documents of Vatican* II, edited by Walter M. Abbott, translated by Joseph Gallagher, 437-57. New York: Guild Press, 1966.

Fiasse, Gaëlle. "Aristotle's *Phronesis*: A True Grasp of Ends as Well as Means?" *Review of Metaphysics* 55, no. 2 (2001): 323-37.

------. "Droit naturel, finalité, nature et esclavage chez Aristote." In *Le droit naturel. Relancer l'histoire?* edited by L-L Christians, F. Coppens, X. Dijon, P. Favraux, G. Fiasse, J.-M. Longneaux and M. Ruol, 133-54. Brussels: Bruylant, 2008.

Freedman, Benjamin. *Duty and Healing: Foundations of a Jewish Bioethic*. Introduction by Charles Weijer. New York and London: Routledge Press, 1999.

Fowler, Robert Booth. *The Greening of Protestant Thought*. Chapel Hill: University of North Carolina Press, 1995.

General Assembly of the Presbyterian Church in the U. S. "Westminster Larger Catechism." In *The Confession of Faith of the Presbyterian Church in the United States*. Richmond: Board of Christian Education, 1965.

Guy, Alfred. "The Role of Aristotle's *Praxis* Today." *Journal of Value Inquiry* 25, no. 3 (1991): 287-89.

Haslam, Nick. "Prudence: Aristotelian Perspectives on Practical Wisdom." *Journal for the Theory of Social Behaviour* 21, no. 2 (1991): 151-69.

Hauerwas, Stanley. *Character and the Christian Life: A Study in Theological Ethics*. San Antonio: Trinity University Press, 1975.

------. *A Community of Character: Toward a Constructive Christian Social Ethic*. Notre Dame: University of Notre Dame Press, 1981.

------. *The Peaceable Kingdom: A Primer in Christian Ethics*. Notre Dame: University of Notre Dame Press, 1983.

------. *Vision and Virtue: Essays in Christian Ethical Reflection*. Notre Dame: University of Notre Dame Press, 1974.

------. "Why the Truth Demands Truthfulness: An Imperious Engagement with Hartt." *Journal of the American Academy of Religion* 52, no. 1 (1984): 141-47.

Hopp v. Lepp, [1980] 2 S.C.R. 192.

Irenaeus of Lyons. *Against the Heresies*. Translated by Dominic J. Unger, with revisions by John J. Dillon. New York: Paulist Press, 1992.

John Paul II. "Letter to Families." February 2, 1994, http://www.vatican.va/holy_father/john_paul_ii/letters/documents/hf_jp-ii_let_02021994_families_en.html.

------. "Peace with God the Creator, Peace with All of Creation." January 1, 1990,

http://www.vatican.va/holy_father/john_paul_ii/messages/peace/documents/hf_jp-ii_mes_19891208_xxiii-world-day-for-peace_en.html.

------. *Veritatis Splendor*. August 6, 1993, http://www.vatican.va/holy_father/john_paul_ii/encyclicals/documents/hf_jp-ii_enc_06081993_veritatis-splendor_en.html#$2J.

Jones, William B., and A. Warren Matthews. "Toward a Taxonomy of Technology and Religion." *Research in Philosophy and Technology* 10 (1990): 3-23.

Jonson, Albert R. "A History of Religion and Bioethics." In *Handbook of Bioethics and Religion*, edited by David E. Guinn, 23-36. New York: Oxford University Press, 2006.

Kant, Immanuel. *The Doctrine of Virtue*. New York: Harper and Row, 1964.

------. *Grounding for the Metaphysics of Morals*. 3rd ed., translated by James W. Ellington. Indianapolis: Hackett, 1993.

Lewis, C. S. *The Abolition of Man*. New York: Harper Collins, 2001.

MacIntyre, Alasdair. *After Virtue: A Study in Moral Theory*. 2nd ed. Notre Dame: University of Notre Dame Press, 1984.

------. *Dependent Rational Animals: Why Human Beings Need the Virtues*. Chicago: Open Court, 2001.

------. *Whose Justice? Which Rationality?* Notre Dame: University of Notre Dame Press, 1988.

McArdle, Patrick. "Called by Name: Contemporary Christian Anthropology." *Scottish Journal of Theology* 58, no. 2 (2005): 219-36.

McInerny, Ralph. "Grisez and Thomism." In "The Revival of Natural Law: Philosophical, Theological and Ethical Responses to the Finnis-Grisez School," edited by Nigel Biggar and Rufus Black, 53-72. Aldershot: Ashgate, 2000.

Midgley, Mary. "Biotechnology and the Yuk Factor." In *The Essential Mary Midgley*, edited by David Midgley, 269-80. New York: Routledge, 2005.

Miguel, Carlos Ruiz. "Human Dignity: History of an Idea." In *Jahrbuch des öffentlichen Rechts der Gegenwart*, Neue Folge, edited by J. C. B. Mohr, 281-99. Tübingen, 2002.

Miller, Robert D. "Reasonable Medical Certainty: A Rose by Any Other Name." *Journal of Psychiatry and Law* 34, no. 3 (2006): 273-90.

Mitcham, Carl, and Jim Grote, eds. *Theology and Technology: Essays in Christian Analysis and Exegesis*. New York: University Press of America, 1984.

Murphy, Nancey. "Scientific Perspectives on Christian Anthropology." *CTI Reflections* 8 (2004-5): 82-100.

The Official Report of the Lambeth Conference 1998. Harrisburg: Morehouse, 1999.

Ozbekhan, Hasan. "The Triumph of Technology: 'Can Implies Ought.'" In *Planning for Diversity and Choice: Possible Futures and Their Relations to the Man-controlled Environment*, edited by Stanford Anderson, 204-19. Cambridge: MIT Press, 1968.

Plato. *Plato: Complete Works*, edited by John M. Cooper. Indianapolis: Hackett, 1997.

Rawls, John. *A Theory of Justice*. Cambridge: Harvard University Press, 1971.

Reibl v. Hughes, [1980] 2 S.C.R. 895.

Ricœur, Paul. *The Just*. Translated by David Pellauer. Chicago: University of Chicago Press, 2000.

------. *Oneself as Another*. Translated by Kathleen Blamey. Chicago: University of Chicago Press, 1992.

Sokolowski, Robert. "Friendship and Moral Action in Aristotle." *Journal of Value Inquiry* 35, no.3 (2001): 355-69.

Thielicke, Helmut. *Being Human…Becoming Human: An Essay in Christian Anthropology*. Translated by Geoffrey W. Bromily. Garden City: Doubleday & Company, 1984.

Thomas, Lewis. *Lives of a Cell: Notes of a Biology Watcher*. New York: Viking Press, 1974.

Thomas Aquinas. *The Collected Works of St. Thomas Aquinas*. Charlottesville: InteLex, 2002.

------. *Summa Contra Gentiles* I. Translated by Joseph Rickaby. London: Burns and Oates, 1905.

------. *Summa Theologica*, Parts I, I-II, II-II. Translated by Fathers of the English Dominican Province. New York: Benziger Brothers, 1947.

United States Conference of Catholic Bishops. *United States Catholic Catechism for Adults*. Washington, D.C.: USCC Publishing Services, 2006.

Volti, Rudi. *Society and Technological Change*. New York: St. Martin's Press, 1988.

Wesley, John. *Sermons on Several Occasions*. London: Epworth Press, 1946.