CHAPTER

Reigniting the Debate: The Impact of Terri Schiavo on the Care of the PVS Patient

INTRODUCTION

The Care of the PVS Patient at the Turn of the Millennium

The true impact of Terri Schiavo’s life and death on the national debate regarding the level of care owed to the PVS patient can be measured by the fact these events single-handedly reignited an issue that the vast majority of medical, legal and even theological professionals did not expect to be resurrected. When one considers the fact that Terri Schiavo’s story began to emerge at a time when the amount of public and professional attention focused on the care of the PVS patient was almost non-existent, the veritable flood of interest that would ultimately be generated in the PVS on her account was no mean feat. By any logical measure, the events surrounding Terri Schiavo and the decision to provide or withdraw the assisted nutrition and hydration (hereafter ANH) sustaining her life came at least decade too late to merit serious attention. In the first place, by the time of her illness in 1990, the PVS was already a relatively known quantity; as such it lacked the novelty of the 1976 Quinlan case when the then recently crafted term, “persistent vegetative state,” burst unexpectedly on the national consciousness.\(^1\) In the second place, the benefit of hindsight shows that it was the events leading up to and immediately following the 1990 U.S. Supreme Court case involving Nancy Cruzan that marked the apex of the medical and moral debate on the PVS question.\(^2\) The high level of attention in the PVS would not, however, be sustained. In the wake of *Cruzan*, interest in the PVS swiftly faded; after only a few years, nearly all

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public and professional debate on this issue had ceased. In relation to 
Cruzan, the earliest sparks that would eventually become the Schiavo firestorm did not begin until 1998 and the first legal ruling on the case was not made until the year 2000, nearly a full decade after the Cruzan decision. Thus, from the perspective of the majority of medical, legal, theological professionals it was reasonable to conclude that, short of the presentation of startling new medical evidence, it was unlikely that the question of food and fluid provision for the PVS patient would ever again become a dominant question for medicine and morality.

To fully appreciate the astonishment felt by medical and ethical professionals regarding the unlikely rise to prominence of the Schiavo case, it is important to first examine the medical and moral ground from which the events surrounding Terri Schiavo’s life and death would eventually spring. At its root, the magnitude of the tumult over Terri Schiavo was due, in large part, to two general assumptions that were made about the PVS question during the latter half of the 1990s. The first assumption, held by the major American medical organizations and a number of Catholic theologians, believed that the PVS question was satisfactorily settled as a result of the Cruzan case. The second assumption, held by the majority of American bishops and a minority of health care personnel, contended that the inability of medical science to provide a conclusive diagnosis of the PVS patient’s level of awareness or his/her ability to experience pain and suffering precluded a more definitive treatment directive than had been given to that point. Ultimately, it will be the assumptions that arose after Cruzan that will lead to the subsequent misjudgments about impact of the Schiavo case on the question of the level of care owed to the PVS patient.

Based upon the importance of the assumptions and attitudes of professionals in the medical and theological disciplines towards the PVS question in general and the Schiavo case in particular, this chapter will begin in the years leading up to the initial public awareness of the events surrounding Terri Schiavo’s life and death. At the bottom line, these years

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1It must be noted that the level of surprise experienced by medical professionals in the United States was vastly more the product of the public’s interest in, and reaction to, the Schiavo case than anything else. Basically, the prominence of Schiavo did not cause a re-evaluation of medical conclusions regarding the PVS condition. See: Robert D. Truog, M.D., and Thomas I. Cochrane, M.D., M.B.A., “Refusal of Hydration and Nutrition: Irrelevance of the ‘Artificial’ vs ‘Natural’ Distinction,” Archives of Internal Medicine, 165(22), December 12/26, 2005, 2574.
are crucial for the establishment of a solid frame of reference from which to view the true scope of the Schiavo case. In addition, they also serve to summarize nearly thirty years of medical moral debate on this issue.

*Apparent Closure: The Status of the Medical Debate over the PVS Patient*

At the turn of the millennium, ranging approximately from late 1994 to early 2001, there existed within the professional ranks of the major American medical organizations a state of relative calm regarding the question of the level of care that was owed to a patient in the PVS. While the reason for this atmosphere of apparent tranquility was, as we will see, due to an entirely different cause than that found in Catholic circles, the latter half of the 1990s can be accurately characterized as the quiet interlude between two storms. The decade before Schiavo erupted on the scene was, more than anything else, a time of assimilation in which the fruit that resulted from the significant debates of the mid to late 1980s, and particularly the Cruzan case of 1990, was integrated into policy and practice. This is not to give the impression that nearly universal agreement reigned in the medical field concerning the care of the PVS patient at this time; on the contrary, disagreements, debates and questioning did continue. It does contend, however, that before Schiavo an overarching atmosphere of contentment with the *status quo* permeated the professional medical ranks regarding the PVS question. Serious debate over the level of care owed to the PVS patient first began in the medical arena in the early 1980s and the year 1983 was particularly pivotal in terms of the classification of ANH provision. Before 1983, the common understanding of the medical profession identified ANH, even when delivered through artificial means, to be an aspect of basic care that should be given to all patients. For example, in a March 1983 article published in the *New England Journal of Medicine*, one physician argued against a current practice in medicine which assumed that all patients should receive a maximal level of care to treat any illness.

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Instead, he argued that in certain circumstances, the decision not to do everything possible was justified. Using one of his own patients as an example, a woman unconscious for five years, he reported that the practice in his medical facility was to deliver only basic nursing, and not maximal care to such individuals. He said, “Although there is no meaningful chance that she will ever improve, she is certainly not ‘brain dead’ and is supported only by routine nursing care that consists of tube feedings, regular turnings, urinary catheters, and good hygiene; she is on no respirator or other machine.”\(^5\) The classification of ANH provision as an aspect of basic nursing care was also corroborated in a more comprehensive way by the 1983 President’s Commission document, *Deciding to Forgo Life-Sustaining Treatment: A Report on the Ethical, Medical, and Legal Issues in Treatment Decisions*. Here, rather than simply indicating the belief and action of one physician, the President’s Commission document noted that, in relation to patients in long-term unconsciousness, it was the common medical practice to provide supportive, but not highly aggressive care that would likely include basic hygiene and artificial nutrition and hydration.\(^6\) Thus, eight years after *Quinlan* the bulk of the medical profession still considered the delivery of ANH, even to persistently unconscious patients, to be basic nursing care and in no way an aggressive medical treatment.

The commonly held opinion of medical professionals that ANH be classified as an aspect of basic nursing care was not, however, to continue for much longer. For in addition to reporting that common medical practice placed assisted food and fluid delivery in the category of basic nursing care, the 1983 President’s Commission document also noted the rise of medical opinions that objected to this practice for patients in long-term unconsciousness. The Commission voiced the concerns of this minority group when it stated:

Most patients with permanent unconsciousness cannot be sustained for long without an array of increasingly artificial feeding interventions – nasogastric tubes, gastrostomy tubes, or


intravenous nutrition. Since permanently unconscious patients will never be aware of nutrition, the only benefit to the patient of providing such increasingly burdensome interventions is sustaining the body to allow for a remote possibility of recovery. The sensitivities of the family and of care giving professionals ought to determine whether such interventions are made.

Bolstered by judicial rulings in two major medical ethics cases, one involving Mr. Clarence Herbert in 1983 and another involving Miss Claire Conroy in 1985, that declared ANH delivery to be a medical treatment similar to other life-sustaining technologies, a 1986 publication of the Council on Judicial and Ethical Affairs of the American Medical Association (AMA) initiated the shift in the classification of ANH that would eventually become the dominant policy in all the major American medical organizations to the present day. Section 2.18 of the 1986 AMA document was only four short paragraphs in length, however, those four paragraphs contained the policy that began the classification shift of ANH from an aspect of basic nursing care to a medical treatment and permitted its removal from irreversibly unconscious patients. The recommendation of the 1986 AMA statement regarding life-sustaining medical treatment was constructed upon four interconnected steps: (1) the obligation incurred by the physician in relation to the care of an autonomous patient, (2) the limits of treatment for terminally ill, imminently dying patients, (3) the limits of care for irreversibly unconscious patients, and (4) the kinds of care that could be classified as medical treatment and the physician’s obligation to provide them to seriously ill patients. The first two paragraphs of the AMA

\[\text{\textsuperscript{7}}\] Ibid., at 190. Dr. Jennett noted that the 1983 Commission alluded positively towards several court cases that ruled against the provision of assisted hydration and nutrition to persistently unconscious patients. Bryan Jennett, M.D., \textit{The Vegetative State: Medical Facts, Ethical and Legal Dilemmas}, (Cambridge University Press, U.K., 2002), 75.

\[\text{\textsuperscript{8}}\] Regarding the Herbert case see: Barber v. Superior Court, 147 Cal. App. 3d 1006, Cal. Rptr. 484, (1983) Judge Compton stated the following at 490: “each pulsation of the respirator or each drop of fluid introduced into the patient’s body by intravenous feeding devices is comparable to a manually administered injection or item of medication.” Regarding the Conroy case see: \textit{In re Conroy}, 98 N.J., 321, Atl. Rptr. 486 A.2d. (1985). The New Jersey Supreme Court ruled that medical treatment, including nourishment by artificial means may be withheld from nursing hope patients with a life expectancy of less than one year provided that certain safeguards were met.
statement only tangentially affected the PVS patient, because their primary focus was centered upon the obligation and limits of medical treatments for terminally ill and imminently dying patients. The latter two paragraphs of the AMA statement, however, were directly aimed at the level of care owed to the PVS patient. In the third paragraph, the AMA Council stated:

Even if death is not imminent but a patient’s coma is beyond doubt irreversible and there are adequate safeguards to confirm the accuracy of the diagnosis and with the concurrence of those who have responsibility for the care of the patient, it is not unethical to discontinue all means of life prolonging medical treatment.

To complete the shift, the AMA Council then broadened the definition of the term “life-prolonging medical treatment” to include ANH in a category in which it had not been previously placed. The document stated that, “life prolonging medical treatment includes medication and artificially or technologically supplied respiration, nutrition or hydration…” Hence, just as it was ethical to cease providing a burdensome medical treatment to a terminally ill and imminently dying patient, The AMA Council now determined that a similar choice could be ethically made with regards to the withdrawal of ANH to an irreversibly unconscious patient.

By 1990, shortly before the U.S. Supreme Court ruled in Cruzan, the classification of ANH as a medical treatment was written into the policy statements of the major American medical organizations. Ultimately,

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10Robert Barry, O.P., “Withholding or Withdrawing Treatment,” (Letters), Journal of the American Medical Association, 256(4), July 25, 1986, 469-470. He considered the new AMA statement to be an admission that nothing could be done for patients in this condition and the only option available was to ensure their deaths by the removal of ANH.
12Ibid., at 2.18.
however, it was the national scope of U.S. Supreme Court ruling in *Cruzan*, however, that provided the gravitas necessary to firmly etch the classification of ANH as a medical treatment into the relatively undisputed policy and practice of the major American medical organizations. While at first glance the U.S. Supreme Court’s ruling in *Cruzan* appeared to those who advocated the removal of the ANH sustaining Nancy Cruzan’s life to be a serious blow to the perceived right to refuse medical treatment in the event of incompetence, clearer heads eventually realized that ruling in *Cruzan* actually significantly benefited their own understanding. In the first place, the higher “clear and convincing” evidentiary standard required by the State of Missouri to allow the removal of life-sustaining ANH from an incompetent patient was not applied to the nation as a whole; the higher standard was merely acknowledged as a permissible standard for judgment in Missouri. Second, the Court upheld the right of competent patients to refuse life-sustaining medical technologies and further ruled that this right perdured in spite of a person’s eventual incompetence. Finally, for the purposes of this examination, the Court determined that ANH was properly classified as a medical treatment and not as an aspect of basic nursing care. The ruling stated:

“As to the last item, the court acknowledged the ‘emotional significance’ of food, but noted that feeding by implanted tubes is a ‘medical procedure with inherent risks and possible side-effects, instituted by skilled health care providers to compensate for impaired physical functioning’ which analytically was equivalent to artificial breathing using a respirator.”

At the bottom line the Court’s ruling settled the question of how to classify ANH so well that, within a few short years, it would almost entirely cease to be a significant ethical issue within the bounds of the medical realm. After *Cruzan* the question of the classification of ANH would only be seriously debated within the bounds of Catholic medical ethics and among

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some marginalized medical groups outside the mainstream of their profession.

The last word from the medical community on the question of providing or withdrawing ANH to PVS patients was the Multi-Society Taskforce (MSTF) on PVS document published in the New England Journal of Medicine in 1994.\textsuperscript{16} The landmark MSTF document, a collaborative work of five medical “societies,” was the definitive medical response to the questions regarding condition and treatment of the PVS patient in the aftermath of \textit{Cruzan} case.\textsuperscript{17} It addressed the characteristics, etiology, epidemiology, pathology, related conditions, and the prognostic likelihood for recovery of the PVS condition; for all intents and purposes it represented the apex of medical knowledge regarding all aspects relating to the PVS condition. More importantly to the topic of this discussion, however, the document set the tone for overwhelming majority of medical opinion regarding the care of PVS patients.\textsuperscript{18} Based upon the glaring lack of published material on the PVS condition after the MSTF document was released, the actual, though probably unintended, result of its findings was that it effectively ended the medical debate surrounding the decision to provide or withhold/withdraw ANH from the PVS patient. After the 1994 MSTF document, the ethical issues surrounding the PVS patient swiftly faded into the medical-moral background in favor of the cutting-edge questions surrounding the medical, legal and ethical ramifications of physician-assisted suicide (PAS) and euthanasia. On the rare occasion that the decision to provide or withhold/withdraw ANH from PVS patients was


\textsuperscript{17}The medical organizations that comprised the MSTF were the following: The American Academy of Neurology, Child Neurology Society, American Neurological Association, American Association of Neurological Surgeons, and American Academy of Pediatrics.

\textsuperscript{18}Christian J. Borthwick disputed the widespread acceptance of the MSTF interpretation of the medical data surrounding PVS patients. He remarked: “This consensus statement built on the 1990 work of the American Medical Association’s Council on Scientific Affairs and Council on Ethical and Judicial Affairs and presents the appearance of virtual unanimity among the governing elements of American medicine on a linked series of beliefs on the diagnosis, treatment, and ethical status of post-coma patients. These medical conventions are generally accepted unquestioningly as constituting a factual foundation for ethical debate in this area…” In: Christian J. Borthwick, LL.B., “The Permanent Vegetative State: Ethical Crux, Medical Fiction?” \textit{Issues in Law and Medicine}, 12(2), (1996), 167-168.
raised at all, it was usually to showcase the question as a former medical dilemma that had, thankfully, been resolved. One commentator illustrated this point rather well when he commented:

The legitimacy of patient claims – both moral and constitutional – for withholding or withdrawing life-sustaining treatment now appears so well settled, it is easy to forget that they were bitterly contested but a short time ago.”

From the perspective of the major American medical institutions, therefore, it is probably not too strong of a statement to say that the advent of the Schiavo case was as unwelcome as it was unexpected. Reactions from medical professionals and those associated with the medical field largely ranged from a resigned disbelief to genuine consternation. One commentator (among many) contended that the events surrounding the Schiavo case were a tragedy for her and her husband and, further, that the debates and court cases argued over the past thirty years should have fully resolved the question of caring for PVS patients. He noted that,

Since Ms. Schiavo was in a medical and legal situation almost identical to those of two of the most well-known patients in medical jurisprudence, Karen Ann Quinlan and Nancy Cruzan, there must be something about cases like theirs that defies simple solutions, whether medical or legal. In this sense, the case of Terri Schiavo provides and opportunity to examine issues that most lawyers, bioethicists, and physicians believed were well settled – if not since the 1976 New Jersey Supreme Court decision in the case of Karen Quinlan, then at least since

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the 1990 U.S. Supreme Court decision in the case of Nancy Cruzan.\textsuperscript{20}

Others used the events surrounding the \textit{Schiavo} case to once again draw attention to the need for the public to complete an advance directive that indicated their treatment preferences in the event of incapacity.\textsuperscript{21} What is interesting to note, however, is that irregardless of the reaction medical professionals displayed concerning the rise of the \textit{Schiavo} case to prominence, the vast majority did not question the ethical correctness of a decision to remove the ANH sustaining the life of a persistently unconscious patient.\textsuperscript{22} At the bottom line, while the \textit{Schiavo} case did create a stir in health care, it did not affect the basic contention that the provision of ANH was a medical treatment that could be ethically refused by a patient or his/her surrogate decision maker.

\textit{Civilized Debate: Catholic Theologians and Bishops Before Schiavo}

Unlike the precipitous decline in ethical debate over the PVS question that took place within the bounds of medicine and law, the care of the PVS patient continued to be intensely discussed among Catholic bishops and


\textsuperscript{22}Thomas Koch, “The Challenge of Terri Schiavo: Lessons for Bioethics,” (http://intljme.bmjjournals.com/cgi/content/full31/7/376), \textit{Journal of Medical Ethics}, (31), July 20, 2005, 376. The author contended that, “The extremely emotional, extraordinarily public battle in the USA over the fate of a Florida woman Terri Schiavo presents a fundamental challenge to what most medical and legal ethicists have long assumed to be long settled issues if care for restricted persons. It is not that currently accepted procedures, and the ethical framework on which they are based are wrong, just that they are again up for grabs.”
theologians after the 1990 *Cruzan* decision. In fact, some of the most significant documents to address the level of care owed to the PVS patient were promulgated in the aftermath of *Cruzan*. On the surface, the interval between *Cruzan* and *Schiavo* was marked by an atmosphere of civilized debate in which the care of the PVS patient could be properly examined and discussed. At a deeper level, however, the years immediately prior to the *Schiavo* case also involved serious challenges to Catholic moral teaching on this issue. While many in the Church did not automatically accept the declaration in medicine and law that the PVS question was well settled, a strong and united teaching from the Church on the level of care owed to the PVS patient was ultimately stalled by two difficult problems. First, the division that existed between groups of theologians and bishops pertaining to the application of the Catholic moral tradition in relation to the PVS patient widened in the wake of *Cruzan* decision. Concretely, fundamental disagreements revolved around the decision to provide or withdraw ANH from a patient in the PVS. Although a majority of theologians and bishops publicly acknowledged that decisions about PVS patients should be guided by a presumption in favor of medically assisted nutrition and hydration, practical interpretation and application of this statement were not uniform.

The second factor that inhibited a stronger directive from the Church was an apparent lack of sufficient medical evidence. Contrary to pronouncements of the major American medical organizations regarding the true condition of the PVS patient, e.g., the MSTF statement, a minority of medical professionals indicated that a serious lack of definitive medical evidence existed regarding the PVS condition. Basically they contended

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23Mark Repenshek and John Paul Slosar, “Medically Assisted Nutrition and Hydration: A Contribution to the Dialogue,” *The Hastings Center Report*, 34(6), November-December 2004, 15. They write: “In recent decades, two extreme views have emerged concerning medically assisted nutrition and hydration for persons in a persistent vegetative state (PVS). One view considers it always obligatory as long as it sustains physiologic life; the other considers it never obligatory insofar as there is only a very small probability that such individuals will ever regain consciousness.”

that medical technology could not accurately measure all the effects of brain damage on the PVS patient, or completely rule out the possibility of some form of inner awareness.\textsuperscript{25} Thus from the perspective of Catholic moral teaching, a more directive pronouncement regarding the care of such patients was not considered feasible until more accurate medical evidence was made available.\textsuperscript{26}

In terms of the latter difficulty, it is logical to assume that the often ambiguous moral parameters proposed by Catholic theologians and bishops regarding the care of the PVS patient were given as a result of the absence of definitive medical evidence about the PVS condition. By far, however, the more serious difficulty lay in the unwillingness or inability of Catholic moral leaders to arrive at an acceptable interpretation of the central guiding directive: “a presumption in favor of providing ANH to all patients.” In the interim years between \textit{Cruzan} and \textit{Schiavo}, a consistent body of authoritative moral teaching on the level of care owed to the PVS patient had begun to develop from the plethora of statements and opinions presented by bishops, bishops’ conferences, and individual theologians in the mid to late 1980s. This emerging moral teaching examined the relevant factors inherent in caring for the PVS patient, namely, the available medical knowledge on the PVS, the current methods and risks of sustaining life, and the benefits and/or burdens of care for the individual patient. Based upon these factors, the resulting moral teaching determined that a presumption in favor of medically assisted nutrition and hydration should guide treatment.


\textsuperscript{26}NCCB Committee for Pro-Life Activities, \textit{Nutrition and Hydration: Moral and Pastoral Reflections}, at 6.
decisions for such patients. In its most authoritative form, Directive #58 of the 1994 USCCB statement, *Ethical and Religious Directives for Catholic Health Care Services* stated:

> 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 outweigh the burdens involved to the patient."

Although these new statements promulgated by bishops’ conferences, the NCCB/USCCB and Pope John Paul II were not intended to definitively address the just care of the PVS patient, in hindsight they did ultimately comprise the initial steps towards a more authoritative set of moral guidelines than had been previously enjoyed by the Church.

Nearly parallel to the increasingly unified teaching of the American hierarchy in the interim between *Cruzan* and *Schiavo* arose an almost equally unified opposition. Already at odds with moral guidelines that potentially imposed a presumption in favor of providing ANH to the PVS patient on Catholics, some moral theologians further reacted against, what they perceived to be, the excessive and mistaken moral weight of the directives themselves. The thrust of the criticism directed at the hierarchical guidelines, therefore, first questioned the competence of the Pennsylvania bishops and the NCCB Committee for Pro-Life Activities

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29The 1992 NCCB Committee for Pro-Life Activities document specifically stated that the document was intended to be only a “first word, not our last word, on some of the complex questions involved in this subject.” at 7.

30Richard A. McCormick, “‘Moral Considerations’ Ill Considered,” *America*, 166(9), March 14, 1992, 211.
etc… to teach authoritatively on the just care of the individual PVS patient. For example, Richard McCormick S.J., maintained that the binding nature of general moral principles did not equally transfer its binding character to the concrete application of those principles. Thus, in his understanding, while the Pennsylvania bishops could definitively promote the Catholic moral principle forbidding the willful taking of innocent human life, it lay beyond their authority to definitively proclaim the existence of a presumption in favor of providing ANH to the individual PVS patient. Ultimately, McCormick believed that the application of general moral principles to specific circumstances was more the province of an individual person’s conscience and interpretation. In the case of the just care of the PVS patient, both McCormick and O’Rourke asserted that the bishops’ appeal for a “presumption in favor of providing ANH to all patients,” and by inference, the PVS patient, was more properly relegated to the category of a pastoral pronouncement. The presumption in favor of providing ANH to the PVS patient, they contended, should be the subject of serious consideration; but in the final analysis, it should not be promulgated as a morally binding directive.  

In addition to the question of moral authority, another hotly debated, but unresolved area of contention, revolved around the nature of ANH itself and a determination of the benefit or burden associated with employing it to sustain the life of the PVS patient. Beginning in the mid to late 1980s, one school of Catholic moral thought maintained that the life of the PVS patient remained a great good for the person even if a return to consciousness was unlikely. Rather than constituting merely an instrumental good for a person’s use, bodily life remained an inherent good of the person that ought to be preserved through ordinary means including ANH. Thus, when the provision of food and fluids could be delivered with a reasonable hope of

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31Ibid. See also: Kevin D. O’Rourke, O.P., and Jean deBlois, C.S.J., “Removing Life Support: Motivations, Obligations, An Opinion on NCCB Committee for Pro-Life Activities Statement on Artificial Hydration and Nutrition,” Health Progress, 73(4), July-August 1992, 20-21. In relation to the 1992 NCCB Committee for Pro-Life Activities document they remark: “At best, the document and its conclusions may be viewed as a pastoral statement, offering some tentative reasoning and conclusions to be considered in cases that concern the use of medically assisted nutrition and hydration. We should seriously consider the advice given by the bishops’ committee, but we have no moral obligation to accept in detail the contents of “Nutrition and Hydration: Moral and Pastoral Reflections.”
sustaining life and without undue burden, pain, or expense, such delivery constituted a sufficient benefit that outweighed negligible burdens. Catholic theologians holding a contrary view argued that persons in the PVS who were incapable of pursuing the goals of life, lacking self-awareness, powerless to engage in relationships with loved ones, etc…were the unwilling recipients of an excessive burden through a useless delivery of food and fluids through a gastrostomy. In their estimation, a person’s physiological life was not, in itself, of sufficient benefit to a patient no longer able to recover consciousness or function. Thus, from the mid to late 1980s, the Catholic debate concerning the nature of ANH has continued unabated with no signs of reaching a unified conclusion. At the bottom line, the intervening years between *Cruzan* and *Schiavo* did not serve to strengthen and unify Catholic moral teaching on the just care of the PVS patient. Instead, they basically served merely to solidify the arguments used in opposition to each other.

As a final point of interest, it is worth commenting upon the character of the PVS debate as it existed among Catholic moral theologians in the interim years between *Cruzan* and *Schiavo*. From the mid 1990s until the turn of the millennium the quality of the Catholic debate concerning the PVS question seemed to possess, for want of a better term, a rather relaxed and respectful nature. Regardless of contrasting conclusions or the intensity of the arguments recommending or rejecting the provision of ANH to the PVS patient, the debate remained energetic and civilized. Published articles written, for example, by William E. May or Kevin O’Rourke, O.P., appeared in Catholic or national periodicals and attempted to persuade professional and public alike to the reasonableness of their respective positions. The merits and flaws of the 1990 Texas bishops’ statement were discussed with interest, as were those of the Pennsylvania bishops or the NCCB Committee on Pro-Life Activities. Although Catholic moral

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professionals viewed the PVS question in a most serious manner, there appeared to be relatively little pressure to forcefully advance one standard of care over the other. Perhaps the air of civility was due to factors already mentioned, namely, the indeterminate nature of the medical science surrounding the diagnosis of PVS or the absence of a highly directive Magisterial pronouncement regarding the level of care owed to the PVS patient. Whatever the reason, at the turn of the millennium it seemed as if the Catholic debate over the PVS question lacked the antagonistic and heavy-handed tenor that would later characterize it as knowledge of Terri Schiavo’s situation became more wide-spread.  

Particularly after the 2004 allocution by Pope John Paul II on the care of the PVS patient, the nature of the debate quickly devolved into an entrenched rhetoric in which both sides merely talked past each other.

*Out of the Blue: The Rise to Prominence of the Schiavo Case*

It was certainly ironic that the beginning of the ordeal of Terri Schiavo coincided so closely with the ending of the events surrounding Nancy Cruzan’s life and death. On February 25, 1990, Terri Schiavo, a 26-year-old Florida woman collapsed as the result of cardiac arrest and suffered such severe hypoxia that she lapsed into a state of persistent unconsciousness.

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37 Parties on all side of the Schiavo debate, agreed on only the most basic aspects of the events surrounding Terri Schiavo’s life and death, namely, the dates when a particular event occurred. Beyond the basic aspects of the case, almost no other aspect of the case was free from dispute. For example, from the condition of the patient to the motivations of the primary agents, everything about the Schiavo case was open to speculation, supposition and accusation. It is difficult to believe that two more different accounts of the events surrounding the Schiavo case could exist than those written by the primary agents of this case. See: Mary and Robert Schindler et al., *A Life that Matters: The Legacy of Terri Schiavo – A Lesson for Us All*, (Warner Books, New York, N.Y., 2006) and Michael Schiavo and Michael Hirsh, *Terri: The Truth*, (Dutton [Penguin Books] New York, N.Y., 2006).
By the end of the year she was diagnosed to be in a vegetative condition and a percutaneous endoscopic gastrostomy (PEG) tube was placed in her stomach to deliver the food and fluids necessary to sustain her life. Due to the fact that Terri had not completed an advance directive, her husband, Michael, was appointed her legal guardian several months after her collapse. By all accounts no objections to this arrangement were raised by Terri’s parents, Robert and Mary Schindler; at least in the first two years of Terri’s illness, the relationship between the Schindler family and Michael Schiavo was, for all intents and purposes, amicable.

Appearances of friendly cooperation, however, came to an abrupt end on February 14, 1993 when, disagreements surfaced regarding the use of the more than two million dollar malpractice settlement awarded to Terri and Michael Schiavo. In July 1993 Robert and Mary Schindler took the first legal steps of what would ultimately encompass a twelve year battle to sustain their daughter’s life. Initially they sought to remove Michael Schiavo as Terri’s guardian, but the court dismissed the suit. Another setback for the Schindler’s occurred early in 1994 when the first guardian ad litem, John H. Pecarek, submitted his report to the court which declared that Michael had acted in an appropriate and attentive manner towards his injured wife. Although a lull of sorts characterized the legal relations between the Schindler’s and Michael Schiavo in the mid-1990s, their personal relations continued to deteriorate. During this time, Michael gradually reached the conclusion that his wife’s PVS condition was irreversible and that she would not want her life maintained under such circumstances. Concurrently, the Schindler’s became increasingly

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38From the perspective of the Schindler family, Michael refused to honor a promise to devote the monies gained from the malpractice suit to their daughter’s rehabilitation. See: Robert and Mary Schindler, et al., A Life that Matters, at 53. Michael basically asserted that the Schindler’s, particularly Robert, merely wanted a portion of the malpractice suit monies for himself. See: Michael Schiavo, Terri: The Truth, at 76-82.


40Joshua E. Perry, J.D., Larry R. Churchill, Ph.D., and Howard S. Kirshner, M.D., “The Terri Schiavo Case: Legal, Ethical, and Medical Perspectives, Annals of Internal Medicine, 143(10), November 15, 2005, 745. Instrumental to Michael Schiavo’s decision to request the removal of the ANH sustaining the life of his wife was the 1997 death of his mother,
convinced that the diagnosis of PVS was incorrect in Terri’s case and that she could benefit from rehabilitative therapy.\textsuperscript{41} The character of the dispute between the Schindler’s and Michael Schiavo changed drastically in May 1998 when Michael and his lawyer, George Felos, petitioned the Pinellas County Circuit Court for authorization to discontinue the provision of ANH sustaining Terri’s life. What had been, in the estimation of the Schindler family, an highly unsatisfactory, but ultimately acceptable arrangement, since it allowed Terri’s life to be maintained, was suddenly transformed into their worst fears come true. Similarly, what had been a small but intense family disagreement ultimately was transformed into a national clash of ideology, theology, legal and medical policy that would re-awaken the debate regarding the just care of the PVS patient.

\textsuperscript{41} Ibid., at 745. See also: Robert and Mary Schindler, \textit{A Life that Matters} at 124 and 96 respectively. Although only one reference is provided here, for almost the entire fifteen years in which Terri lived in her injured condition, her parents and siblings continued to assert that Terri was not PVS and that she could benefit from rehabilitative therapy.
TERRI SCHIAVO: MEDICAL CONDITION AND PUBLIC REACTION

Terri Schiavo's Medical Condition

The diagnosis of a patient’s medical condition is generally a straightforward and objective starting point from which an examination of most medical cases can begin. In this instance, however, diverse medical opinions and contradictory eyewitness testimonies regarding the true nature of Terri Schiavo’s physical condition have precluded such a logical starting point. As the increasingly polarized struggle between the Schindler family and Michael Schiavo became better known outside the bounds of Pinellas County, Florida, the clearer became the realization that two divergent interpretations of Terri Schiavo’s medical condition were being reported. From a disinterested perspective, it is interesting to note that even the physicians tasked by the Schindler family and Michael Schiavo to provide the court with an accurate diagnosis of Terri Schiavo’s medical condition produced results that were widely dissimilar, and even contrary to each other. The inability of these medical professionals to arrive at an accurate and mutually acknowledged diagnosis was disturbing, particularly since the decision to provide or withdraw AHN from a seriously brain injured person depended heavily upon the correctness of their conclusions.

One group of commentators asserted that “[t]he Schiavo case rests critically on the concept of the persistent vegetative state and the certainty of the prediction that a patient in this state will have no meaningful recovery.” While on the surface, this statement sounds authoritative and straightforward, in reality it contains assumptions that should not be taken at face-value. On the one hand, the concept of the PVS was a not a universally accepted concept in medicine, and on the other, not every medical professional was convinced that such a diagnosis necessarily

42From the Schindler’s perspective, the diagnosis of PVS was highly questionable. Terri understood and responded to commands, and interacted with visitors, particularly her family. See: David Gibbs III, Fighting for Dear Life: The Untold Story of Terri Schiavo and What it Means for All of Us, (Bethany House, Minneapolis, MN, 2006), 22-26. From Michael Schiavo’s perspective, Terri definitively in a PVS and, therefore, she was incapable of interaction or communication. See: Michael Schiavo, Terri: The Truth at 74.

applied to Terri Schiavo.\textsuperscript{44} Credible, but conflicting opinions about Terri’s medical condition were ubiquitous in this case: the eyewitness and videotaped accounts presented by the Schindler family; the matter-of-fact statements of Michael Schiavo; or the various diagnoses of the physicians who examined her. Because of this, from the very outset, the truth about Terri’s condition was nearly impossible to ascertain. At the same time, even in spite of the conflicting information regarding her condition, one of the hallmark characteristics of the Schiavo case was the definitive manner in which each side represented the “facts” of Terri’s medical condition. Regardless of their assertions, however, neither side was able to successfully respond to the questions raised by their opponents in a manner that was truly convincing. The following examples provide a glimpse into the dilemma that faced anyone attempting to accurately assess Terri Schiavo’s medical condition. First, Dr. Ronald E. Cranford, one of the neurologists retained by Michael Schiavo to examine his wife, argued that, without a doubt, Terri was in a PVS. He stated:

The two most recent EEG’s have demonstrated no electrical activity on July 8, 2002: “no evidence of cerebral activity;” and October 4, 2002 – “does not have any definite brain activity.” thus the CT scans demonstrated massive atrophy of the cerebral hemispheres, indicating irreversibility (permanency) of the patient’s clinical condition...The clinical exams over the years

\textsuperscript{44}Dr. Eugene F. Diamond provides one of the best critiques of the PVS concept as it is presented in the 1994 Multi-Society Task Force document he wrote: “Criteria 1-3 [MSTF criteria of the PVS] are negative and 4-7 are positive. Furthermore, criteria 2 and 3 are subservient to criterion 1. If a patient lacks awareness of self, he will not respond to stimuli or language. The diagnosis therefore really comes down to one central criterion, i.e., no evidence of awareness of self or environment. If this continues for a month, the patient is said to be in a persistent vegetative state. After a year of persistence without improvement, the patient is said to be in a permanent vegetative state. How reliable, then, is the diagnosis of PVS? Two distinct possibilities qualify the reliability of the diagnosis. 1) The patient does exhibit evidence of awareness but the diagnostician has missed the relevant evidence and, 2) The patient does not exhibit any evidence of awareness but does, nevertheless, retain some measure of awareness. The evidence that some PVS patients may experience pain would imply that they are not devoid of awareness.” Eugene F. Diamond, M.D., “Definitions of Therapy, Treatment and Care,” in: \textit{Life-Sustaining Treatment and Vegetative State: Scientific Advances and Scientific Dilemmas}, (Instituto per l’Analisi dello Stato Sociale, Rome, Italy, March 2004), at 23-24.
were entirely consistent with diagnosis of permanent vegetative state secondary to hypoxic-ischemic encephalopathy.\textsuperscript{45}

Conversely, from the perspective of the Schindler family, the medical data cited by physicians and neurologists to prove that Terri was in a PVS did not coincide with their experience of her. Based upon their observations, Terri did demonstrate a certain degree of awareness of self, and she did interact with her environment on a minimal level. David Gibbs, an attorney representing the Schindler family, related the following incident to highlight the awareness Terri apparently possessed of her surroundings:

Interestingly, Terri responded very differently to her dad. Bob had developed this playful routine he’d go through with her each time they were together. I watched Bob announce, “Here comes the hug” as he wrapped her in a bearlike embrace. Then Bob said, “You know what’s coming next – the kiss!” He then moved in close for a smooch. Keep in mind that Bob sports a scratchy mustache. His chin was often unshaved too, which caused his facial hair to tickle Terri’s face. Over the years, as she did during our visit, Terri would scrunch up her whole face in preparation for the assault on her cheeks that she knew was coming with Bob’s scratchy kiss. Her family called this Terri’s “lemon face.” With a giggle, she’d turn her head away as if toying with her dad. In the end she’d laugh as his lips made contact with her cheek. She responded the exact same way every time to her father’s auditory cues as he consistently initiated this playful routine.\textsuperscript{46}

Beyond the confident, but ultimately contradictory, assertions made by individual physicians and family members regarding Terri’s medical condition, the one genuine contribution the \textit{Schiavo} case provided to the larger PVS debate was a clear demonstration of the difficulties inherent in accurately assessing the condition of a seriously brain injured patient. At the bottom line, the \textit{Schiavo} case showed that achieving a correct diagnosis of


\textsuperscript{46}David Gibbs III, \textit{Fighting for Dear Life: The Untold Story of Terri Schiavo and What it Means For All of Us}, at 22-23.
the severity of brain injury was no easy task, and that incorrect conclusions could be, and frequently were, reached. The incidence of mistaken diagnosis (noted in one study to be as high as 43 percent) was a recurring theme raised by physicians and neurologists at the 2004 International Congress in Rome.\textsuperscript{47} While the 1994 MSTF document concluded that few patients in a PVS ever experienced a verified recovery of consciousness after permanence could be declared, other studies and examples indicated otherwise.\textsuperscript{48} The recent example of Mr. Terry Wallis, an Arkansas man who unexpectedly recovered consciousness after nineteen years in a PVS, is but one example of the scientific uncertainty inherent in neurological medicine. Scientific discoveries that describe the ability of the brain to repair itself, as well as surprise cases of a return to consciousness are more than periodically reported in medical journals and the popular press.\textsuperscript{49} In an


article more than slightly applicable to the *Schiavo* case, Dr. D. Alan Shewmon, a professor of neurology and pediatrics at UCLA Medical School, commented upon a common practice of physicians who conduct neurological examinations of seriously brain injured patients. He stated that

What often happens in these cases is that a neurologist will spend ten or fifteen minutes examining the patient, elicit some brain-stem and spinal cord reflexes, not observe any evidence of consciousness, and declare the patient to be in a VS. But nurses or family members, who spend all day with the patient, may notice subtle signs of adaptive interaction with the environment, perhaps only intermittently. Too often their observations are dismissed as “subjective,” “denial,” or “projection.” Sometimes that is the case, but other times the one in denial is a proud physician who refuses to be diagnostically contradicted by non-physicians. Whose “evidence” counts?50

More than anything else, the *Schiavo* case has come to be the clearest example to date of the difficulties inherent in accurately diagnosing a patient with persistent unconsciousness. In some quarters it has also called into question the very foundation upon which the PVS is grounded. Because the current state of medical science remains, as yet, incapable of definitively determining the presence or absence of consciousness in patients suffering persistent unconsciousness, scientific theories collide with eyewitness accounts and vice-versa. In terms of the *Schiavo* case, such an environment made discerning the truth of her medical condition challenging if not almost impossible.

**Contradictory Diagnostic Conclusions**

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50D. Alan Shewmon, M.D., “The ABC of PVS,” at 220. The neurological examination of Terri Schiavo by Drs. Bambakidis, Greer, and Cranford most lasted between thirty minutes and one hour. Dr. Hammesfahr’s examination was conducted over a three hour period. In: Ronald E. Cranford, M.D., “Facts, Lies and Videotapes: The Permanent Vegetative State and the Sad Case of Terri Schiavo,” at 370.
The divergent interpretations of Terri Schiavo’s medical condition, produced by the physicians who directly examined her provide an excellent perspective from which to review the difficulties inherent in this case. At an evidentiary hearing conducted from October 11-22, 2002, five board-certified physicians (two selected by the Schindler family, two selected by Michael and one selected by Judge George Greer) were chosen to examine Terri and to provide expert testimony regarding her physical condition. The experts chosen by the Schindler’s were William Hammesfahr, M.D., and William Maxfield, M.D. Michael Schiavo chose Ronald E. Cranford, M.D., and Melvin Greer, M.D., (no relation to the presiding judge), and Judge George Greer selected Peter Bambakidis, M.D. While all of the examining physicians agreed that Terri suffered serious brain injury, their testimony, even after viewing videotaped evidence of her apparent ability to follow commands, varied significantly regarding her capacity for awareness and her potential for a certain degree of improvement. To provide a glimpse into how wide the diagnostic conclusions of Terri Schiavo’s medical condition actually were, the following paragraphs will briefly cover the testimony given by the five physicians who examined her in 2002.

The first expert witness, Dr. William Hammesfahr, a resident of Clearwater Florida and a board-certified neurologist conducted a two hour and fifty minute, videotaped, examination of Terri, which was by far the longest single test administered by the five physicians. Using the videotaped examination to confirm Terri’s capabilities, Dr. Hammesfahr described to the court the behaviors that distinguished Terri’s various reflex actions from those that were voluntary. He pointed out Terri’s ability to differentiate background noises from specific, meaningful sounds, to smile in relation to certain stimuli, for example, her mother’s nearness or

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51 When asked by Ms. Anderson, the Schindler’s attorney, about the extended length of his examination, Dr. Hammesfahr responded: “Examining patients with brain injuries takes a long time…There are a lot of reasons it takes a long time. One of them is that you have to observe them with respect to people around them. Second, they don’t process the way we do. So you can’t go through examinations very rapidly. You have to give them time to do different parts of the exam very slowly, and very frequently, repetitively, while you try to identify how their body is working and what can be done about it.” In: Transcript: In Re: The Guardianship of Theresa Marie Schiavo, Incapacitated, no. 90-2908-GD-003, (October 11-22, 2002), http://www.northcountrygazette.org/documents/2002trialpart1.txt, (Accessed: November 24, 2006), at 239-240.
52 Ibid., at 243.
53 Ibid., at 249 & 256.
music, and her propensity to respond better to a gentle tone of voice than to tones that were harsh. He further testified that Terri responded to commands to open and close her eyes, to squeeze his hand and to lift her leg against the pressure of his hand. In Dr. Hammesfahr’s opinion, Terri Schiavo was not merely aware of her surroundings; she was able to interact with it in a minimal fashion. He stated that,

She is communicating already. She is communicating through following instructions. She is communicating through gaze preferences towards people...She is clearly, as you saw earlier listening to music or responding to music. She responds to specific voices. She responds to specific tones of voices from specific voices.

In his judgment there was no doubt that, although Terri was a severely injured person, she was most certainly not in a PVS and with therapy could benefit significantly.

The second expert chosen by the Schindler family was Dr. William Maxfield from Tampa Bay, Florida. Dr. Maxfield, a board-certified physician in radiology and nuclear medicine personally observed Terri three separate times in 2002, and conducted a videotaped examination on a separate occasion. According to Dr. Maxfield’s testimony, Terri obviously

54 Ibid., at 252 & 255.
55 Ibid., at 256, 257, 261, 262. According to Dr. Hammesfahr, Terri responded better to her mother than her father in this regard. He specifically stated that this kind of discrimination was not an involuntary reflex, but a sign of cognitive awareness. Later on in his testimony, he commented that Terri responded positively to her father’s voice as he attempted to ease the contraction in one of her arms (at 277).
56 Ibid., at 293-296 (eyes); 288 and 302 (hand squeeze) and 296 and 317-321 (leg movements).
57 Ibid., at 297-298. Dr. Hammesfahr pointed out that the severity of Terri’s brain injury affected her ability to respond to stimuli. Thus, while a normal person would respond to a specific stimulus almost instantaneously, for Terri, the response to specific stimuli would be noticeably longer (at 311).
58 Ibid., at 306-307. Also at 333-334, Dr. Hammesfahr was reasonably convinced that vasodilation and hyperbaric-oxygen therapy which would deliver greater supplies of oxygen to the brain.
suffered a serious brain injury; however, based upon his interpretation of the CT (computerized tomography) and SPECT (single-photon emission computerized tomography) scans of her brain, he did not consider the severity of the insult to be such that she would be incapable of some degree of awareness, or the ability to see and track objects as they moved across a room.\^60 He further reported that Terri not only visibly reacted to the presence of her mother when she came into the room, but that she turned towards her mother, smiled, and made sounds as if she was trying to communicate with her.\^61 He firmly believed that Terri was not in a PVS because, among other things, she possessed the ability to interact with her environment and she recognized people familiar to her. Based upon the examination he conducted of Terri, his numerous observations, and the scans of her brain, Dr. Maxfield concluded that the therapy he recommended could produce significant improvement in her condition.\^62 Ultimately Dr. Maxfield and Dr. Hammesfahr concurred in the belief that Terri possessed a degree of awareness and interactive ability with her environment that could be expanded by the treatments they offered.\^63

The late Dr. Ronald E. Cranford was the first physician selected by Michael Schiavo to testify about his wife’s medical condition. Although he was undoubtedly the most renowned of the physicians tasked to examine Terri Schiavo, his selection was not devoid of controversy.\^64 On the one hand, Dr. Cranford’s credentials were undeniably impressive. He was a board-certified neurologist and head of the neurology clinic at Hennepin

\^60Ibid., at 85, 89, 113, 114, 117.
\^61Ibid., at 33-34.
\^62Ibid., at 105 and 12. Dr. Maxfield recommended hyperbaric oxygen therapy for Terri Schiavo. Hyperbaric oxygen therapy involved the use of an oxygen chamber which increased oxygen pressure and subsequently increased the amount of oxygen that reached the brain.
\^63Transcript: In Re: Schiavo, no. 90-2908-GD-003, (Part 1), at 216 and 333. Dr. Hammesfahr recommended vasodilation and hyperbaric oxygen therapy to help improve Terri Schiavo’s condition. Basically vasodilators are medications that help increase the blood flow, and thus, oxygen to (in this case) the brain.
County Medical Center in Minneapolis, Minnesota. In addition he was the second chairman of the Ethics and Humanities Subcommittee of the American Academy of Neurology, the co-chairman of the Multi-Society Task Force on the PVS, and author of hundreds of peer-reviewed articles in prestigious medical journals.\textsuperscript{65} Conversely, Dr. Cranford was also well-known as a serious advocate for the right-to-die and someone who often argued against providing food and fluids to patients in the PVS.\textsuperscript{66} Similar to Drs. Hammesfahr and Maxfield, Dr. Cranford also conducted a videotaped examination of Terri Schiavo; however, beyond that, no further similarities were forthcoming. Based upon the CT and SPECT scans of her brain, Dr. Cranford concluded that Terri had suffered severe cortical damage that ultimately led to massive atrophy and shrinkage of the cerebral cortex and thalamus over the course of her fifteen year illness.\textsuperscript{67} While he frequently acknowledged during his testimony that the interpretation of a patient’s neurological scans, his or her movements, and/or responses to stimuli were often difficult to analyze,\textsuperscript{68} Dr. Cranford unequivocally concluded that Terri was in a PVS and that her condition was completely beyond the capacity of

\textsuperscript{65} Transcript: In Re: Schiavo, no 90-2908-GD-003, (Part 2), at 572, 574, 584 and 589.


\textsuperscript{67} Transcript: In Re Schiavo, no 90-2908-GD-003, (Part 2) at 631-634. See also: Ronald E. Cranford, M.D., “Facts, Lies and Videotapes: The Permanent Vegetative State and the Sad Case of Terri Schiavo,” at 364. The author stated: The initial CT scan on the day of admission, February 25, 1990, was normal, but further CT scans documented a progression of widespread cerebral hemisphere atrophy, eventually resulting in CT scans of 1996 and 2002 showing extreme atrophy.”

\textsuperscript{68} Ibid., at 610, 645, 652 and 655.
any therapy to correct.\footnote{Ibid., at 669-670. In response to the questions about the possible application and success of vasodilation or hyperbaric oxygen therapy Dr. Cranford responded, “My opinion is it’s beyond bizarre. It’s incredibly strange and boggles the imagination that anyone can come along after being in a vegetative state after 12 years and say with any treatment – it has to be totally bogus, completely bogus…”} In his judgment, Terri only exhibited reflex motions and reactions and she produced no consistent and sustainable responses to stimuli to indicate a degree of awareness.\footnote{Ibid., at 642-644, 654 and 663.} He further testified that Terri could not hear sounds, that she did not consistently focus on specific objects and track them across the room, nor did she voluntarily smile.\footnote{Ibid., at 644, 647-648.} In the final analysis, Dr. Cranford rejected any individual moment in which it appeared that Terri consciously responded to a specific stimulus. He asserted that a valid medical assessment of Terri Schiavo was founded upon the whole body of evidence regarding her condition and not merely a specific incident or two. Basically he argued that, “[I]t’s not the few seconds that counts, but it’s the overall film and the overall observation of others to find consistent reproducible responses over a period of time, not just a few seconds.”\footnote{Ibid., at 650.} Thus he determined that what many people, including trained medical professionals, believed to be evidence of awareness and consciously chosen actions was in reality simply the result of a functioning brain-stem and not higher cortical activity.\footnote{Ibid., at 645 and 667.}

The second physician chosen by Michael Schiavo was Dr. Melvin Greer, a board-certified physician in psychiatry and child neurology, professor of neurology at the University of Florida College of Medicine in Gainesville, Florida, and former president of the American Academy of Neurology.\footnote{Ibid., at 392, 397 and 402.} After reviewing the assessments of the other four physicians tasked to evaluate her, the results of several neurological diagnostic texts (CT EEG and SPECT scans), as well as conducting his own brief examination, Dr. Greer testified that the evidence clearly indicated that Terri Schiavo was in a PVS.\footnote{Ibid., at 404-406.} He determined the CT scans that were taken of Terri’s brain in 1996 and 2002 indicated that profound atrophy and shrinkage of her brain had occurred and that no form of treatment could ever produce a tangible
benefit for her. Consequently, Dr. Greer concluded that any apparently cognitive reactions to stimuli were, in fact, merely reflex actions that were consistent with his diagnosis of the PVS. The last of the physicians to examine Terri was Dr. Peter Bambakidis, a board-certified physician in adult neurology and clinical physiology at the Cleveland Clinic Foundation in Cleveland, Ohio. Chosen by Judge Greer to provide an impartial perspective from which to gauge the conclusions of the other experts selected by the Schindler family and Michael Schiavo, Dr. Bambakidis’ testimony was not completely free of controversy. After a delayed flight from Ohio, Dr. Bambakidis finally arrived to perform his examination of Terri Schiavo more than three hours after it had originally been scheduled. He reviewed Terri’s medical history and then conducted a brief, non-videotaped examination in the presence of her husband and his attorney alone. During his testimony, Dr. Bambakidis stated that, while he was no expert at the interpretation of CT or SPECT scans, the images of Terri’s brain clearly showed that the cerebral cortex was no longer present and that the tissue had been replaced by fluid. Despite the fact that he noted the presence of some brain activity recorded by her EEG, Dr. Bambakidis further suggested that, because the cerebral cortex was no longer present, Terri had consequently lost the crucial physiological

76 Ibid., at 410-417.
77 Ibid., at 541, 543, 545, 547.
78 Ibid., at 269-276. During the cross-examination it was revealed that Dr. Bambakidis had a significantly greater degree of contact with the Petitioner and his lawyer, (Michael Schiavo and George Felos respectively) than he did with the respondents and their attorney (the Schindler family and Patricia Anderson respectively). Dr. Bambakidis was in contact with George Felos on approximately ten occasions from May 2002 through the evidentiary hearing in October 2002. See also: Robert and Mary Schindler, A Life that Matters, at 124-125; and Diana Lynne, Terri’s Story: The Court-Ordered Death of an American Woman, (WND Books, Nashville, TN, 2005), 150-151.
79 Diana Lynne commented that, “The prior arrangement was for the Schindler’s to also be there for his examination. Due to Bambakidis’s flight delay, however, they were not present when he arrived. He testified he made no attempt to contact them to supplement his understanding of Terri’s history that evening or anytime thereafter. In: Diana Lynne, Terri’s Story: The Court-Ordered Death of an American Woman, (WND Books, Nashville, TN, 2005), 151.
80 Transcript: In Re: Schiavo, no. 90-2908-GD-003, (Part 2) at 234-236 and 247-248.
81 Ibid., at 243-244. Dr. Bambakidis stated that the brain wave amplitude measured by the EEG was low and showed little in the way of spontaneous variability.
foundation for awareness and perhaps a great deal more. Regarding the importance of the cerebral cortex, he remarked:

Oh, it’s very, very vital. Those aspects of human existence involving awareness of one’s self, awareness of those around us, our ability to communicate, our ability to experience pleasure on a conscious level and our ability to suffer as well is a function of the cerebral cortex. And it’s frightening to think that such a relatively small area of the brain has such an important role in what makes us – I don’t mean pejorative [sic] I was going to say totally human, to have those experiences as well as those trials and tribulations that come with being human.  

Based upon his examination and the body of medical information available to him, Dr. Bambakidis concluded that Terri Schiavo only produced responses that were consistent with a diagnosis of PVS. He considered every piece of evidence, from the scans of her brain, to her reflexive stimulus responses, to her posture, to confirm the severely abnormal nature of her condition. Rather than object to Mr. Felos’ attempt to equate Terri Schiavo with a plant on a windowsill, Dr. Bambakidis testified that, in an analogous manner, a patient in a PVS could produce involuntary

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82Ibid., at 237-238. Arguing against the 1989 American Academy of Neurology statement on the PVS, and specifically, what he considered to be the unproved establishment of conscious awareness in the cerebral cortex, Dr. Shewmon stated, “First, they do not simply refer to ‘cognitive function,’” but specifically to “cerebral cognitive function.” Why? The final phrase seems to suggest that all cognitive function is ipso facto cerebral, gratuitously taking for granted as established fact what is a mere hypothesis. Second, there may be forms of subjective consciousness other than ‘cognitive function’ or ‘thinking,’ e.g., self-awareness, basic awareness of body and environment; nor is ‘experiencing pain’ a ‘cognitive function’ in any usual sense of the term.” He further asserted that, “In the final analysis, the dogmatic assertions of VSC (Vegetative State – Consciousness) in official position statements were based not on scientific evidence but on an unproved and philosophically biased assumption that consciousness is an ‘emergent property’ of cortical neurons, at a time of intense socio-political pressure to provide courts with the medical ‘facts’ about PVS. It is not the first time in history, and no doubt not the last, that one generation’s medical ‘facts’ become future generations’ medical myths.” In: D. Alan Shewmon, M.D., “A Critical Analysis of Conceptual Domains of the Vegetative State: Sorting Fact from Fancy,” at 345 and 346.

83Ibid., at 234-236; 248, and 257.
movements, sounds, and responses, but have no degree of awareness. In the final analysis, Dr. Bambakidis asserted that the evidence overwhelmingly supported his diagnosis that Terri Schiavo was in a PVS. 

Exactly one month after the conclusion of the hearing, Judge Greer finally delivered his ruling. Despite the fact that three of the five physicians who examined Terri testified that she was in a PVS, the judge insisted that his decision did not rest on that numerical basis alone, but upon all the relevant factors impacting the case. First and foremost he referred to the mandate accepted by the court at the beginning of the hearing that intended to determine Terri’s “current medical condition, the nature of the new medical treatment and their acceptance in the relevant scientific community, the probable efficacy of these new treatments and any other factors the trial court deems relevant.” Based upon the parameters set by his mandate, the judge ultimately determined that the Schindler’s experts were significantly less convincing than the other three physicians who testified that Terri was in a PVS. In the judge’s estimation, Terri’s responses to stimuli, irrespective of the testimony offered by Drs. Hammesfahr and Maxfield, were not consistent and reproducible. Judge Greer was particularly critical of Dr. Hammesfahr’s videotaped examination, in which the doctor and Mrs. Schindler issued to Terri over one hundred commands and asked over seventy questions without eliciting responses that he considered to be indicative of conscious understanding on her part. He was similarly

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84Ibid., at 258-260. Mr. Felos commented upon the movement of a plant towards the light and its subsequent lack of consciousness as an analogy of Terri Schiavo’s ability to move, see, respond, etc… without awareness.
85Ibid., at 261-262.
87Ibid.
88Ibid. According to the judge, the total number of commands issued was 111: Dr. Hammesfahr issued 105 and Mrs. Schindler gave 6. The total number of questions was 72: Dr. Hammesfahr asked 61 and Mrs. Schindler asked 11. Further, in his statement, Judge Greer appeared very skeptical of the claims made by Dr. Hammesfahr and Dr. Maxfield. The judge labeled Dr. Hammesfahr a “self-promoter” and appeared very skeptical of his claims regarding Terri’s responses to stimuli. At one point the judge commented: “The videographer focused on her hands when Dr. Hammesfahr was asking her to squeeze. While Dr. Hammesfahr testified that she squeezed his finger on command, the video would not appear to support that and his reaction on the video likewise would not appear to support that testimony.”
skeptical of the fact that neither physician provided the court with documented evidence to confirm their generalized claims of successfully treating patients in the PVS. In this regard Judge Greer contended that,

[i]t is clear from the evidence that these therapies are experimental insofar as the medical community is concerned with regard to patients like Terri Schiavo which is borne out by the total absence of supporting case studies or medical literature. The Mandate requires something more than belief, hope or “some” improvement. It requires this court to find, by a preponderance of evidence, that the treatment offers such sufficient promise of increased cognitive function in Mrs. Schiavo’s cerebral cortex so as to significantly improve her quality of life. There is no such testimony, much less a preponderance of evidence to that effect.89

Ultimately, despite the fact that Drs. Hammesfahr and Maxfield testified that vasodilation and hyperbaric oxygen therapy offered the potential for substantial improvement in Terri Schiavo cognitive abilities, their credibility was seriously hampered by the fact that they offered insufficient corroborating evidence to confirm their claims.

By contrast, although the judge acknowledged the fine credentials of all five physicians, he was greatly influenced by the unified testimony given by the three physicians who believed Terri to be in a PVS. He also found to be credible their testimony that Terri was beyond any effort to improve her condition. Interestingly, Judge Greer professed to be most deeply affected by the agony and soul-searching that Dr. Bambakidis experienced while reaching the conclusion that Terri Schiavo was in a PVS.90 The doctor’s emotional wrestling notwithstanding, however, it seemed to be the judge’s contention that the testimony of Drs. Cranford, Greer and Bambakidis more consistently reflected the accepted body of medical knowledge on the PVS that actually swung his decision in favor of Michael Schiavo. Thus it was his ruling that the motion filed by Robert and Mary Schindler be denied and

89Ibid. See also: Joshua E. Perry, J.D., Larry R. Churchill, Ph.D., and Howard S. Kirshner, M.D., “The Terri Schiavo Case: Legal, Ethical, and Medical Perspectives,” at 746.
90Ibid.
a new date was set for the removal of the food and fluids sustaining Terri Schiavo’s life.\textsuperscript{91}

In the end, granted the fact that Judge Greer was convinced by the physicians who evaluated Terri Schiavo’s medical condition to be consistent with the PVS, the difficulties regarding the truth of her condition did not simply disappear. During the course of the trial to maintain Terri’s feeding and hydration the Schindler family received the unsolicited and sworn affidavits of more than thirty physicians who disputed the diagnosis of the PVS and offered their assistance in evaluating Terri’s medical condition.\textsuperscript{92} Even the results of the autopsy report (used to support the diagnosis of PVS), in which her brain was revealed to be a substantially abnormal specimen, did not produce conclusive and incontrovertible proof that Terri Schiavo lacked some degree of awareness, inner or otherwise.\textsuperscript{93} To paraphrase the argument often raised by Dr. D. Alan Shewmon, the absence of any evidence of consciousness (e.g., the patient does not respond consistently to stimuli) is not equivalent to positive evidence that consciousness is absolutely and incontrovertibly absent. He further reasoned that, due to the severity of the brain injury, it was entirely possible that a patient in a PVS would be completely incapable, physically or psychologically, of producing consistent and convincing evidence of

\textsuperscript{91}Ibid. Judge Greer set the date for the removal of Terri’s ANH to be 3:00 p.m. on January 3, 2003.

\textsuperscript{92}See: \url{http://www.terrisfight.org/mainlinks.php?tablesingle=main_terri_story&id=7}; Diana Lynne quoted Heidi Law, a certified nursing assistant who cared for Terri Schiavo: “I personally saw her swallow the ice water and never saw her gag...On three or four occasions I personally fed Terri small mouthfuls of Jell-O, which she was able to swallow and enjoyed immensely...Law similarly reported hearing Terri say ‘mommy,’ ‘momma,’ and ‘help me,’ a number of times.” In: Diana Lynne, \textit{Terri’s Story: The Court-Ordered Death of an American Woman}, at 131 and 154-157.

\textsuperscript{93}From “Report of Autopsy – Theresa Marie Schiavo, Case No. 5050439,” June 13, 2005. In his report, Dr. Jon Thogmartin, M.D., noted that Terri Schiavo’s brain weighed only 615 grams (less than half its expected weight), and had, among other injury, significant damage of the occipital lobes. On the other hand, this fact must be assessed in light of thirteen day dehydration process that ultimately led to her death. See: Diana Lynne, \textit{Terri’s Story: The Court-Ordered Death of an American Woman}, at 161-162. See also: Fred Charatan, “Autopsy Supports Claim that Schiavo was in a Persistent Vegetative State,” \textit{British Journal of Medicine}, 330 (June 25, 2005), 1467 and Joshua E. Perry, J.D., Larry R. Churchill, Ph.D., and Howard S. Kirshner, M.D., “The Terri Schiavo Case: Legal, Ethical and Medical Perspectives,” at 746.
consciousness even if he or she desired to do so. In such an instance, an evidentiary standard that required consistent or reproducible responses to demonstrate some degree of awareness would be completely beyond the capabilities of some patients. Currently, it is still the case that, substantial minorities of physicians maintain the belief that persistently unconscious patients retain the capacity to experience pain and suffering despite the unequivocal contention by the major American medical organizations that they do not. And even in spite of all medical training and conviction to the contrary, some physicians continue to provide patients in a PVS with various anesthetics just in case. In the final analysis, therefore, the extent

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94 D. Alan Shewmon, M.D., “Recovery from ‘Brain Death’: A Neurologist’s Apologia,” *Linacre Quarterly*, 64(1), February 1997, 58-59. He stated, “Moreover it occurred to me that in the context of such a lesion an empirical demonstration of absence of subjective consciousness is inherently impossible, even if that were the case. Diffuse cortical destruction results in spastic quadriplegia and pseudobulbar palsy, apraxia of whatever little motor control remains, global aphasia, dementia, cortical blindness, etc. How could anyone with such a disability possibly externally manifest inner consciousness convincingly, even if it were present? Furthermore, anyone aware of him-or-herself being in such a state (and perhaps aware of being considered a “vegetable” by caregivers) would probably also be significantly depressed, impairing the motivation even to attempt to communicate.”

95 Dr. Shewmon has proposed the possibility of a “super locked-in syndrome” to account for the possibility of self-awareness, but no ability to communicate it, in a patient diagnosed PVS. See: D. Alan Shewmon, M.D., “A Critical Analysis of Conceptual Domains of the Vegetative State: Sorting Fact from Fancy,” at 345346. See also: Adam Zeman, “Consciousness,” *Brain*, 124(7), July 2001, 1263-1289.


97 Bryan Jennett, M.D., *The Vegetative State: Medical Facts, Ethical and Legal Dilemmas*, (Cambridge University Press, New York, N.Y., 2002), 18-19 and Kirk Payne, M.D., Robert M. Taylor, M.D., Carol Stocking, Ph.D., and Greg A. Sachs, M.D., “Physicians’ Attitudes about the Care of Patients in the Persistent Vegetative State: A National Survey,” *Annals of Internal Medicine*, 125, (1996), 104-110. In response, Dr. Eric Cassell opined that: “Neurologists know these things better than I do, so these discordant views are probably not the result of ignorance of neurophysiology. Rather, one can speculate that anyone who looks at these patients, whose eyes may be open when awake, will see someone who looks so much like an ‘intact’ person that it is difficult to imagine their lack of cognitive function. Appearance overrides scientific knowledge – not a rare phenomenon.” In: Eric J. Cassell,
of scientific uncertainty with regards to brain injury, persistent unconsciousness, and the potential for recovery of consciousness remains significant.\textsuperscript{98} While the purpose of raising these questions at this point is not to endorse one conclusion of Terri Schiavo’s medical condition over another, it is intended to highlight the serious doubts that exist, not only in this particular case, but in the entire medical arena where the PVS is concerned.

\textit{A Brief Overview of the Legal Progression of the Schiavo Case}

Other than the eventual death of Terri Schiavo due to the withdrawal of the food and fluids sustaining her life, undoubtedly the greatest tragedy of the \textit{Schiavo} case was the bitter enmity that developed between the Schindler family and Michael Schiavo during the fifteen years of Terri’s illness. Based upon the separate accounts of the whole affair, it is nearly impossible to ascertain the truth behind the stated reasons for their animosity; however, despite numerous attempts for reconciliation, the outcome of their disagreement eventually resulted in a nearly seven year legal battle to maintain or end Terri’s life. The acrimony that characterized the relations between the Schindler family and Michael Schiavo began on February 14, 1993 as the result of disagreements regarding the use of nearly two million dollars that the Schiavo’s gained from the 1992 malpractice trial.\textsuperscript{99} Due to periodic legal clashes and conflicts of opinion, the animosity between the Schindler family and Michael Schiavo continued to intensify during the years between 1993 and 1998. At the heart of the hostility dividing them was Michael’s apparent change in attitude regarding his wife and the

\textsuperscript{98}Ibid., at 221. Dr. Jennett commented: “However, there remains much that we do not yet know – in particular about the nature of consciousness and about how even partial recovery can occur after many months. The diagnosis and prognosis remain matters of probability rather than of certainty.”

\textsuperscript{99}Not including minor disagreements that may have existed between the Schindler’s and Michael Schiavo before February 14, 1993, the Schindler family alleged that their dispute with Michael began with his apparent refusal to devote a portion of the award to Terri’s rehabilitation. See: Mary and Robert Schindler, \textit{A Life that Matters}, at 53. Conversely, Michael Schiavo contended that the Schindler’s (mostly Robert) were only concerned with getting “their share” of the proceeds from the malpractice award and not the well-being of their daughter. See: Michael Schiavo, \textit{Terri: The Truth}, at 72-75.
medical care she received.\textsuperscript{100} During the initial years of Terri’s illness, Michael was noted for his enthusiastic and willing participation in her rehabilitation; even Mary Schindler remarked upon the level of his devotion to her daughter. She said, “Michael and I became very close during this period, treating each other as partner and friend. Michael never talked about his feelings or about his childhood, but he fought hard for his wife and was tireless in her care.”\textsuperscript{101} After February 1993, however, his actions abruptly shifted away from efforts to assist Terri’s rehabilitation and towards efforts that would allow her to die. In relatively rapid succession Michael initiated a “do-not-resuscitate” order in case of cardiac arrest, he refused to authorize further rehabilitative care, and he chose not to allow Terri’s care-givers to provide antibiotics to treat an infection that had developed in her urinary tract. During testimony he offered in a November 1993 deposition, he indicated that his refusal to consent to the provision of antibiotics was specifically calculated to encompass Terri’s death. According to information recently given to him by Terri’s physician, Dr. Mulroy, Michael testified that he understood the consequences of his refusal to authorize treatment for Terri’s urinary tract infection and that those consequences were potentially fatal. Contrary to his instructions, the staff at Sabal Palms Health Care Center refused to comply with such an order and Michael was ultimately forced to relent; however, he asserted, as he would

\textsuperscript{100}The Schindler family initiated a failed attempt to have Michael removed as Terri’s guardian on July 29, 1993. The guardian \textit{ad litem} for the case, John H. Pecarek, submitted a report to the judge in which he stated that Michael had acted appropriately and attentively towards his wife. He further concluded that, although Michael was a difficult person with whom to work, Terri likely reaped the benefits of greater attention from the nursing home staff as a result. In: \url{http://www.mayoclinicproceedings.com/inside.asp?AID=1054&UID}, (Accessed: December 4, 2006).

\textsuperscript{101}Mary and Robert Schindler, \textit{A Life that Matters}, at 45. From 1990 through 1994, a serious effort was undertaken to rehabilitate Terri Schiavo, including a trip to California that she took in November 1990 with Michael and her mother to receive an experimental brain stimulator treatment. A major component of the treatment that Terri received at this time entailed neurological testing, as well as rehabilitation efforts. See: Kathy Cerminara, and Kenneth Goodman, “Schiavo Case Resources: Key Events in the Case of Theresa Marie Schiavo,” \url{http://www.6.miami.edu/ethics/schiavo/terri_schiavo_timeline.html} (Accessed: December 6, 2006).
regarding his decision to withdraw the ANH sustaining her life, that his
decision was made in conjunction with what Terri would have wanted.102

The confrontation that was ultimately to become the Schiavo case did not
truly begin until May 1998 when Michael first petitioned to the Pinellas-
Pasco County Circuit Court for the authority to remove the ANH sustaining
Terri’s life. According to Michael’s description of these events, it was due
to his experience with the death of his mother in 1997 that finally made it
possible for him to make the request that would allow Terri to die.103 On the
other hand, differing accounts, and even prior statements made by Michael
himself, provided some indication that his assertions regarding Terri’s
wishes were not based solely upon specific direction given by his wife.
Several factors lend credence to this charge. First, from the very beginning
of Terri’s collapse and subsequent lack of normal consciousness and
responsiveness, Michael gave no indication that Terri had made statements
regarding her preferences in the event of incompetence. Affidavits
presented to the court on behalf of Terri Schiavo raised a certain level of
doubt about the veracity of Michael’s later statements regarding the
knowledge he possessed of his wife’s preferences. One such statement
alleged that,

…Schiavo indicated he didn’t know Terri’s wishes during the
early years of her incapacitation. Casler described a
conversation in which Schiavo was reportedly ‘complaining that
he did not know the answers to questions he was being asked’
by lawyers gathering information for the medical malpractice
trial. I specifically remember Michael’s saying, ‘How should I

102 Michael testified to his understanding that a failure to treat Terri’s urinary tract infection
could ultimately lead to sepsis that might spread throughout her body and eventually cause
her death. In Re: The Guardianship of Theresa Marie Schiavo, Incompetent, no. 90-2908-
GD, Deposition of Michael Schiavo, (November 19, 1993), at 15. See also: In Re: The
Guardianship of Theresa Marie Schiavo, Incapacitated, no 90-2908-GD-003, Report of
Guardian Ad Litem, (December 29, 1998)., In: Arthur L. Caplan, James J. McCartney, and
Dominic A. Sisti, The Case of Terri Schiavo: Ethics at the End of Life, (Prometheus Books,
Amherst N.Y., 2006), 88.

103 In his book, Michael quoted his girlfriend Jodi Centonze who said, “It wasn’t that Mike
suddenly remembered what Terri wanted; it was just a psychological thing for him. Now
that he’d walked through it with his mom, he felt it was okay to walk through it with
know what she wanted?’ He was gesturing at the time in a somewhat grandiose way…^104

Additionally, it was the opinion of the second guardian ad litem, assigned to Terri Schiavo, Richard L. Pearse Jr., that the only direct evidence pertaining to Terri’s wishes was the hearsay evidence of her husband, and he considered that evidence suspect.^105

Second, as Terri’s illness continued, the development of several glaring conflicts of interest in Michael’s life effectively raised serious doubts about his credibility where Terri’s treatment preferences were concerned. In the first place, Michael’s adamant refusal to withdraw the ANH sustaining Terri’s life in the early years of her illness belied his later assertions that she did not want receive life-sustaining treatments in the event of incompetence, and that he was simply honoring her expressed wishes. His early legal testimony confirms this inconsistency. For example, during the 1992 malpractice trial Michael testified that his one desire was to finish nursing school so that he could take care of his wife because “[s]he’s my life and I wouldn’t trade her for the world. I believe in my wedding vows.”^106 In a similar manner, he indicated in a 1993 deposition that he couldn’t even think about removing the feeding tube sustaining Terri’s life. “I couldn’t do that to Terri,” he stated. ^107 Interestingly, however, it was only a short time after the conclusion of the 1992 malpractice trial, and the subsequent award of nearly two million dollars, that his story regarding Terri’s wishes began to modify and his attitude toward his her rehabilitation and continued existence began to change. ^108 Terri’s second guardian ad litem, Richard L.


[^108]: In an affidavit written by a registered nurse who cared for Terri from 1995-1996, Michael allegedly stated on numerous occasions, “When is she going to die?” “Has she died yet?” and “When is that bitch gonna die?” In: Diana Lynne, *Terri’s Story: The Court-Ordered Death of an American Woman*, at 71 and 97.
Pearse Jr., revealed to the Court concerns of this nature in a 1998 report in which he stated:

However, his [Michael’s] credibility is necessarily affected by the obvious financial benefit to him of being the ward’s sole heir-at-law in the event of her death while still being married to him…Mr. SCHIAVO’s credibility is also adversely affected by his chronology of this case. For the first four years (approximately) following the ward’s accident, he aggressively pursued every manner of treatment and rehabilitation conceivable, as well as lawsuits to compensate the ward for her injuries in connection with which he presumably argued she would require substantial funds for future care and treatment. At our around the time the litigation was finally concluded, he has a change of heart concerning further treatment…

Concurrent with the financial benefits that he acquired from the malpractice trial, another basis for a conflict of interest arose as public knowledge of Michael’s pursuit of, or at least participation in, other romantic relationships emerged. In the testimony of his 1993 deposition Michael acknowledged that he was intimately involved with two women, one of whom he continued to maintain contact. Aware of the apparent conflict of interest, Terri’s guardian ad litem speculated in his report that Michael had likely concluded that Terri no longer enjoyed any hope for recovery and that he might as well move on with his life as best he could.

\[109\] In Re: The Guardianship of Theresa Marie Schiavo, Incapacitated, no. 90-2908-GD-003, Report of Guardian Ad Litem, (December 29, 1998). In: Arthur L. Caplan, James J. McCartney, and Dominic A. Sisti, The Case of Terri Schiavo, at 92-93. See also: Michael Schiavo, Terri: The Truth, at 121-130. In his account, Michael mentioned that the relationship between his lawyer, George Felos, and Mr. Pearse was, based upon a previous encounter, adversarial. As a result, they both were concerned whether or not the guardian ad litem would give them a fair hearing.

\[110\] In Re: The Guardianship of Theresa Marie Schiavo, Incompetent, no. 90-2908-GD, Deposition of Michael Schiavo, (November 19, 1993), at 3-8. See also: Michael Schiavo, Terri: The Truth, at 92-97 and 104-112. In his account of these events, Michael discussed his relatively short involvement with Cindy Brashers, and the relationship developed with Jodi Centonze, his future second wife.

While it is undoubtedly true that conflicts of interest do not automatically signify the existence of impropriety, the presence of such conflicts do make suspect Michael Schiavo’s insistence that he only followed his wife’s treatment preferences when he petitioned for the removal of the ANH sustaining her life, especially since he stood to gain so much as a result of her death. Once again, as has dogged this case from the beginning, it is difficult to ascertain exactly where the truth lies.

The trial to determine whether or not Michael Schiavo could authorize the removal of Terri’s ANH in accord with “her wishes” began on January 24, 2000 and ended eighteen days later on February 11, 2000. Judge George W. Greer, circuit court judge of Pinellas-Pasco County presided over the case. Although Judge Greer seriously considered the recommendation of Terri’s guardian ad litem, Richard L. Pearse, Jr., to refuse Michael’s request to remove the ANH sustaining her life, he concluded that sufficient evidence of Terri’s treatment preferences did exist and that it did coincide with the assertion of her husband. The judge determined that Michael Schiavo had acted in good faith with regards to the care of his wife, and that his decision to wait eight years before making the request to remove the ANH sustaining her life should not be counted against him. Ultimately, since he was completely convinced that Terri was in a PVS, and that her treatment preferences were accurately presented by her husband, he found in favor of Michael Schiavo and granted his petition to discontinue the life-sustaining food and fluids that allowed her to live.

The Schindler family appealed Judge Greer’s ruling, but their petition did not succeed; on January 24, 2001, the Florida Second District Court of

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“After Pearse’s report was submitted, Michael successfully sought to have him removed as guardian ad litem. During the ensuing years, as her fate was being decided, Terri was not represented by a guardian ad litem until late 2003.”

In Re: The Guardianship of Theresa Marie Schiavo, Incapacitated, no. 90-2908-GD-003, Order, (February 11, 2000), at 4 and 9. At 3 and 5-6, Judge Greer specifically mentioned the testimony of Michael’s brother Scott, his sister-in-law Joan and Father Gerald Murphy to be the most credible and unbiased. See also: C. Christopher Hook, M.D., and Paul S. Mueller, M.D., “The Terri Schiavo Saga: The Making of a Tragedy and Lessons Learned,” http://www.mayoclinicproceedings.com/inside.asp?AID=1054&UID, (Accessed December 4, 2006), at 3. Apparently, Terri remarked to Scott Schiavo at a funeral that she would not want to be kept alive on a machine, and to Joan Schiavo that she would want the tubes taken out if she were ever in a comatose condition.

Ibid., at 6 and 10.
Appeal upheld the ruling and consented to the removal of Terri’s ANH.\textsuperscript{114} Fighting to halt the April 20, 2001 removal of their daughter’s PEG-tube, the Schindler’s filed a series of motions with the Second District Court, the trial court, and the Florida Supreme Court. Although the removal of Terri’s ANH was halted for several days, on April 24, 2001, Judge Greer ordered the removal of her feeding tube and the nursing facility complied.\textsuperscript{115} Two days later, the Schindler family filed an emergency petition with Judge Greer citing new evidence regarding Terri’s treatment preferences and charges of perjury against Michael Schiavo. The new source of information, one of Michael’s former girlfriends, testified that Michael had admitted to her that he actually had no knowledge of Terri’s treatment preferences.\textsuperscript{116} Judge Greer denied the motion, but a hastily filed civil suit was accepted by Judge Frank Quesada who ordered the reestablishment of Terri’s ANH pending the outcome of a trial.

On October 3, 2001, the Second District Court of Appeals delayed the removal of Terri’s ANH indefinitely, and two weeks later they ruled that Terri should be examined by five board-certified physicians to determine whether or not her condition could be improved with therapy. As was examined earlier in this section, the evidentiary hearing began on October 11, 2002 and concluded on October 22, 2002. One month later Judge Greer announced his ruling in favor of Michael Schiavo. Although the judge ordered that Terri’s ANH be removed on January 3, 2003, he delayed the implementation of his ruling in the middle of December to provide time for the appeals process. Just over six months later, in June 2003, the Second District Court of Appeals upheld Judge Greer’s ruling and determined that a hearing should be held to set a new date for the removal of Terri’s ANH.\textsuperscript{117} During this time, the Schindler family employed every means at their

\textsuperscript{114}\textit{In Re: Guardianship of Theresa Marie Schiavo, Incapacitated,} no. 2D00-1269, (January 24, 2001).

\textsuperscript{115}Regarding the process of ANH withdrawal, Dr. Eugene Diamond explained, “[I]n the celebrated court cases in which the court orders discontinuation of ANH the gastrostomy is typically not removed but hydration and nutrition are withheld. The effect of the court order then is thus not to discontinue medical treatment but to forego ordinary care.” In: Eugene F. Diamond, M.D., “Linacre Institute Paper: Assisted Nutrition and Hydration in Persistent Vegetative State,” \textit{Linacre Quarterly}, 71(3), August 2004, 202.

\textsuperscript{116}Rita L. Marker, J.D., “Terri Schiavo and the Catholic Connection,” at 560.

disposal to postpone, or prevent entirely, the establishment of a new date for the withdrawal of Terri’s ANH. They filed petitions to the Second District Court and the Florida Supreme Court, as well as a request of Judge Greer to allow an attempt to determine if Terri could consume food and fluids by mouth. Despite these efforts, however, every appeal to delay or halt the process was denied, and on September 17, 2003, Judge Greer once again ordered the removal of Terri’s food and fluids. Although he recognized the desires of a parent to hold out all hope for the recovery of an irreparably injured child, he felt compelled to base his judgment upon the right of Terri Schiavo to make her own treatment decision, therefore, he ordered the removal of her ANH on October 15, 2003.\textsuperscript{118}

Thus in the middle of October, 2003, the delivery of Terri Schiavo’s food and fluids was stopped for a second time. But for an extraordinary effort by the Florida State legislature and the governor of the State of Florida, it is entirely possible that Terri would have died of dehydration and malnutrition towards the end of that month. Contrary to any rational assessment of possible outcomes, however, the Florida legislature hastily drafted and passed legislation that permitted the governor to halt a patient’s death by dehydration. Although the bill [HB 35-E], was narrow in scope, and effectively applied only to Terri Schiavo,\textsuperscript{119} it was signed by the governor on October 21, 2003 and he immediately ordered her feeding to resume.\textsuperscript{120} While at first the new law appeared to be a major coup for the Schindler family, in reality the new law only delayed the removal of Terri’s ANH by five months. In response, Michael Schiavo and his attorney filed a lawsuit challenging what had come to be known as “Terri’s Law,” declaring it to be unconstitutional. On May 5, 2004, “Terri’s Law” was struck down by the Second District Court of Appeals on the grounds that it violated the

\textsuperscript{118}In Re: The Guardianship of Theresa Marie Schiavo, Incapacitated, no. 90-2908-GD-003, Order (September 17, 2003), 2-3.

\textsuperscript{119}According to the amendment, the governor of the State of Florida could issue a one-time stay to prevent the removal of food and fluids under the following conditions: 1) The patient had no written advance directive; 2) The court found the patient to be in a PVS; 3) The patient’s food and fluids were removed; and 4) A member(s) of the patient’s family challenged the decision to remove his/her food and fluids. In: H.B. 35-E (Chapter 2003-418, Laws of Florida).

\textsuperscript{120}The narrow scope of HB 35-E eventually doomed it to be struck down as unconstitutional because it violated the separation of powers. See: David Gibbs III, Fighting for Dear Life, at 44.
separation of powers of the Florida State constitution.\textsuperscript{121} The Florida Supreme Court unanimously affirmed the appellate ruling four months later, and for all intents and purposes, removed the last significant barrier preventing the removal of the ANH sustaining Terri Schiavo’s life.

By this time in the process, the \textit{Schiavo} case was long past anonymity. Not only was the case becoming known across the country, numerous special interest and religious groups were getting involved as well. Despite the notoriety, however, no attempt to legally prevent the withdrawal of Terri’s food and fluids, or any amount of public display, proved sufficient to obtain what the Schindler family wanted. Throughout the remainder of 2004 and the early months of 2005 the Schindler family, their attorneys, Governor Bush, and even the President of the United States were engaged to some degree in the final efforts to maintain Terri’s life. On February 25, 2005, Judge Greer denied yet another motion to postpone the date on which Terri’s ANH delivery would finally be halted and he ordered the removal of her food and fluids to take place at 1:00 p.m. on March 18, 2005. Without further delays, the delivery of the food and fluids sustaining Terri’s life was suspended on the afternoon of the 18\textsuperscript{th} for the third and final time. Once again a highly unusual and even spectacular legislative action was undertaken, this time by the U.S. Congress, to accomplish the reestablishment of Terri’s ANH. The debate in the House and the Senate, as one might expect, was sharply divided between members who viewed their actions as an attempt to protect the life of an innocent citizen and those who viewed it as an intrusion into the private matters of family life.\textsuperscript{122} Nevertheless, shortly after midnight on March 21, 2005, the House and the Senate both passed legislation which made it possible to move \textit{Schiavo} case from state court to a federal judge in order to retry the case. President George Bush signed the legislation into law at 1:11 a.m. in the morning on

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\textsuperscript{121}In Re: Schiavo v. Bush, no. 03-008212-CI-20, (May 5, 2004), at 2. Circuit Judge W. Douglas Baird cited the Florida State constitution and wrote, ‘‘…No person belonging to one branch shall exercise any powers appertaining to either of the other branches unless expressly provided herein.’ This principle embedded in both the State and Federal constitutions, that the three branches are to be independent and separate of each other exemplifies the concept of separation-of-powers…It is a safeguard designed precisely to prevent the concentration of power in the hands of one branch.’’

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March 21st; and yet, despite being granted the authority to approach a federal judge with their petition, the Schindler family and their attorneys would be thwarted one last time. Judge James Whittemore, a federal district court judge, ultimately refused the petition to overturn Judge Greer’s ruling and retry the case in federal court; thus his order remained in effect. Ten days later, on March 31, 2005, Terri Schiavo died from the withdrawal of the food and fluids that sustained her life; she was 41-years-old.123

Development of Church Teaching Regarding the Care of Patients in the PVS in Light of the *Schiavo* Case

CATHOLIC RESPONSE TO *SCHIAVO*

Since the conclusion of the *Cruzan* case in 1990, the application of Catholic moral principles to the care of seriously debilitated patients steadily progressed from the state of uncertainty and disarray that characterized the Church’s response to the PVS dilemma in the mid to late 1980s, towards a more developed moral teaching that offered firmer guidelines for health care decision making in the event of incompetence. Without question, the health care directives promulgated by the American bishops became significantly more unified after the *Cruzan* case. Seen most clearly in Directive #58 of the 1994 *Ethical and Religious Directives of Catholic Health Care Services*, the Church promulgated a decision making guideline that presumed in favor of providing food and fluids to all patients including those who required ANH.

Despite the greater moral clarity provided by the *ERD* guidelines, however, in their application to the circumstances of seriously brain-injured patients, not all Catholic theologians and health care personnel appeared to be rowing in the same direction. While on the surface the vast majority of Catholic medical and ethical professionals accepted the end-of-life directives contained in the *ERD* and elsewhere, the deeper conflicts that divided Catholic theologians were never adequately resolved and continued to adversely affect the Catholic response to the care of patients in the PVS. Persistent unconsciousness notwithstanding, one group of theologians and hierarchy maintained that such patients were still persons who could benefit from the relatively simple provision of ANH. The other group determined that, because of the irreversible loss of consciousness, personhood had ended and, therefore, the loving thing to do for the patient was to withdraw...

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the undue burden of ANH. While various attempts were made to resolve this dispute, no resolution of the problem was realized. Instead, while the directives of the ERD were quickly adopted as the guiding moral principles for health care decision making, the opposing positions only became more entrenched, until eventually an atmosphere of comfortable ambiguity characterized the decision to provide or withdraw food and fluids from patients with serious brain injuries. Thus in practice, depending upon one’s interpretation of the benefit of continued existence in the PVS, the principles of the ERD were used to provide moral justification for either the provision or withdrawal of ANH to such persons.

In light of the impasse that had almost become the status quo within the Church, the Schiavo case provided the event that would further the development and clarification of the Church’s moral teaching, and ultimately, break the deadlock regarding the level of care owed to patients in the PVS. The questions surrounding the care of Terri Schiavo, and particularly the national stage upon which they were asked, demanded clearer moral direction from the Church than could be obtained within the sphere of comfortable ambiguity that characterized its response to the PVS question. While the Schiavo case was not obliged to completely reignite the PVS debate within Catholic circles as it was within the popular, medical and legal arenas, it did have the effect of overcoming the inertia that had lately permeated the Catholic approach to this most significant moral dilemma.

Two factors surrounding the Schiavo case contributed to its importance and helped to further the debate among Catholic theologians and hierarchy. In the first place, rather than an hypothetical situation, Schiavo provided an immediate, real-world stage upon which opposing moral approaches could be applied to the care of a person whose life or death hung in the balance. In the second place, the national exposure received by the Schiavo case made it apparent that the repercussions from the decision to provide or withdraw ANH from Terri Schiavo would likely not affect only her, but in the future, possibly uncounted numbers of persons suffering from severe brain injury or debilitation. Hence, because the ramifications of the Schiavo case

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potentially included the treatment decisions of numerous other patients, it
should be expected that bishops and theologians across the United States
and around the world would feel compelled to issue a response to the
situation of this solitary American woman from central Florida.

As important as these factors were to the development of Catholic moral
teaching regarding the care of patients in the PVS, however, in and of
themselves they were insufficient to effect any genuine resolution of the
PVS dilemma within the Church. Without further assistance, in all
likelihood they would merely have contributed to another ineffectual
chapter in the long unresolved debate over the decision to provide or
withdraw ANH from patients in the PVS. In the final analysis, while the
Schiavo case helped to set the stage for a possible resolution on this issue,
the true catalyst for change came in the form of the 2004 allocution of Pope
John Paul II on the care of patients in the PVS. Ultimately, it was the
impact of the Holy Father’s address to the physicians, ethicists and medical
professionals at the International Congress that broke through the moral
ambiguity regarding the degree of care owed to patients in the PVS and
provided the solid foundation upon which treatment decisions for such
patients could be based.

In order to adequately address the response of the Church regarding the
care of patients in the PVS, the tasks of this section will be threefold. The
first task will be to examine the response of the American hierarchy as they
once more confronted a highly contentious and public decision to provide or
withdraw ANH from a seriously brain-injured person. Second, a
comparable exploration into the response of Catholic theologians will be
undertaken. This approach will offer the benefit of covering the body of
Catholic arguments regarding the care of patients in the PVS and clearly
presenting the conflicts that existed within the Church on this issue. Third,
and most importantly, a thorough examination of the Holy Father’s 2004
papal allocution on the PVS question will be conducted. The authoritative

November 11, 2006). See also: Florida Bishops: “Florida Bishops Urge Safer Course for
Terri Schiavo,” http://www.flacathconf.org/Publications/Bishops/Statements/Bpst2000/-

127 Pope John Paul II, “To the Participants in the International Congress on ‘Life-Sustaining
Treatments and the Vegetative State: Scientific Advances and Ethical Dilemmas’,”
L’Osservatore Romano, Anno CXLIV(67) Sabato-Domenica, 20-21 Marzo, 2004; ET:
nature of the Holy Father’s statement will provide the appropriate lens through with to assess the theological conclusions reached by the various bishops and theologians who responded to the Schiavo case, as well as providing a firmer response to the level of care owed to patients in the PVS.

**Response of American Bishops**

In the Catholic arena, the response of the bishops concerning the morality of the decision to provide or withdraw ANH to Terri Schiavo was by far the most unified. Drawing upon the fruits of the theological debate and scientific research gained from numerous earlier PVS cases (most notably *Quinlan* and *Cruzan*) the bishops had for more than a decade promoted moral guidelines that they believed adhered most closely to the Catholic moral tradition regarding the care of patients in the PVS. Grounded upon the truths of the natural law and divine revelation that declared the inestimable value of human life and the dignity of the human person created in the image and likeness of God, the bishops saw in Terri Schiavo a seriously injured, but not-dying person who deserved the care and respect due a living human being.

At the most basic level, the Schiavo case was viewed as another instance in which the battle between the culture of life and the culture of death was waged in Western society. The response of the bishops was ultimately calculated to uphold the inherent value of human life, disabilities notwithstanding. While the focus of their statements revolved around the nationally recognized condition of Terri Schiavo, their arguments in favor of life were not intended for her alone; in this regard they cast a vastly larger net. Instead, consistent with Catholic moral teaching that promoted the value of human life from conception to natural death, the bishops’ remarks included all patients who were vulnerable to the increasingly widespread belief that continued existence in a seriously debilitated condition constituted, almost *de facto*, an excessively burdensome existence, and that such individuals were likely better off dead.

The conclusions reached by nearly all the bishops who contributed to the debate over the level of care owed to Terri Schiavo were ultimately based upon a decision making process that applied the ordinary principles and guidelines of the Catholic moral tradition to the medical condition of a specific patient. Their overwhelming consensus to recommend the continued provision of ANH did not invoke any special exemption for Terri
or include any unusual considerations on her behalf. Their conclusions were
grounded on the needs of a seriously injured person, not on a misguided
belief that human life must be preserved at all costs. From the statements
issued by the bishops on behalf of Terri Schiavo, it is possible to ascertain
four common threads that typified the reasoning behind their conclusions.
They were: 1) an assessment of Terri Schiavo’s medical condition, 2) the
presumption in favor of providing ANH to anyone who could benefit from
its use, 3) an assessment of the benefits or burdens of delivering food and
fluids to a person in the PVS, and 4) the proper use of advance directives. A
brief examination of each will follow here.

While the bishops acknowledged the difficulties and uncertainties
inherent in obtaining an accurate diagnosis of Terri Schiavo’s medical
condition (was she in a PVS or some degree of the minimally conscious
state [MCS]) they all, either directly or indirectly, recognized that she could
neither be classified as brain-dead, nor as a dying patient. Based upon
this fact and the constant teaching of the Church regarding the nature of
human personhood, the bishops recognized in Terri a living person and
subsequently defended her right to life. Contrary to secular and theological
arguments that only recognized in Terri’s continued existence the
preservation of mere biological life, the bishops argued that even in the case
of someone as seriously injured as Terri Schiavo, it was the whole person
who remained alive and not simply her physical component. As a result
they insisted that Terri, no less a person because of her injuries, was the
beneficiary of the care provided her and that the decision to provide ANH
was an ordinary means owed to her and not merely a vitalistic attempt to
preserve her physical life at all costs. As indicated by Archbishop Myers,

See also: Archbishop John Myers, “End-of-Life Decisions: Ethical Principles,” at 249, and
Bishop Michael J. Sheridan, “Statement of Bishop Michael J. Sheridan Concerning Terri

129 Numerous arguments, both secular and theological, contended that advocates of
continued ANH provision to patients like Terri Schiavo were acting from a vitalist
mentality that overemphasized the continuation of mere physical existence. In
circumstances embodied by Terri Schiavo and others similarly injured, such an assertion
ultimately carries with the seeds of a dualism that effectively separates the human person
into constitutive parts contrary to Catholic teaching. An excerpt from a document written
by Bishop Elio Sgreccia indicates the Catholic understanding of the nature of human
personhood. He writes: “There cannot be a vegetative vitality that is separate from the
“When facing end-of-life situations, we should never forget that personhood and human life are inextricably bound together...Personhood and human life can never be separated, for they are a unity willed by God.”130 At the bottom line, the bishops rejected any decision to remove the ANH sustaining Terri’s life based on the contention that she had already “departed” or that such measures merely sustained physiological, but not personal life. A decision of this kind was inherently at odds with Catholic teaching and the truth surrounding the nature of human personhood.

In light of this understanding, therefore, decisions regarding the level of care owed to Terri, or anyone similarly injured, became an immediate concern. Thus the Florida bishops remarked:

No longer able to speak on her own behalf, Mrs. Schiavo is a defenseless human being with inherent dignity, deserving of our respect, care and concern. Her plight dramatizes one of the most critical questions we face: To be a truly human society, how should we care for those we may not be able to cure?131

The response of the American bishops to this question was both unified and forceful. As a representative example, Bishop Robert Vasa of Baker, Oregon stated emphatically that, “Terri is alive. She is kept alive by the same things that keep me alive – Food, water, air. Her disability deprives her of the ability to ingest these things, it does not deprive her of the ability unique and vital principle exercised by the only soul that exists in man, the intellectual or spiritual soul that makes the body living. Only the loss of the vital unity of the organism can be taken as the sign of death.” Elio Sgreccia, “The Subject in Vegetative State: For a Personalistic View,” In: Life-Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas (L’ Arco Di Giano, Insituto per l’Analisi dello Stato Sociale, Roma, Italia, 2004) at 100.


to digest them.” In the hypothetical event that Terri’s physical condition had deteriorated to the point in which her body could no longer assimilate the nutrients provided her, or when the end of her life was imminently approaching, a decision to cease the ineffectual delivery of food and fluids would be understood by all reasonable people as a caring and morally justifiable response. A decision to cease the useless provision of ANH under such circumstances would be widely acknowledged as a proper recognition of the finitude of human life and a matter of trust in the plan of divine providence for that person. By contrast, however, the decision to withdraw ANH from a non-dying person like Terri Schiavo was perceived by most bishops to be a nearly incomprehensible course of action and one that could only be aimed at ending a life judged to be devoid of value. It was, therefore, with disbelief and outrage that the bishops regarded the decision to withdraw the ANH sustaining Terri’s life. One bishop who lamented the eventual outcome of the Schiavo case stated that, “Terri was alive. She was not dying. Yet the courts decreed that Terri’s basic nourishment should cease. The feeding tube was removed. Her life was not ebbing away under a terminal illness. Yet the courts sanctioned starving her to death. There is no moral justification for such an action.”

Closely related to each other, the second and third elements common to all the bishops were their conclusions regarding the obligatory or optional nature of providing ANH to patients in the PVS. Commensurate with the fundamental teaching of the Catholic moral tradition related to the preservation of human life, the bishops based their recommendation for the level of care owed to Terri Schiavo on the dignity of the human person, the value of human life, and the principles of the ordinary and extraordinary means of conserving life. Rooted in divine revelation and the natural law, the bishops upheld the tenet that each person receives the gift of life from God, in whose image he is made, and that he always bears the responsibility to sustain it using the ordinary means available to him. Generally,

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ordinary or proportionate means “describes those medical remedies and procedures that in the judgment of the patient and competent medical authority, in light of the Christian understanding of the dignity of human persons offer a reasonable hope of benefit.”

In terms of the specific circumstances surrounding Terri Schiavo’s medical condition, all of the bishops affirmed the good of her life and insisted that a presumption in favor of providing ANH existed for her if the benefits of its delivery outweighed the burdens. While a few bishops were more circumspect in the practical application of the benefit/burden calculus with respect to the condition of Terri Schiavo, the majority offered, to greater or lesser extents, more substantial direction. For most bishops, the guidelines of the ordinary and extraordinary means of conserving life provided a useful measure with which to gauge the effectiveness of the care necessary to sustain her life. For example, Archbishop Charles Chaput commented that, “[r]emoving food and water from a patient can only be justified if the person is terminal, and natural death is imminent. For disabled persons not in imminent danger of death and able to breathe on their own, starvation and dehydration to provoke death amount, in effect, to

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a form of murder.”

Similarly, referring directly to the circumstances experienced by Terri Schiavo, Bishop Vasa stated:

“The Catholic Church teaches that hydration and nutrition are simply water and food. These must always be provided as long as the food and water or the method of delivery is not unduly burdensome to the PATIENT. There does not appear to be any indication that the provision or the method of provision of food and water is burdensome to her.”

Based upon the bishops’ statements regarding the obligatory or optional nature of the ANH sustaining Terri Schiavo’s life and the tone with which their comments were delivered, there was no doubt that they were willing to entertain the possibility that, relative to her physical condition, the provision of ANH constituted an excessive burden that could be justifiably withdrawn. Further, there was no statement in which any bishop indicated or even hinted that everything should be done to maintain her life. Rather, it was because of the determination that her death was not imminent, and the provision of food and fluids was an effective measure which did not cause her harm, that the claim of excessive burden failed to convince. In Terri’s case, the value of her life, combined with the simple means needed to sustain her, ultimately led the bishops to conclude that the provision of ANH was an ordinary, and thus obligatory, means of conserving life. Conversely, the conclusion of one contributor aptly illustrated the bishops’ skepticism where the demand for ANH removal was concerned: “But food and hydration given to a person disabled for years is hardly the case of extraordinary means and imminent death. It is the normal care expected for a sick or disabled person. Denying food and water to anyone is simply cruel.”

Ultimately, because Terri was considered to be a severely injured, but living patient, the bishops were on guard against arguments or

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137 Archbishop Charles F. Chaput, O.F.M. Cap., “Statement by Archbishop Chaput on Terri Schiavo.”
movements calculated to hasten her death based upon a perceived disvalue of life in the PVS.

The fourth element common to several of the bishops’ statements concerning the Schiavo case involved the subject of advance directives, particularly the manner in which they could and could not be used to assist in the process of medical decision making. The issue of advance directives occupied a significant place in the events surrounding Terri Schiavo’s life and death particularly because the absence of written directives upon which to guide medical decision making according to her wishes led to the grounding of her treatment largely on the basis of hearsay evidence. Many bishops (especially the Florida bishops), acknowledged and sympathized with the difficulties faced by those directly involved in her care. Since an occurrence of this nature was not an uncommon event in the practice of American medicine, the bishops subsequently recommended that all adults take the time to complete an advance directive that would indicate their treatment preferences in the event that some future incompetence made it impossible to do so.\textsuperscript{140} At the same time, however, the simple exhortation to formulate advance directives was not, in the bishops’ estimation, a sufficiently specific request. In nearly all the statements in which the bishops addressed the benefits of advance directives, there was also an accompanying caution with regards to their use. Seen most clearly in their desire to ensure that the moral parameters and limits of such documents be properly understood by those who would complete them, the bishops attempted to put the brakes on the common misconception that a person’s treatment preferences were nearly limitless. At the bottom line, depending upon the circumstances of each individual patient and the treatment in question, not all preferences or instructions could be considered consistent with the tenets of the Catholic moral tradition.\textsuperscript{141} The bishops were,


\textsuperscript{141}See: William E. May, et al., “Feeding and Hydrating the Permanently Unconscious and Other Vulnerable Persons,” \textit{Issues in Law and Medicine}, 3(3), 1987, 205. Professor May and his colleagues commented: “While competent persons have the moral and legal right to refuse any useless or excessively burdensome treatment, they must exercise great care in reaching the judgment that a treatment is useless or excessively burdensome…Too often,
therefore, careful to provide the guidance necessary for the proper moral formulation of advance directives.

Within the realm of Catholic health care, morally justifiable treatment decisions, whether those made by a competent patient in consultation with his physician, family, etc… or those carried out through the guidance of an advance directive, have always been predicated upon their adherence to Catholic moral teaching.\textsuperscript{142} Foremost among the guiding principles upheld by the Catholic Church to assist in the decision making process has been the ordinary and extraordinary means of conserving life distinction. In terms of their practical application to the situation of an individual patient, the Church has relied upon the judgment of the patient or his surrogate decision maker, in conformity with Catholic teaching, to assess the morally optional or obligatory nature of a specific treatment recommended to him. Thus in Directive # 32 of the ERD the USCCB stated:

While every person is obliged to use ordinary means to preserve his or her health, no person should be obliged to submit to a health care procedure that the person has judged, with a free and informed conscience, not to provide a reasonable hope of benefit without imposing excessive risks and burdens on the patient or excessive expense to family or community.\textsuperscript{143}

From the perspective of the Catholic Church, it was commensurate with the dignity of the human person and the respect owed to him that, informed by the teaching of the Church and in the light of his own conscience, he have the right to direct the course of his own treatment. This, the Church acknowledged, was most consistent with the exercise of true human freedom.\textsuperscript{144} Unfortunately, in the modern day, a person’s right to determine the course of his own treatment has often been considered separately from the guidance of Catholic moral teaching. Instead of being subject to the
parameters of that teaching, the moral or immoral nature of an individual patient’s treatment decision has been arrogated to the dictates of the individual will alone. In this instance, the justifiability of a particular treatment choice, namely its moral character, is related entirely to the wish or desire of the patient without sufficient reference to the moral parameters embodied in the ordinary and extraordinary means of conserving life. Thus by the simple act of overextending the authority of one’s personal will and overlooking the parameters of Catholic moral teaching, what began as a manifestation of human dignity ended up crossing a very important moral line.

In terms of the response of the bishops to the formulation of advance directives, it was precisely the major separation of individual preference from the guidance of the Catholic moral tradition they wanted to highlight and correct. This should not be surprising. In much of the popular (and even professional) literature concerning the Schiavo case, the only substantial basis for the decision to remove the ANH sustaining Terri’s life appeared to be the exercise of the right she possessed to direct her treatment decisions (the supposed “fact” that she would have wanted it so), relevant moral considerations notwithstanding. For many people, the mere thought of

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145 Directive 28 and 59 of the ERD set the necessary moral parameters to guide a patient’s treatment decisions. Directive #28 states: “Each person or the person’s surrogate should have access to medical and moral information and counseling so as to be able to form his or her conscience. The free and informed health care decision of the person or the person’s surrogate is to be followed so long as it does not contradict Catholic principles.” Likewise, Directive # 59 instructs: “The free and informed judgment made by a competent adult concerning the use or withdrawal of life-sustaining procedures should always be respected and normally complied with, unless it is contrary to Catholic moral teaching.”

146 It is even possible to observe the importance of personal will over the parameters of the Catholic moral tradition in the publications of Catholic moral theologians. For example, Brother Daniel P. Sulmasy, O.F.M., commented that: “In fact, if a person motivated by a charitable desire to relieve others of the burdens such care might impose, executes an advance directive that states that he or she would not want artificial hydration and nutrition if ever in a state of post-coma unresponsiveness, then even the most conservative of Catholic moralists would conclude that the treatment should not be given.” In: Daniel P. Sulmasy, O.F.M., M.D., Ph.D., “Are Feeding Tubes Morally Obligatory?” St. Anthony Messenger, 113(8), January 2006, 32.

life marked by the PVS or some similar disability induced in them an almost automatic reaction against continued existence in such a state. Consequently, for those contemplating an advance directive, the provision of ANH in the event of a persistent unconsciousness was regarded with skepticism, fear, and confusion.

Aware of the difficulties inherent in properly formulating an advance directive, particularly as they concerned the PVS, the bishops interjected with the firm, but reassuring, teaching of the Church. At the heart of the bishops’ cautionary statements in this regard, there was on the one hand, a proper acknowledgement of the advantages and usefulness that advance directives provided to patients, families, and health care professionals struggling with treatment decisions. On the other hand, however, the bishops could not ignore the teaching of the Church which held that such documents could not morally contain instructions contrary to life. Although they recognized the importance of an person’s right to guide, either on his own or through the formulation of an advance directive, the course of his own treatment, the bishops’ taught that the moral assessment of a specific medical decision did not rest solely upon the dictates of the patient’s wishes. In the midst of the debate over Terri Schiavo’s fate, the fierce rhetoric from both sides that invoked her wishes often obscured this point. Because the fruit of a person’s autonomous decision making capacity does not constitute an absolute authority, a morally justifiable advance directive must conform to the principles and guidelines of Catholic moral teaching. The bishops, in agreement with regards to the limits of that authority, commented:

> It is also important to note that such health care surrogates and medical directions can never “trump” or override appropriate

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moral considerations. In this regard, Catholic teaching notes that the proxy may not deliberately cause a patient’s death or refuse ordinary and normal treatment, even if he or she believes a patient would have made such a decision.\textsuperscript{149}

In the final analysis, the events surrounding Terri Schiavo’s life and death, similar to those surrounding Karen Quinlan and Nancy Cruzan, once again raised people’s awareness to the difficulties inherent in the medical decision making process in certain circumstances. The contribution made by the bishops’ statements on this subject provided a clear example of the benefits and limits of advance directives. At the bottom line, the bishops helped to return the question of health care decision making away from a mere exercise in unbridled personal autonomy towards one that properly placed a person’s right to direct his treatment choices within the parameters of Catholic moral teaching. At the very least, the bishops’ statements regarding advance directives made some impact upon the belief that an individual’s autonomy was the supreme arbiter in the realm of medical decision making.

Response of Catholic Theologians

When compared to the generally concordant response of the U.S. Catholic bishops to the events surrounding Terri Schiavo’s life and death, the reaction of American Catholic theologians was, by contrast, widely divergent. Within the realm of theological discussion, it is ordinarily the case that dissimilar positions and conclusions constitute a routine and often expected aspect of theological conversation. In this instance, however, the intensity of the debate over the decision to provide or withdraw ANH from Terri Schiavo was such that it appeared to overwhelm the normally respectful bounds of theological discourse. In some cases, civilized debate devolved into ideological attacks, thinly veiled hostility, and open contempt of opposing viewpoints. Whether the discord among Catholic theologians was caused by the exasperation that some felt at the renewal of an issue that they considered to be well-concluded,\textsuperscript{150} the high-stakes nature of the

\textsuperscript{149}Florida Bishops, “Florida Bishops on Terri Schiavo,” at 1.

The polarization of the theological response to the case was glaringly evident. Since Catholic moral theologians have based their arguments and conclusions regarding the level of care owed to patients in the PVS on the same foundational principles of life, an outside observer might wonder why this particular issue had become so contentious. In the first place, as has been true of the Catholic response to the PVS question throughout its thirty-plus year history, the areas of greatest disagreement among theologians did not primarily revolve around fundamental principles of the Catholic moral tradition. Even a cursory reading of the opinions published by Catholic moral theologians demonstrates that every serious contributor to the debate appealed in some fashion to the fundamental principles of life promulgated by the Catholic Church. Fundamental moral principles such as the inherent dignity of the human person, man’s creation in the image and likeness of God, the worth of human life, and even the general demands and directives of the ordinary and extraordinary means of conserving life were all employed to support decisions to provide or withdraw ANH from patients in the PVS.

Rather than engaging in a head-on collision of contradictory principles, the greatest areas of disagreement among Catholic theologians were based, not upon the principles themselves, but upon each theologian’s interpretation and application of principles they all held in common. In theory, all Catholic theologians assented to the general parameters of the ordinary and extraordinary means of conserving life. In practice, however, the interpretation of those principles and their application to the condition of a persistently unconscious patient were something else entirely. When considering the specific condition of patients in the PVS, some theologians interpreted the ordinary/extraordinary guidelines to mean that the provision of ANH could likely offer a “reasonable benefit.” Others, employing the same moral guidelines, unequivocally declared ANH delivery to be an “excessively burdensome” medical treatment for patients in the PVS.

Similarly, despite the fact that nearly all Catholic theologians recognized the dignity possessed by each human person (even one in a PVS) some concluded that ANH did not constitute an ordinary means of conserving life for a patient in the PVS because he did not possess the cognitive-affective

ability necessary to enable him to connect with God and his fellow man.¹⁵¹ Conversely, others argued that, despite the level of brain injury, patients in the PVS continued to be living human beings who could benefit from the administration of basic nursing care including life-sustaining and non-burdensome food and fluids.¹⁵² In order to provide more detail regarding the specific response of Catholic moral theologians to the life and death of Terri Schiavo, a brief examination of statements by William E. May, Edward J. Furton, Rev. Kevin O’Rourke, O.P. and Rev. John J. Paris, S.J. will follow here.

Professor William E. May, an extensive contributor to the moral debate regarding the care of patients in the PVS,¹⁵³ analyzed the events surrounding Terri Schiavo’s life and death and arrived at conclusions consistent with the earlier determinations he had made concerning the level of care owed to such patients. According to Professor May and other like-minded theologians, patients in the PVS are nothing more or less than living human beings. As such, the provision of ANH to sustain the life of such individuals constitutes a moral obligation insofar as it offers a reasonable benefit to the patient and is not excessively burdensome to him.¹⁵⁴ While his position has often been misconstrued by some theologians as a misguided and ultimately vitalistic worship of bodily life, May’s primary consideration in this regard was not, as critics have charged, to mandate the provision of ANH so long as it sustained mere physiologic life.¹⁵⁵ Rather, he correctly

interpreted the Catholic moral tradition regarding the fundamental nature of the human person which, stated succinctly, teaches: “Though made of body and soul, man is one.” From his perspective, as well as that of the Church, it is a false argument to insinuate the separation of a person’s biological life from his personal life where no such division exists. Consequently, employing ANH to maintain the life of a patient in the PVS maintains the life, not merely of person’s physiological existence, but of the entire person. In the specific case of Terri Schiavo, William May based his recommendation to continue the delivery of food and fluids on the fact that she was neither imminently dying nor in the process of dying. He remarked:

“Terri is simply a fellow human person unable to feed herself—much like a newborn baby. She has suffered severe trauma to her brain, but she is in a stable condition and there is no imminent danger of death so long as she receives the nourishment and hydration that all living human persons need if they are to continue living.”

While it was entirely possible that the provision of ANH could, for one plausible reason or another, have risen to the level of an excessive burden, given the conditions reported in Terri Schiavo’s case, and the fact that her life had been maintained with relative ease for fifteen years, a credible

156 Vatican Council II: Pastoral Constitution on the Church in the Modern World, Gaudium et Spes, December 7, 1965, AAS 58 (1966); ET (Pauline Books and Media, Boston, MA, 1966), 14 § 1. William E. May and his colleagues adhere to this teaching of the Church in the presuppositions and principles they use to discuss the level of care owed to all human beings, even those in the PVS. They stated: “Human bodily life is a great good. Such life is personal, not subpersonal. It is a good of the person, not merely for the person. Such life is inherently good, not merely instrumental to other goods.” See: William E. May, et al., “Feeding and Hydrating the Permanently Unconscious and Other Vulnerable Persons,” at 204.

157 Regarding the inseparable unity of body and soul, even in a patient in the PVS, Bishop Elio Sgreccia commented: “To come to our question and our case, if we adopt this unitary anthropology the body in a persistent vegetative state, which has vitality at the level of an organism, albeit of a merely vegetative nature, is united to the rational soul, the only soul that makes the body living. In: Elio Sgreccia, “The Subject in Vegetative State: For a Personalistic View,” In: Life-Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas, at 100. William E. May also commented: “Life, for a living person, is that person’s very being.” In: William E. May, “The Florida Supreme Court and ‘Terri’s Law’,” at 2.

argument of the burdensomeness of ANH delivery was difficult to substantiate. In the final analysis, Professor May contended that the deliberate withdrawal of the ANH sustaining her life was tantamount to euthanasia by omission. He concluded that, “[d]eliberately to deprive her of the food and hydration needed to prevent her death by dehydration and starvation would be to kill an innocent person because other people…think that she would be better off dead than alive.”

Arguing from a position similar to William E. May, Dr. Edward J. Furton also concluded that Terri Schiavo should be provided with the ANH necessary to sustain her life. According to Furton, Terri Schiavo was not a dying patient, nor during the years in which her life was sustained through the provision of ANH, did she appear to suffer pain. Although the injury to her brain caused serious mental impairment, she remained, in most other respects, a healthy person. She could breathe on her own, the various processes of her body (e.g., digestion, kidney activity, etc…) continued to perform their functions, and she did not suffer from pain, infection, or difficulties associated with aspiration.

While Furton cited several situations in which the provision of food and fluids by gastrostomy could be legitimately withdrawn because of some undue burden, none corresponded to the circumstances experienced by Terri Schiavo. Instead, he contended that Terri, who was living comfortably in her bed and regularly surrounded by friends and family, should not have had her food

159Ibid., at 1-2.


161Ibid., at 248-249. Dr. Furton cited several examples in which ANH could be legitimately removed from a patient: 1) when food and fluids were not assimilated by the patient’s body; 2) when the placement of the tube causes repeated infections; 3) when patients, agitated by the sight of the tube repeatedly pulled out the tube; 4) during end-stage dementia because the placement of a feeding tube does not produce an appreciable survival rate; and finally 5) when patients experience significant complications, e.g., repeated aspiration and a consequent need for repeated suctioning of the throat.

162Msgr. Kevin T. McMahon, rebutting on the famous “300-bed” scenario of the late Rev. Richard A. McCormick, remarked that such a response was commensurate with the heart of Christian love. He stated: “Now, looking at the same scenario, I can imagine observers making quite a different remark: ‘Look how these Christians love one another. This is an extraordinary testimony to the faithfulness and selflessness of Christian love; it is truly edifying to see that Christian love can be so genuine and disinterested that such care continues to be given even when those who receive it can show no appreciation. Even
and fluids removed simply because her condition offered scant hope for improvement.

Furton further believed that many of the arguments used to support the removal of the ANH sustaining Terri Schiavo’s life were faulty because they were grounded either upon an incorrect understanding of, or an unsubstantiated speculation regarding, her physical condition. In the case of the former error, Furton expressed incredulity with regards to the contention that Terri Schiavo absolutely did not suffer from the withdrawal of food and fluids because she was already in the dying process (in such a state patients naturally lose a desire for food and fluids). The common refusal of imminently dying patients to accept unwanted and non-beneficial nourishment at the end of life notwithstanding, Furton could not see how such an argument applied to Terri Schiavo since she was not close to death, nor in the dying process. He stated, “[s]he began to die only after her food and water had been taken away. The point had no application whatsoever to her case. How telling that it was so often repeated.”163 Regarding the latter error, namely, the unsubstantiated speculation regarding Terri Schiavo’s physical condition, Furton challenged the assertion that her lack of awareness guaranteed that she was unable to experience the pain and suffering associated with dehydration and starvation. He remarked:

“[b]ut honestly, how can we prove that someone is unaware? The question requires us to go beyond all empirical modes of inquiry and into the realms of philosophy. No scientific instrument has ever recorded the existence of consciousness. We can only detect the external signs of that inner awareness, and not all of these may be evident to scientific instrumentation.”164

In the end, however, based upon the unproved conviction that Terri Schiavo could not experience pain and suffering, coupled with the inability or unwillingness of Terri’s decision makers to see in her an injured, but very much alive person who needed and deserved the care and support due a human being, the ANH sustaining her life was removed which led directly

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164 Ibid.
to her death. Furton considered this decision to be a blatant and public act of euthanasia by omission.\footnote{Ibid., at 250-251. See also: Edward J. Furton, Ph.D., “To the Editor,” Hastings Center Report, 35(3), (2005), 5.}

On the other side of the Catholic spectrum, the Rev. John J. Paris, S.J., a leading contributor to the PVS debate, and a vocal proponent of the decision to withdraw ANH from patients in the PVS, strongly supported Michael Schiavo’s request to remove the ANH sustaining his wife Terri’s life.\footnote{Father Paris was one of 55 ethicists who signed an \textit{amicus curiae} brief that supported Michael Schiavo’s legal petition to remove the ANH sustaining his wife’s life. See: In the Supreme Court of Florida: Jeb Bush v. Michael Schiavo, “\textit{Amicus Curiae} Brief in Support of Michael Schiavo as Guardian of the Person of Theresa Marie Schiavo,” SC04-925, July 27, 2004, vii.}

According to Paris, the provision of ANH to a patient in the PVS constituted an extraordinary means of conserving life that, consistent with the 400-year-old Catholic tradition, patients were not obliged to accept.\footnote{See: John J. Paris, S.J., “To Feed or Not to Feed: Terri Schiavo and the Use of Artificial Nutrition and Fluids, Southern Medical Journal, 98(8), August 2005, 757. See also: Andrew Leonard, “This Has Nothing to Do with the Sanctity of Life,” Salon.com, March 22, 2005, http://dir.salon.com/story/news/feature/2005/03/22/father_john/index.html, (Accessed: February 24, 2007), 3.}

In the case of Terri Schiavo, a woman unconscious for more than fifteen years and in his opinion completely unable to engage in vital relationships with loved ones and God, Paris contended that the benefits of continued existence were clearly outweighed by the burdens.\footnote{Brian Braiker, “A Jesuit Bioethicist on Schiavo’s Right to Die,” Newsweek, (March 27, 2005), http://www.msnbc.msn.com/id/7276850/site/newsweek/print/1/displaymode/1098/, (Accessed, February 24, 2007), 2. See also: Patrick J. Reilly, “Teaching Euthanasia,” Crisis, 23(6), June 14, 2005, 31. The author stated: “In March, Father Paris admitted that Schiavo ‘is quite alive,’ but still, ‘she has no obligation to medical interventions if they prove disproportionately burdensome’.”}

So strongly did he adhere to this belief that some of his comments on the matter crossed over the accepted bounds of scholarly criticism and into the realm of stereotyped attacks directed against the group he thought
responsible for the Schiavo controversy, specifically, the Christian right.

Ultimately, in light of medical, legal, and ethical precedent, Paris considered the entire Schiavo extravaganza to be bizarre. In his estimation, every authority since the 1990 Cruzan case, e.g., law, medicine, and ethics clearly determined that a request to remove ANH from a patient in the PVS was the correct decision to make and only the agenda of radical special interest groups prevented it.

Within Catholic circles arguably the most well-known and articulate advocate in favor of removing ANH from patients in the PVS is the Rev. Kevin D. O’Rourke, O.P. For O’Rourke, the crucial question that needed to be considered in any situation involving a patient in the PVS was whether the proposed action offered a proportional benefit to the patient or whether it imposed an excessive burden on him. When considering patients in the PVS, O’Rourke has contended that because such a person no longer possessed the cognitive-affective potential necessary to pursue the spiritual goals of life, the delivery of ANH was an ineffective treatment and thus morally optional.

Several statements made by Father Paris indicate the nature of his attacks against opposing viewpoints: In one article, he remarked: “First of all, this is not a fight about a feeding tube in a woman in Florida. This is a fight about the political power of the Christian right,” in: Brian Braiker, “A Jesuit Bioethicist on Schiavo’s Right to Die,” at 2. In another place, Paris commented, “Of course the family has the radical, antiabortion, right-to-life Christian right, with its apparently unlimited resources and political muscle behind them,” in: Andrew Leonard, “This Has Nothing to Do with the Sanctity of Life,” at 2.

Andrew Leonard, “This Has Nothing to Do with the Sanctity of Life,” at 2. He remarked, “[E]very relevant legal issue has already been decided; the only thing keeping the case alive is the fact that the Christian right has made Schiavo a cause célèbre.” See also: John J. Paris, “To Feed or Not to Feed,” at 757-758.


Judith Graham, “Schiavo Case Puts Priest on Hot Seat,” 3. The author remarked: “For O’Rourke, the value of life lies in an individual’s ability to connect with God and his fellow man, and ‘if you’re not able to love, think, plan, relate, or consciously direct activity toward God, then just maintaining a physical existence is not beneficial’.” See also: Kevin D. O’Rourke, O.P., J.C.D., S.T.M., “Should Nutrition and Hydration Be Provided to
There is one clinical condition however, which is incompatible with human acts. People in a medically diagnosed persistent vegetative state (PVS) suffer from a dysfunctional cerebral cortex and thus are unable to perform the bodily acts which dispose for acts of the intellect and will, that is, acts of cognitive affective function...While they are still persons, they do not benefit from life support.\textsuperscript{174}

Concerning the specific circumstances experienced by Terri Schiavo, O’Rourke simply could not acknowledge that the ANH sustaining her life offered any tangible benefit to her; as a result he had only harsh words for those whom he believed were needlessly prolonging her life. He remarked, “[f]or Christians, it is blasphemy to keep people alive as if you were doing them a favor, to keep people alive in that condition as if it benefits them. It doesn’t benefit them.”\textsuperscript{175}

In the final analysis, (and as we will see in greater detail in the final section of this chapter) Catholic theologians like Fathers Paris and O’Rourke have based their recommendations regarding the level of care owed to PVS patients on that part of the Catholic moral tradition which holds that an individual possesses the right to refuse any treatment that he believes to offer too little benefit or is perceived to be excessively burdensome.\textsuperscript{176} In most cases their interpretation of the Catholic moral tradition, which places legitimate control of health care decision making in the hands of individual patients, poses no problems. Such an interpretation correctly recognizes the dignity of the human person and allows that dignity to be properly exercised through the specific act of choosing treatment options. No Catholic theologian would deny to patients the right to direct their health care or the legitimate application of the benefit/burden calculus to their specific medical condition. On the other hand, the legitimate right of a patient to direct his own health care does not constitute an absolute right without boundaries. There are hard limits that patients or their surrogate


\textsuperscript{175} Jim DeFede, “Priest Disputes Governor’s Role In Schiavo Case,” \textit{Miami Herald}, (October 30, 2003), \url{http://www.cogforlife.org/orourkearticle.htm}, (Accessed: February 24, 2007), 1.

\textsuperscript{176} Judith Graham, “Schiavo Case Puts Priest on Hot Seat,” 2.
decision makers may not morally cross. Those Catholic theologians who consider the provision of ANH to a patient in the PVS to be an excessively burdensome, and thus morally optional, means of conserving life appear to be playing fast and loose with those limits. While a person’s treatment desires must be a serious consideration in health care decision making, they are not, as clearly stated in Directive 28 of the ERD, the only consideration. Thus when O’Rourke contends that “[o]ur tradition has always held that it’s the people who have the right to make decisions for themselves when their lives are coming to an end, based on their personal circumstances, not the church,” he seems to appeal to that part of the Catholic moral tradition that coincides with his argument while ignoring the part that imposes necessary moral boundaries. In this manner, while also relying upon emotional appeals and recourse to the “legality” of the decision to withdraw ANH from patients in the PVS, O’Rourke, Paris, and others, come very close to absolutizing an individual’s will in the decision making process at the end-of-life. This dynamic and others will be examined further in the final section of this chapter which specifically addresses the direction provided by Pope John Paul II in his 2004 statement on the care of patients in the PVS.

Meaning and Impact of the 2004 Papal Allocution on the PVS

In conjunction with the events surrounding Terri Schiavo’s life and death, the promulgation of Pope John Paul II’s 2004 allocution on the condition and care of patients in the PVS was the single most significant event to impact the Catholic debate regarding PVS question since the 1990 U.S. Supreme Court decision in Cruzan v. Director, Missouri Department of Health. The 2004 allocution was not the first papal statement to address the moral parameters involved in the care of seriously debilitated patients; however, it was first papal document to specifically address the PVS

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177 Ibid., at 3.
178 Both O’Rourke and Paris ask emotionally charged rhetorical questions to elicit the response they are seeking, e.g., “[W]ould you tell your loved ones to continue keeping you alive in this fashion?” or “would you want to be put on a feeding tube knowing that you can be sustained in this existence?” In: Jim De Fede, “Priest Disputes Governor’s Role in Schiavo Case,” at 1; and Andrew Leonard, “This Has Nothing to Do with the Sanctity of Life,” at 3.
condition by name and to directly refer to the level of care owed to such patients;\textsuperscript{179} as a result, the allocation represents a major development in the Catholic response to the PVS question. Conversely, despite the authoritative voice of Pope John Paul II, and its importance to the PVS debate, the allocation encountered serious opposition from the outset. So strong was the reaction from Catholic theologians (both positive and negative), that only at the most superficial level could a common characterization of the document be achieved. As far as any substantive aspect of the document was concerned no common ground could be found. Although some Catholic theologians pointed to the 2004 allocation as an authoritative voice that should have helped to settle the PVS debate,\textsuperscript{180} others consistently sought to diminish its significance.\textsuperscript{181} Thus, considering the few areas in which Catholic theologians agreed about the 2004 papal allocation, it could only be characterized in the broadest of terms, namely as: 1) a catalyst for renewed debate concerning the PVS question (even in the midst of the Schiavo phenomenon), 2) a source of great division among Catholic theologians, and 3) a complete surprise to public and professional alike. Each of these points will be examined briefly.

\textsuperscript{179} In a 1998 address to the bishops of California, Nevada, and Hawaii on the dignity of human life, Pope John Paul II cited the 1992 NCCB Pro-Life Committee document \textit{Nutrition and Hydration: Moral and Pastoral Considerations} and commented upon the presumption in favor of providing ANH to all patients who need it. While the Holy Father did not specifically mention the PVS condition in his statement, his message did open a window into the direction of the John Paul II’s thought regarding the level of care owed to the most vulnerable members of society. See: Pope John Paul II, “America: Be Hospitable to Life,” \textit{The Pope Speaks}, 44(2), October 2, 1998, 115-119.


\textsuperscript{181} As we shall see, in an effort to deny, dismiss or discredit the conclusions reached by Pope John Paul II in the 2004 papal allocation certain Catholic theologians have pursued different routes to shunt the document to the background. Some Catholic theologians have questioned the moral weight of the allocation and have, thereby, effectively underemphasized its importance to the decision making process. Others have delayed the application of the direction provided by the 2004 allocation by stressing the supposed ambiguity of the address and calling for greater clarification from the U.S. Bishops, the Congregation for the Doctrine of the Faith, or the Holy Father himself. Still others have completely dismissed the 2004 allocation as a message tailored for a fringe radical-right Christian group which could and should be ignored by the majority of Catholics.
First, based upon the great volume of articles and letters written by Catholic theologians who reacted to it, there is no doubt that the 2004 papal allocution added fuel to the general PVS debate, and specifically to the circumstances surrounding Terri Schiavo. Second, reaction aside, the document did little or nothing to repair the increasingly sharp divide that separated Catholic theologians on the subject of food and fluid provision to patients in the PVS. Despite the attempt to provide moral clarification and guidance to the care and condition of patients in the PVS, the document served only to intensify and exacerbate the rift that divided Catholic theologians. Depending upon their individual analyses, the 2004 allocution was either praised as an authoritative (but not definitive), contribution to Catholic teaching regarding the level of care owed to patients in the PVS or it was vilified as a frightening and irresponsible departure from the Catholic moral tradition that could have serious negative consequences down the road, including a greater recourse to euthanasia.

Based upon the difficult and often confusing history of the PVS debate among Catholic theologians, the likelihood that the 2004 allocution would widen the gulf that separated Catholic theologians on this issue should have been anticipated from the outset. It might have been hoped that the 2004 papal allocution would begin to heal this breach; however, such a hope would have had little basis for actualization. Such an outcome was not simply a possibility; it was probable. In practical terms, one of the major effects of the document was not the achievement of an acceptable closure to the PVS question, but a further entrenchment of opposing sides. And while at first glance, this outcome might appear to be detrimental to the Church and the medical decision making process, such an assessment would not be entirely accurate. At the very least the 2004 allocution broke through the torpidity that characterized the PVS debate at the turn of the millennium and forced Catholic theologians to reexamine their application of moral principles to the condition of patients in the PVS.

The third aspect of the Holy Father’s allocution commonly cited by Catholic theologians was that its promulgation was completely

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unexpected.\textsuperscript{183} Depending upon one’s perspective, however, the astonishment experienced as a result of the 2004 allocution was either pleasant or most disagreeable. On the one hand, some Catholic theologians were quite edified by the Holy Father’s statement which they considered to be a strong affirmation of the level of care owed to patients in the PVS. Conversely, other theologians were seriously disturbed by the allocution. More than the fact that they did not expect the Holy Father’s contribution to the PVS question, their distress was primarily based on the document’s content and recommendations which were not consistent with their own interpretation of the Catholic moral tradition. Stated differently, it was not the papal allocution itself, but the moral direction of the statement that caught theologians and health care administrators completely off-guard, many quite unpleasantly. Judging from the intensity of the negative reaction and outrage, it was as if they felt completely blind-sided by the Holy Father’s recommendations. Soon after its promulgation, articles and statements began to appear in both Catholic and secular publications which questioned the moral weight of the allocution, as well as its theological and medical accuracy. Closely associated with these charges was the assertion certain aspects of the allocution departed from the Church’s 400-year history regarding the ordinary and extraordinary means of conserving life principle. Ultimately the doubt that was sown served to muddy the waters as to the “true” meaning of the allocution and to delay its integration into the medical decision making process for patients in the PVS.\textsuperscript{184}

The vocal antagonism towards the allocution was most puzzling for one simple reason: though more directive and concrete than earlier hierarchical statements, Holy Father’s statement was not substantially different from them. The conclusion that food and fluids constituted a minimal measure

\textsuperscript{183}Many statements, like the following one written by Nancy Guilfoy Valko, R.N., remarked upon the unexpected nature of the papal allocution. She began her article with the words: “In March 2004, Pope John Paul II shook the bioethics world…” In: Nancy Guilfoy Valko, R.N., “A Study in Contrasts: The Deaths of Pope John Paul II and Terri Schiavo,” \textit{Voices Online Edition}, XX(2), (Michaelmas 2005), 1.

that should be provided to all patients who could receive it without undue burden appeared in hierarchical documents as early as 1981 and continued to develop through the events surrounding Nancy Cruzan and beyond. After 1990, the determination that a presumption in favor of providing food and fluids, including ANH, existed for all patients who needed it was a solidly established directive.\textsuperscript{185} While it is true that the various letters and directives promulgated by the American bishops from the aftermath of \textit{Cruzan} onward were more obviously tentative than the 2004 papal allocution, what is clear is that they were all consistently leaning in the same direction. Further, several serious questions regarding: 1) the alleged inability of patients in the PVS to possess any level of inner awareness, 2) the ambiguous motives of patients or caregivers with regard to the withdrawal of effective ANH delivery, and 3) warnings concerning euthanasia by omission were already solidly established aspects of the moral debate well before the 2004 papal allocution was promulgated.\textsuperscript{186} At the bottom line, it would appear that anyone who observed the hierarchical treatment of the PVS question from the aftermath of \textit{Cruzan} onward should not have been so completely unaware of the moral direction taken by the Holy Father’s 2004 statement. I believe it is fair to say, “\textit{that}” there was an allocution was legitimately unanticipated; “\textit{what}” the allocution said, however, should not have been such a surprise.

Without question, the strongest reaction to the Holy Father’s address centered upon two statements regarding the nature of nutrition and hydration. The first contends that ANH, even if delivered artificially, constitutes a natural means of preserving life, not a medical act. The second


asserts that the delivery of food and fluids should be considered, in principle, an ordinary and, therefore, proportionate means of conserving life.\textsuperscript{187} Other equally important aspects of the allocution included the following: 1) an accurate assessment of the state of medical science with regards to the PVS itself, 2) an unequivocal reaffirmation of the human dignity possessed by patients in the PVS, and 3) cautions against engaging in actions that would willfully hasten the death of such patients based on a perceived low quality of life or certain evaluations of cost.\textsuperscript{188} The purpose of this final section will be to briefly examine these statements and recommendations contained in the 2004 papal allocution, with a particular emphasis on the response of Catholic theologians. To accomplish this, the section will be divided into three parts: 1) the condition and dignity of patients in the PVS; 2) the requirements of care and the nature of ANH, and 3) ANH and the ordinary means of conserving life.

\textit{Condition and Dignity of Patients in the PVS}

While it is true that the majority of medical and ethical professionals have concluded that patients in the PVS are completely unaware of self or their environment, and that they lack the capacity to interact with others or to specific stimuli, legitimate reasons to doubt this claim do exist.\textsuperscript{189} Acknowledging the difficulties inherent in the formulation of a correct diagnosis of PVS and the not uncommon instances of misdiagnosis, the Holy Father was careful to use language that accurately described the reality of the PVS condition.\textsuperscript{190} When speaking about the observable aspects of persistently unconscious patients he stated, “The person in a vegetative state, in fact shows no \textit{evident} sign of self-awareness or of awareness of the environment, and \textit{seems} unable to interact with others or to react to specific stimuli (emphasis mine).\textsuperscript{191} Instances in which patients suddenly and inexplicably recover consciousness, though not a regular event, occur frequently enough to produce a substantial crack in the purportedly
incontrovertible edifice of medical certainty on this issue. At the very least such occurrences raise legitimate questions regarding the likelihood of inner awareness or a possible return to consciousness in patients diagnosed as PVS.  

In conjunction with his assessment of the PVS itself, Pope John Paul II raised similar concerns with regards to the term “permanent vegetative state”. This term is the label used to describe the condition of a patient who has remained persistently unconscious for more than a year. Recognizing first, that the term was a prognostic conclusion based upon the statistical improbability of recovery rather than a completely new diagnosis, and second, that instances of recovery belied such a declaration, the Holy Father concluded that, at present, medical science lacked the ability to accurately predict which patients would recover consciousness and which would not. Although more commonly seen within the medical community, some Catholic theologians have applied the term “permanent” or “irreversible” to describe the vegetative state of persistently unconscious patients.

A recent case involving a woman in the PVS who exhibited a definitive level of inner awareness was published in 2006. Using a functional MRI to measure neural responses, the patient was first asked to imagine playing a tennis match and then to imagine walking through her home. In each instance, such a significant level of neural activity was measured that they were indistinguishable from the healthy control group. The authors concluded: “These results confirm that, despite fulfilling the clinical criteria for a diagnosis of vegetative state, this patient retained the ability to understand spoken commands and to respond to them through her brain activity, rather than through speech or movement. Moreover, her decision to cooperate with the authors by imagining particular tasks when asked to do so represents a clear act of intention, which confirmed beyond any doubt that she was consciously aware of herself and her surroundings.” In: Adrian M. Owen, Martin R. Coleman, Melanie Boly, Matthew H. Davis, Steven Laureys, and John Pickard, “Detecting Awareness in the Vegetative State,” Science, (313), September 8, 2006, 1402. See also: Associated Press, “Woman Awakens for 3 Days After 6 Years,” MSNBC, http://www.msnbc.msn.com/id/17516126/, (Accessed: March 8, 2007).

The 1994 MSTF document declared that a persistent vegetative state could be declared permanent when irreversibility could be established with a high degree of clinical certainty. In practical terms the MSTF concluded that permanence could be declared twelve months after traumatic brain injury and three months after non-traumatic brain injury. In: The Multi-Society Task Force on PVS, “Medical Aspects of the Persistent Vegetative State,” at 1501 and 1575.


Fr. Michael Place commented, “I will…stipulate for the sake of our reflection that there is a clinical condition of permanent unconsciousness. A condition which, if fact, is a fatal pathology from which a patient does not have the ability to recover and can be the ultimate
theologians, however, have tended to avoid using the term largely because the word “permanent” doesn’t adequately account for those individuals who have recovered consciousness many years after permanence was declared. One commentator remarked,

I think the problem...is the potential for medical determinations of permanence or irreversibility to mislead the lay public by creating false impressions of certainty. Since identifying a particular PVS as permanent just seems to mean that recovery of unconsciousness in this instance is very unlikely – and, importantly, if consciousness were recovered, it very likely would be significantly impaired – why retreat from the direct use of the language of probability to begin with?  

Despite the fact that many medical professionals, the public, and some theologians remain convinced that the likelihood for recovery from the PVS after one year is so statistically small that it becomes possible to arrive at a nearly certain prognosis, the application of a speculation, however likely, to the condition of such patients can easily become one more way to write-off a seriously debilitated patient as someone beyond assistance. In the final
analysis, since there are substantial problems in using a predictive term of questionable reliability, the Holy Father’s caution with regards to it was both correct and prudent.  

After examining the specifically medical aspects of the PVS, the Holy Father chose to address the negative connotations associated with the term “vegetative” now ubiquitously used to describe a medical condition of persistent unconsciousness. Concerned that the word “vegetative” carried with it the potential to subtly or even directly demean the dignity of a human being, Pope John Paul II spoke against its application to seriously debilitated persons. At the outset, it can be justly stated that no individual or group appears to be particularly satisfied with the PVS terminology. From its debut in 1972, the term “persistent vegetative state” (based upon the observable tendencies of patients suffering from severe brain injury), was accepted by the medical community only because other diagnostic terms had proved to be anatomically or pathologically inaccurate. Although

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As Drs. Jennett and Plum noted in 1972 and all medical professionals have noted since, the site and the nature of the injury may vary widely according to the circumstances of each individual brain injured patient; at the bottom line, medical science has yet to understand

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199 Dr. J.P. Hubert Jr., stated: “Thus the Pope was teaching that even in the case of PVS one can never be certain that the diagnosis is correct or that eventual improvement will not occur; a reality which is in agreement with the accumulated medical literature on the subject. In: J.P. Hubert Jr., M.D., F.A.C.S., “Fr. Richard McBrien and Others Mislead Catholic Public: Allege Schiavo Feeding Tube Removal OK,” Catholic Online, (March 8, 2006), http://www.catholic.org/printer_friendly.php?id=3006&section=Featured+Today. (Accessed February 24, 2007).

200 As Drs. Jennett and Plum noted in 1972 and all medical professionals have noted since, the site and the nature of the injury may vary widely according to the circumstances of each individual brain injured patient; at the bottom line, medical science has yet to understand
some medical professionals continue to be vocally dissatisfied with the PVS designation and offer less blatantly objectionable replacements (e.g., PCU – post-coma unresponsiveness), its decades-long history makes the term PVS the predominant designation used to describe the condition of persistent unconsciousness.\textsuperscript{201}

Following the lead of the medical community, most theologians have continued to employ PVS terminology to describe persistently unconscious patients. For all intents and purposes, this fact merely indicates a decision to utilize the term common to the medical-moral debate on this issue. All Catholic theologians both affirm the inherent dignity of all patients and decry any action or omission that would intentionally dehumanize seriously debilitated patients. In principle, all Catholic theologians concur with the Holy Father’s adamant declaration that, “A man, even if seriously ill or disabled in the exercise of his highest functions, is and always will be a man, and he will never become a ‘vegetable’ or an ‘animal’.”\textsuperscript{202} On the other hand, there can be little doubt that the mere association of the term “vegetable” with a human being only has deleterious effects on the manner in which such individuals are perceived.\textsuperscript{203} The Holy Father’s justified objection to the word “vegetative” was an attempt to break through the status quo acceptance that has characterized its use in the medical and theological arenas. Released in the midst of the controversy surrounding Terri Schiavo, the 2004 allocution provided a rare opportunity for theologians and medical professionals to confront and correct a long-standing and harmful affront to the dignity of all patients suffering persistent unconsciousness. Unfortunately, the opportunity for an
adjustment to the terminology passed and the weight of inertia once again reasserted itself; consequently, the term “vegetative” remains firmly entrenched in all areas of discourse on the subject.

Requirements of Care and the Nature of ANH

When compared to later portions of the 2004 papal allocution the first three sections of the document contained relatively minor points upon which Catholic theologians held differing opinions. By contrast, however, the pivotal and highly controversial fourth section of the document (especially among Catholic theologians), was a different matter entirely. Placed at the center of the allocution, the fourth section of the document is best divided into two parts: 1) a delineation of moral responsibilities and, 2) a specific assessment of the ANH provided to patients in the PVS. First, and quite surprisingly, the Holy Father indicated three grave and binding responsibilities that a truly caring humanity (individuals, society, and Church) incurred when faced with seriously debilitated patients like those in the PVS. More than a simple focus upon palliative and maintenance measures alone, the document called for a proactive response to the PVS condition that was intended to offer patients a much better opportunity for improvement. Second, and even more importantly, was the Holy Father’s attempt to directly confront the moral questions surrounding the provision of ANH that had for decades constituted a quagmire of disparate and conflicting opinions among Catholic theologians. Based upon the ordinary and extraordinary means of conserving life principles, this section of the allocution provided sorely needed guidance to the decision to provide or withdraw ANH from patients in the PVS. The reaction, however, heightened by the drama of the Schiavo case, ranged from the animated to the volcanic. An important, but concise look at the issues that arose as a result of the Holy Father’s message will follow here.

According to the Pope John Paul II, patients in the PVS “awaiting recovery or a natural end,” have the right to expect three forms of care from professionals and other persons in solidarity with them. First, such patients are owed what the Holy Father termed “basic health care,” including: nutrition, hydration, proper hygiene, warmth, prevention of decubitus ulcers, and so on. Second, more than simply palliative measures, patients in the PVS have the right to expect a regimen of rehabilitative care commensurate with their impaired condition. And finally, these severely
injured patients are entitled to proper monitoring for clinical signs that they may soon return to consciousness or might further advance in their recovery.”

At the outset, it should be honestly stated that the Holy Father’s prescription for the proper and loving care of patients in the PVS represents a breathtaking vision of the level of solidarity that should flow from the inherent dignity of such persons. On the other hand, given the degree of opposition to the requirement of providing basic care to patients in the PVS, including the provision of food and fluids, a widespread acknowledgement and acceptance of appropriate rehabilitative measures and proper monitoring for signs of recovery, was not likely to be forthcoming in the near future.

From the Catholic perspective, there is no doubt that the crux of the entire PVS dilemma revolved around the decision to provide or withdraw ANH from patients suffering from persistent unconsciousness.


205 One group of commentators remarked, “[I]t could be argued that considerations of distributive justice, responsible stewardship, and the common good would require dedicating our health-care resources first to rectifying some of the fundamental inequities in the current structure of access to health care in this country [and others], before dedicating any resources to ‘awakening centers’ that may or may not have any impact on outcomes.” In: Dan O’Brien, John Paul Slosar, and Anthony R. Tersigni, “Utilitarian Pessimism, Human Dignity, and the Vegetative State: A Practical Analysis of the Papal Allocution,” The National Catholic Bioethics Center, 4(3), Autumn 2004, 510.

206 While not examined to the extent that the decision to provide ANH to patients in the PVS was, the issue of proper monitoring for clinical signs of eventual recovery continues to be a serious concern for some medical professionals. Citing the misleading behaviors of patients in the PVS, the lack of experienced medical personnel, and the limitations of existing assessment tools, Dr. Gill outlined the difficulties inherent in properly monitoring patients in the PVS. As a participant at the 2004 International Congress in Rome, Dr. Helen Gill commented that the potential for misdiagnosis of the PVS continues to be considerable likelihood. During the course of her presentation she stated the following: “There have been several studies which have shown that misdiagnosis of the vegetative state is very common. For instance, Tresh et al found that 18% of long term patients in nursing homes in the USA, diagnosed, as being in the Vegetative State were able to communicate. Nancy Childs et al., found that 37% of patients admitted to her rehabilitative unit with a diagnosis of the vegetative state were aware. Research at the Royal Hospital for Neuro-disability by Andrews et al found that 43% of patients admitted with a diagnosis of VS for longer than 6 months were misdiagnosed, including several patients who had been thought to be vegetative for years.” Helen Gill, M.D., “Misdiagnosis of the Vegetative State,” in: Life-Sustaining Treatments and the Vegetative State: Scientific Advances and Ethical Dilemmas, (Instituto per l’Analisi dello Stato Sociale, Rome, Italy, March 2004), 94.
Unsurprisingly, the greatest theological battles fought over the 2004 papal allocution centered upon the Holy Father’s contention that ANH be considered an aspect of basic care that patients in the PVS had a right to receive. What is so interesting about this issue and, at the same time so perplexing, is that theologians with recourse to, and acceptance of, the same moral principles arrived at polar opposite conclusions regarding the decision to provide or withdraw ANH from such patients. The goal of this section, then, will be to explore the reasons for the impasse. From a practical standpoint, the problem can be divided into two interrelated concerns, namely, the interpretation of the patient’s medical condition, and the nature of ANH itself. Each of these subjects will be treated separately.

The first difficulty theologians had with the Holy Father’s claim regarding ANH centered upon the PVS condition itself. Since the late 1980s it had been the firmly established and widely accepted conclusion of the medical community that patients in the PVS retained no awareness of self or the surrounding environment. This determination was a significant factor for many theologians as they attempted to ascertain the moral requirements of caring for such patients. Reacting against the stance taken by the Holy Father, the theologians who claimed that the withdrawal of ANH from a patient in the PVS was morally permissible simply could not imagine how a person suffering from irreversible unconsciousness would receive any tangible benefit from the prolongation of life. At the heart of their argument was the claim, most clearly articulated by Kevin D. O’Rourke, O.P., that patients in the PVS had irreversibly lost the capacity to pursue the goals of life proper to human beings. In such a case, because the nourishment provided could not help the dying patient to recover consciousness (and consequently, enable him to resume his pursuit of the spiritual goals of life), the provision of ANH would not offer a proportional benefit and could be morally refused. Focused specifically on what these theologians considered to be the true condition of the patient, Shannon and Walter argued that:

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207 Kevin D. O’Rourke, O.P., J.C.D., S.T.M., “Artificial Nutrition and Hydration and the Catholic Tradition,” *Health Progress*, 88(3), May-June 2007, 52. He wrote: “Other theologians – we will call them the ‘Beta Group’ – maintain that human life in a condition bereft of cognitive-affective function is not a great benefit, for either the patient, the family, or the community. They base their opinion on the premise that a person in this condition is no longer able to strive for the spiritual purpose of life.”
All the artificial feeding does is maintain the biological processes of the person. It does not directly contribute to the person’s recovery or maintain them in a stable condition as part of an ongoing therapeutic process. Artificial nutrition and hydration cannot make such contributions because recovery is not an option for a person in a persistent vegetative state.208

Thus, while patients in the PVS remained human beings who deserved to be kept clean and comfortable, these like-minded theologians concluded that the decision to withdraw life-sustaining ANH was no more or less than a decision to forego a medical treatment that involved a greater burden or inconvenience than a person should be reasonably expected to bear.209

On the other side of the Catholic debate, theologians who defended the teaching of the Holy Father approached the care of patients in the PVS from a much different viewpoint.210 Contrary to their counterparts who largely remained focused on the negative aspects and apparent hopelessness of the PVS condition,211 these theologians considered such persons to be seriously injured, but not dying patients whose lives could be easily maintained through the simple expedient of providing ANH. Consequently, they were much less willing to accept at face value certain blanket declarations about the PVS (e.g., the “permanence” of the VS or the impossibility and


210 It is important to note that physicians and theologians who favor the decision to provide ANH to patients in the PVS do not hold (as is often attributed to them), the position that food and fluids must always be given. Dr. Eugene F. Diamond stated: “No one is arguing to use all means, at all costs for all persons in all circumstances, particularly those who are imminently dying and unable to benefit from treatment. The question really relates to patients who are not dying…The precise question is not whether to treat comatose non-dying patients but rather whether to conserve or sustain their lives. Since feeding is ordinary care, our choice is really between caring for such persons or abandoning them.” In: Eugene F. Diamond, M.D., “Linacre Institute Paper: Assisted Nutrition and Hydration in Persistent Vegetative State,” at 204.

211 Rev. Gerald D. Coleman provides a representative example. Fr. Coleman commented that, “P.V.S. patients have reached a point in their lives at which their ability to pursue the spiritual goods of life has been totally eclipsed. They are beyond the reach of medical treatment.” In: Gerald. D. Coleman, S.S., “Take and Eat,” America, 190(2), April 5, 2004, 19
irreversible loss of inner awareness), that had not been adequately proved by medical science. As noted earlier in this chapter, the popular medical assertion that patients in the PVS exist in a state of complete unawareness of themselves or their environment, or that such patients retain no capacity to experience pain and suffering, has not been (and as yet still cannot be) credibly demonstrated by scientific means. For over two decades, however, the common practice of medical professionals, and some theologians, has been to overemphasize the diagnostic assertions regarding the PVS, and to parlay the patient’s persistent unconsciousness into a definitive declaration that, in such a condition, awareness has been completely and irrevocably lost. Grounded almost exclusively upon a lack of observable evidence of awareness, this practice has basically constituted a medical and moral leap that simply assumed what it could not concretely verify. Simply stated, the medical and moral decision to remove ANH from patients in the PVS was often based on the tenuous supposition that, because no irrefutable indication of awareness was observed, awareness was, therefore, conclusively and totally absent. Hence, in part because of the medical uncertainty inherent in the PVS diagnosis itself, and because the lives of seriously injured, but non-dying persons were at stake, a significant minority of Catholic theologians urged that greater caution be taken.

212 For example, Kevin O’Rourke wrote: “However, as I have stated in the past, while persons in PVS do not have cognitive-affective function in potency or act, the same is not true of retarded children. Thus, ‘people who are permanently unconscious are considered to have no potential for meaningful mental activity...’” In: Kevin D. O’Rourke, O.P., “Father O’Rourke Responds,” at 16.

213 Richard M. Doerflinger wrote: “In recent years, a number of patients have unexpectedly recovered from the ‘vegetative’ state – a dimly understood condition in which patients have sleep/wake cycles, but do not seem aware of themselves or their environment. And according to medical experts speaking at a March 2004 international congress on the ‘vegetative state’ in Rome, medical science is only beginning to realize how little is understood about this condition.” In: Richard M. Doerflinger, “Human Dignity in the ‘Vegetative’ State,” http://www.usccb.org/prolife/programs/rlp/04doerflinger.shtml. (Accessed: March 6, 2007), 1. See also: Rev. Kevin T. McMahon cites examples of pain studies conducted on patients in the PVS that indicate a similar electroencephalographic response to painful stimuli to that of conscious patients. He wrote: “These findings question the certainty of the claim that PVS patients cannot experience pain, and that they die of dehydration but not starvation.” In: Rev. Kevin T. McMahon, S.T.D., “Nutrition and Hydration: Should They be Considered Medical Therapy?” at 230.

214 D. Alan Shewmon, M.D., “Recovery from ‘Brain Death’: A Neurologist’s Apologia,” at 58.
taken with regards to the decision to provide or withdraw ANH from such vulnerable persons.\textsuperscript{215}

In the end, the unknown elements associated with a medical diagnosis of PVS could not help but spill over into the theological arena. Aimed at the contention that patients in the PVS had absolutely and irretrievably lost cognitive-affective capacity, one commentator remarked:

Ashley and O’Rourke thus base their rationale for any prolongation of life on the ability to strive for the spiritual purpose of life. From this perspective, such striving necessitates some degree of cognitive-affective function. From my standpoint, however, it is far easier to endorse the termination of life-sustaining or life-prolonging measures…if one already assumes that the patient has no ability to pursue that purpose, merely on the basis of behavioral characteristics.\textsuperscript{216}

For these theologians, the presumed lack of awareness in the PVS was an unstable foundation upon which to base a decision to withdraw the life-sustaining ANH that maintained a vulnerable patient’s life. In their estimation, the absence of positive clinical evidence to support the claim of complete unawareness, coupled with occasional reports of patients who had eventually recovered consciousness, provided sufficient cause to question whether moral certainty of the patient’s condition could be reliably achieved.\textsuperscript{217} Although some theologians steadfastly presumed that ANH delivery would not help patients in the PVS to regain cognitive-affective

\textsuperscript{215}Fr. Torchia commented that, “the obligation to adopt those ordinary means which are both necessary and useful still assumes a moral precedence over any right not to do so. From this standpoint, one must not be overly hasty in judging whether a given treatment or procedure is burdensome or disproportionate to its potential benefits. When life is at stake, one should always take the moral high ground, assuming that life is worth preserving; only then should one assess whether the means are disproportionately burdensome. In: Joseph Torchia, O.P., Artificial Hydration and Nutrition for the PVS Patient: Ordinary Care or Extraordinary Intervention?” The National Catholic Bioethics Quarterly, 3(4), Winter 2003, 727.

\textsuperscript{216}Ibid., at 721.

\textsuperscript{217}In a recent article Edward J. Furton and William J. Dennis, M.D., stated that, “Concerning the spiritual purposes argument advanced by Rev. Kevin O’Rourke, we feel that the claim that those in PVS are incapable of spiritual activities is unjustified. Much is unknown about the cognitive abilities of persons in this state.” Edward J. Furton, M.A., Ph.D., and William J. Dennis, M.A., M.D., “Why Providing ANH is a Moral Act,” Ethics & Medics, 32(6), June 2007, 4.
function, the result of withdrawing life-sustaining ANH remains absolutely certain. In the final analysis, the presumption of unawareness should not be permitted to provide what medical science as yet cannot. It was from this perspective, therefore, that the final paragraph of section 4 of the 2004 allocution took on its particular significance. The Holy Father concluded that, “[b]esides, the moral principle is well known according to which even the simple doubt of being in the presence of a living person already imposes the obligation of full respect and of abstaining from any act that aims at anticipating the person’s death.” While these theologians did not discount the possibility that ANH might become an extraordinary means of conserving life for patients in the PVS, they determined that the unsubstantiated claim of complete patient unawareness was not a sufficient foundation upon which to base the decision to withdraw ANH.

Closely intertwined with the question of cognitive-affective capacity, was O’Rourke’s assertion that ANH could be morally withdrawn from patients in the PVS on the grounds that they possessed no ability to pursue the spiritual goals of life. Arguing from a different perspective than the one just examined, critics charged that O’Rourke and his colleagues had seriously misinterpreted the 1957 allocution of Pope Pius XII on the prolongation of life, and that as a result; they produced fatally flawed conclusions regarding the level of care owed to patients in the PVS. Objecting to O’Rourke on interpretive errors, his critics first claimed that Pope Pius XII did not, as O’Rourke presupposed, ever envision the inclusion of persistently unconscious patients in his statement that “life, health, all temporal activities are in fact subordinated to spiritual ends.”

Taking a related tack, Rev. Joseph Torchia argued:

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218 Brother Adam Hildebrand commented that: “People in the ‘persistent vegetative state’ are presumed to have lost all cognitive and affective functions; i.e., they may not be able to think or feel in the same way as most people think and feel. However, are we not more than our thoughts and feelings? A person described as being in a ‘persistent vegetative state’ may well experience an interior life we cannot imagine or comprehend. Our thoughts, our feelings, our moments of inspiration in our very souls, cannot be seen, heard, or touched – not even by the most sophisticated technology.” In: Br. Adam J. Hildebrand, M.S.A., “On ‘Vegetative’ Human Beings,” at 2.


220 Peter Cataldo argued that “[t]he presupposition of this statement is that it pertains to the patient who is conscious and functionally able to pursue the spiritual ends of life. This is evident from the fact that the pursuit of these ends is possible for the individual described in the text absent the use of means that ‘would render the attainment of higher, more
But Pius XII surely did not intend this to mean that anyone incapable of exercising cognitive or affective function loses the right to life. Rather, he wished to stress the fact that temporal and corporeal concerns should never be absolutized or take precedence over our true spiritual end. It is, it seems a gigantic and wholly unwarranted leap to use this position as a basis for excluding PVS patients from the moral community of beings to whom we owe a moral responsibility for care and sustenance...

While certainly worthy of serious consideration on their own merits, the conflicting interpretations of Pius XII’s allocution introduced by O’Rourke and his critics did not provide much more than fodder for those who already held similar positions regarding the delivery of ANH. By contrast, Dr. Peter Cataldo’s recent philosophical contribution to the “spiritual goals of life” disagreement offered a fresh and convincing perspective from which to view the statement of Pope Pius XII.222 To summarize his position, Cataldo basically argued that, although the good of corporeal life was subordinate to the spiritual goals of life, the irrevocable loss of the higher good did not automatically cancel out the duties and responsibilities owed to the lower good because each belonged to a different dimension of human life. Thus he claimed that it was consistent with the Catholic tradition to affirm the higher spiritual goals of life, and at the same time to maintain that an obligation existed to preserve life through the use of effective ANH when

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221 Joseph Torchia, O.P., “Artificial Hydration and Nutrition for the PVS Patient,” at 721-722. See also: Rev. Msgr. Orville Griese, “Pope Pius XII and ‘Medical Treatments,’” Linacre Quarterly, 54(4) November 1987, 47. Msgr. Griese argued that Pope Pius XII intended to address the moral obligation or option to use medical treatments in his allocution, but not ordinary care, e.g., sustenance, proper hygiene and other comfort measures.

the capacity for cognitive-affective function was lost. Based upon this line of thought Cataldo reasoned that:

Communication and fellowship with God should not determine the moral status of that with which it has no intrinsic relation. Why should physiologic life be held to a standard which belongs to a different dimension of human life? It is impossible for a person to communicate with God strictly through his or her physiological life; thus if the spiritual life of the person has ceased due to permanent coma, then it is incongruous to evaluate that person’s corporeal life by a standard for which this dimension of life has no capacity...If the lack of communication and fellowship with God through the physiological life does not affect the obligation to preserve life of a healthy person, then this lack should not affect preservation of physiological life once a person is unable to pursue his or her spiritual good due to permanent coma.\(^\text{223}\)

At the bottom line, Cataldo argued that ANH, as a support for the bodily life of a person, stood independently of the pursuit of the spiritual goals of life. Consequently, if a person’s physical needs could be met through an ordinary and effective means of preserving life, it should be provided.\(^\text{224}\)

The second point of disagreement over the 2004 papal allocution centered specifically upon the nature of ANH delivery itself. At the outset, it should be obvious that the Holy Father’s decision to name ANH an aspect of basic care was, in the opinion of many, a highly controversial decision.\(^\text{225}\) However, since a 1986 American Medical Association committee abruptly changed the classification of ANH from its traditional place as an aspect of basic care to the status of a medical treatment, the Holy Father’s action was not without precedent.\(^\text{226}\) Similar to the Holy Father assessment, one group

\(^{223}\)Ibid., at 532-533.
\(^{224}\)Ibid., at 534.
\(^{225}\)Mark Repenshek and John Paul Slosar, “Medically Assisted Nutrition and Hydration,” at 504.
\(^{226}\)Good reasons exist to defend the Holy Father’s decision mainly because the classification of ANH as a medical treatment, while firmly entrenched in medicine and law is not free from significant criticism. Msgr. Kevin McMahon wrote: “While these [life-sustaining] measures all sustain life, they do so in different ways. Mechanical ventilation and renal dialysis substitute for a lost or compound function of a biological system. Chemotherapy is directed to curing or arresting a disease. Antibiotics treat infection. But
of theologians considered ANH to be an aspect of basic care for patients in the PVS that should generally be provided them because it offers the benefit of sustaining life without causing undue hardship or burden. Opponents cited the accepted medical and legal classification of ANH as a medical treatment, in part, because the placement of the tube required the skills of a competent physician. They further argued that, since ANH offered no proportional benefit to patients dying in the PVS, fluids and nourishment could be morally withdrawn as an excessive burden.\textsuperscript{227}

Because the morally obligatory or optional nature of ANH is not primarily rooted in whether a proposed act is classified as “basic care,” or a “medical treatment,” the heart of the disagreement lay in the separate interpretations of the words “benefit” and/or “burden.” In the practical application of these terms to the concrete situation of a patient in the PVS, the interpretation of the benefits and burdens associated with ANH delivery related by each side of the debate varied widely.\textsuperscript{228} Further, based upon a study of the recent literature, there does not appear to be much hope for an eventual resolution on the matter.

In assessing the optional or obligatory nature of assisted food and fluid provision O’Rourke and his colleagues attributed the greatest weight to several factors: 1) the patient’s apparent lack of cognitive-affective capacity, 2) the recourse to medical expertise, 3) the requirement for

\textsuperscript{227} One bold statement revealed the extent of this perspective: “Timothy O’Connell, a moral theologian at Loyola University...added that people in a persistent vegetative state should be considered ‘already in the dying state.’ When they cannot function or feed themselves, ‘they are in the dying process’ he said. ‘If they can resist the process, they should be assisted, but if not, the process need not be slowed down artificially.” In: Patricia Lefevere and Robert McClory, “Schiavo Autopsy Points Up Need for End-of-Life Discussions,” \textit{National Catholic Reporter}, 41(33), July 1, 2005, 10.

\textsuperscript{228} Fr. Michael Place, “Nutrition and Hydration and the Persistent Vegetative State,” at 20.
anesthesia and surgery in the placement of a G-tube, and 4) the great expense often associated with long-term care.\textsuperscript{229} In one sense, it is difficult to fault this account of ANH delivery. Tube feeding does indeed require placement by a skilled physician, some form of anesthesia and surgery is often necessary, and the cost of care can be considerable. On the other hand, accounts of this type have invariably painted the PVS, and ANH delivery to patients so afflicted, in the most negative and onerous light possible. For example, some viewed the presumption in favor of providing fluids and nourishment as an heroic requirement that promoted an unfortunate inclination among advocates to excessively resist the good of eternal life awaiting such patients.\textsuperscript{230} Others, reminiscent of Fr. Richard McCormick’s 300-bed scenario,\textsuperscript{231} went even farther and declared that the presumption in favor of providing ANH to patients in the PVS constituted an act of idolatry that revered biological life to the point that its preservation became an end in itself.\textsuperscript{232}

Besides its negative slant, the problem with this portrayal is that in practice, the classification of ANH as an excessive burden for patients in the PVS has virtually become a foregone conclusion, rather than a means to be assessed according to the condition of the individual patient. While O’Rourke and others have charged the Holy Father with circumventing the traditional benefit/burden calculus, and thus altering the basis Catholic moral tradition regarding the ordinary and extraordinary means of conserving life, they have overlooked their own insistent and ubiquitous claim that (in the PVS), ANH amounts to an excessive burden.\textsuperscript{233} Further,

\textsuperscript{230}Rev. Michael Place, “Nutrition, Hydration and the ‘Persistent Vegetative State,’” at 22. Challenging Fr. Place’s comment, Dr. John Haas remarked that, “Father rightly speaks of addressing these issues from the perspective of our ultimate goal, eternal life. No Catholic would dispute the beauty of eternal life with God to which we all aspire. However, one cannot merely appeal to that end to justify performing what might be considered a deadly deed.” In: John Haas, “Nutrition, Hydration and the ‘Persistent Vegetative State,’ Origins, 36(2), May 25, 2006, 23.
\textsuperscript{231}Richard A. McCormick, S.J., “Moral Considerations, Ill Considered,” America, 166(9), March 14, 1992, 214.
\textsuperscript{233}John Berkman noted that, “[t]he first type of ‘excessive burden’ argument emphasizes the burden of MANH for the PVS patient himself…However, when the burden is described
O’Rourke and his colleagues also appear to have neglected the Catholic moral teaching indicating that patients are morally bound to bear some degree of difficulty in the preservation of their lives. According to the Catholic moral tradition, even though a person is not morally obligated to accept extreme pain and suffering, he nonetheless remains bound to accept moderate inconveniences, and even suffering, in order to conserve the good of his life. At the bottom line, O’Rourke and his colleagues too easily disregard the patient in the PVS and assume that ANH can provide him no tangible benefit. As one critic noted:

I recognize that hydration and nourishment by intubation is a radical measure that can cause great discomfort for some patients…For this reason, I neither promote AHN for its own sake nor advocate its use in prolonging the patient’s life for its own sake without concern for its quality. But I do wish to challenge the tacit assumption that one can easily dismiss such a life-sustaining measure (simply on the grounds of excessive burdensomeness), or completely deny the benefits inherent in the very continuance of human life.

The duty to accept some degree of burden has not been adequately addressed by O’Rourke and his colleagues and it has adversely affected their interpretation of the PVS and the delivery of ANH. In the final analysis the nearly automatic classification of ANH as an excessive burden for patients in the PVS runs contrary to the Catholic moral tradition.

in this way, it is unclear whether what is being objected to is the burdensomeness of MANH as a form of treatment or care, or rather the form of life of the PVS patient which MANH helps sustain. In: John Berkman, “Medically Assisted Nutrition and Hydration in Medicine and Moral Theology: A Contextualization of Its Past and a Direction for Its future,” The Thomist, 68(1), January 2004, 93

234H. Tournely commented, as did later theologians that although a treatment involving extreme pain did not obligate a patient, a moderate amount of pain did not constitute a moral impossibility. H. Tournely, Theologia Moralis (Venetiis, 1756), Tom. III, Tract. De Decalogo, cap. 2. de Quinto Praec., Art. 1 conc. 2. See also: C. Roncaglia, Theologia Moralis, (Lucae, 1730), Vol. I, Tract. XI, Cap. I, Q. III. Roncaglia divided surgical procedures into categories and separated the ones involving extreme pain from those that involved only moderate amounts of pain. In this way he admitted the moral necessity of accepting a moderate level of pain to conserve his life. In: Daniel Cronin, The Moral Law in Regard to the Ordinary and Extraordinary Means of Conserving Life, diss., (Rome: Pontifical Gregorian University, 1958).

In contrast to the assessment of ANH often reported by O’Rourke and his colleagues, the account presented by J.P. Hubert, Jr., M.D., was significantly more positive and open to possibility. He asserted that,

As anyone even remotely familiar with gastrostomy tube feeding can attest, such feedings can be carried out in the home very easily by a family care-giver who employs a blender and regular food prepared for easy insertion into the tube...Daily maintenance of the feeding tube requires minimal training and care. The initial placement of the feeding tube can be done without general anesthesia percutaneously in a few minutes at very low risk and without discomfort. From a medical perspective, it is a complete fabrication to claim that ‘tube-feeding’ represents extraordinary or disproportionate treatment/care.\(^{236}\)

To some degree, the positive nature of this account, and others like it, served to challenge the prevailing conclusion that ANH delivery should be considered an excessively burdensome, and thus a morally optional, means of preserving life when it was connected to a patient in the PVS. Although the theologians who favored the classification of ANH as an aspect of basic care generally viewed assisted food and fluid provision as a positive means to sustain life, they were not unaware of the occasional difficulties associated with it, nor did they recommend that it be provided to all patients in all situations.\(^{237}\) They did believe, however, that at its heart the feeding

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\(^{236}\)J.P. Hubert Jr., M.D., F.A.C.S., “Fr. Richard McBrien and Others Mislead Catholic Public: Allege Schiavo Feeding Tube Removal OK,” at 10. See also: Ralph P. Miech, M.D., Ph.D., “PVS versus the Dying Process,” The National Catholic Bioethics Quarterly, 4(3), Autumn 2004, 447. Dr. Miech argued that, “The surgical insertion and chronic use of a PEG tube to provide AHN should be considered as an alternative form of normal care for patients capable of being spoon-fed when death is not imminent. In PVS patients, it is not appropriate to classify AHN as a form of extraordinary medical treatment or even as ordinary medical treatment. The PEG tube takes the place of the spoon in providing hydration and nutrition, and thus the PEG becomes a substitute for the spoon as part of the normal care of the patient.”

\(^{237}\)See: William J. Dennis, M.D., and Edward J. Furton, Ph.D., “Why Providing ANH Is a Moral Act,” at 3. They state: “We agree that not every impaired infant or adult should be given ANH. Some of the factors that might lead to a judgment that tube feeding is inappropriate for an adult are when food and water cannot be assimilated, when placement of the tube causes repeated infections, when the patient is agitated by the tube and
tube was merely the simple vehicle by which food and drink were provided to an injured person who required this simple assistance in order to live. They were also of the opinion that the terminology used to describe tube feeding often obscured this fact. They were also of the opinion that the terminology used to describe tube feeding often obscured this fact. Ultimately they were concerned by the growing tendency to undervalue the life of persistently unconscious patients, as well as the refusal to accord such patients the same loving care as those better able to defend themselves.

In the final analysis, the Holy Father’s assessment of ANH as an aspect of basic care did not (either by intention or in practice), overemphasize the value of biological life, or as one commentator suggested, seek to detain patients from union with God (as if this were even possible). Rather, Holy Father’s the classification of ANH as an aspect of basic care attempted to achieve positive results both for the Catholic debate and for the care of seriously debilitated persons. First, the classification was an effort to reorient skewed perceptions of ANH; despite the medical terminology, the nature of ANH remained nothing more than the provision of water and nourishment to a living person who could not receive sustenance in the normal manner. Second, rather than abandoning such patients, the classification helped to concretely demonstrate authentic Christian solidarity as it should be applied to the most vulnerable members of

repeatedly pulls it out, and when there is aspiration pneumonia and repeated need to suction the throat.”

Adam Hildebrand remarked that, “[t]he use of the term ‘assisted nutrition and hydration’ allows one to possibly think that substances other than food and water are involved. Medical terminology is not a magical incantation that has the power to transform the elemental substance of food and water. Neither is medical technology a magic wand that transforms food and water into drugs and plasma. While the means of delivery does involve a medical procedure – inserting plastic tubing to convey nourishment – the essence of food and water…remains unchanged. In: Br. Adam Hildebrand, Ph.D., “On ‘Vegetative’ Human Beings,” at 2.


Joseph Torchia, “Artificial Hydration and Nutrition for the PVS Patient,” at 726. He stated, “But by the same token, I feel that AHN constitutes and extension of the same comfort care we ordinarily owe any patient. In situations where one is a ‘living, breathing human being,’ is hydration and nourishment by intubation really morally different from the intravenous hydration and nourishment of any postoperative patient?”
Contrary to critical voices that leveled charges of vitalism against the 2004 papal allocution, maintaining communion with seriously debilitated patients through the provision of effective and non-burdensome ANH, constitutes an essential Catholic stance in favor of human life. Or as one commentator quoted: “In these circumstances continued feeding [of PVS patients] is wise because it effectively blocks the temptation society may have solely to aim at the death of patients whose ‘biological tenacity’ has become inconvenient and troublesome.”

**ANH and the Ordinary Means of Conserving Life**

In the midst of the general furor caused by the 2004 papal allocution, the one factor that hands-down generated the greatest reaction was the Holy Father’s emphasis on the nature of ANH. He stated that ANH “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.” Critics of the statement considered it bad enough that the pope would, contrary to the universally accepted medical and legal designation, classify ANH as an aspect of basic care instead of a medical act. On the other hand, because every major secular American medical organizations and the Supreme Court of the United States considered ANH to be a medical act, the Pope’s claim was

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242 Br. Adam Hildebrand commented, “If I imagine myself as someone in a ‘persistent vegetative state’ lying in a bed near an open window, with a breeze gently blowing across my face, and a beloved family member, or a caring nurse, caresses my hand and wipes my brow, even should I be completely unable to respond or to express myself in any way, and even if I am in a state where I do not ‘know’ if someone is present, I would still be present. I would still be alive, still be human, and still be ‘being.’” In: Br. Adam J. Hildebrand, Ph.D., “On ‘Vegetative’ Human Beings,” at 1. See also: John F. Kavanaugh, S.J., “Brainism,” *America*, 193(4), August 15-22, 2005, 8; and Rev. Msgr. Kevin T. McMahon, “Nutrition and Hydration: Should They Be Considered Medical Therapy?” at 231-232.


244 Pope John Paul II, “Life-Sustaining Treatments and the Vegetative State,” at 4 § 3.
considered to be little more than an irritant.\textsuperscript{245} By contrast, however, the Holy Father’s claim that ANH should be considered in principle and ordinary means of conserving life, however, was a bombshell, and it shook certain elements of the Catholic moral arena to the core. Faced with a potentially weighty theological document on a notoriously thorny moral problem, the response of the document’s critics was three-fold: 1) to endlessly mull over the possible meanings of the 2004 allocution, 2) to question or even deny the moral authority of the message, and 3) to discredit the message. This issue and some of the responses to it will be addressed here in the final part of this section.

The first response critical to the claim that in principle, ANH should be considered an ordinary and proportionate means of conserving life was to express grave uncertainties regarding the meaning of the Holy Father’s claim. Theologians thus engaged in such a dizzying series of speculations regarding the possible implications and application of the Holy Father’s message that any solid conclusions on the subject were ultimately avoided. Since its promulgation, numerous theologians have wrestled with the meaning of operative phrases like, “in principle,” or “proper finality” to determine both its adherence to the Catholic moral tradition, and specifically, the degree to which Catholics were bound to abide by its conclusions.\textsuperscript{246} Offering little more than a series of “if – then” statements (e.g., “if the pope meant this, then…” the seemingly never-ending rehashing of the document served, not to shed light on the Holy Father’s intent regarding the level of care owed to patients in the PVS, but to further obscure it. Overall, the outcome of this response to the Holy Father’s conclusion regarding the nature of ANH established among Catholic theologians a “wait-and-see” mentality that anticipated further authoritative clarification on the subject before any solid recommendations would be made.\textsuperscript{247} For various reasons, others basically dismissed the Holy Father’s


\textsuperscript{247}Rev. Michael Place, “Nutrition, Hydration and the ‘Persistent Vegetative State,” at 21. Father Place asserted that only an intervention from the Congregation for the Doctrine of
conclusion and clung even more tightly to their own determination regarding the ordinary or obligatory nature of ANH for patients in the PVS. 248

The second critical response to the 2004 allocution involved not merely an attack on the Holy Father’s statement about ANH, but a serious challenge to the document’s entire moral authority. 249 On a most basic level, theologians on both sides of the debate concurred that the Holy Father’s conclusions did not absolutely define the moral obligations regarding the care of persistently unconscious patients. 250 Outside of that small measure of common agreement, however, the moral weight attributed to the allocution by theologians critical to the document ranged from statements of vague uncertainty to a complete rejection of any authoritative significance. A frequent contention of O’Rourke, and similarly minded theologians, asserted that a mere papal allocution was an unlikely vehicle upon which to deliver a definitive moral teaching on the level of care owed to patients in the PVS. Ultimately he argued that, “[t]he statement in question was an allocution, the lowest level of papal teaching, and has not been repeated in the Faith or other high authority could properly resolve the debate. See also: Nancy Guilfoy Valko, R.N., “ A Study in Contrasts: The Deaths of Pope John Paul II and Terri Schiavo.” at 1. Ms. Valko cited a Catholic Health Association memo claiming confusion regarding the 2004 allocution and recommending keeping the status quo until clarification was forthcoming. Germain Kopaczynski concurred saying, “There is a common theme sounded in many press accounts of the Catholic reaction to the pope’s allocution, to wit, no action will be taken, no changes to current practices will take place until those who administer Catholic health-care facilities receive instructions on how to interpret the allocution.” In: Germain Kopaczynski, “Initial Reaction to the Pope’s March 20, 2004 Allocution,” at 479. 248


Joe Feuerherd, “Schiavo Case Highlights Divisions in Catholic Views on Treatment,” National Catholic Reporter, 41(22), April 1, 2005, 6. Mr. Feuerherd commented that, “In the year since he uttered those words, John Paul II’s language has been parsed (‘in principle,’ ‘insofar as and until’) and his intent questioned. Was he speaking authoritatively?” 250

See: Gregory Di Cresce, “In Schiavo’s Shadow,” at 8. Here, Father O’Rourke contends that the 2004 allocution was not an infallible teaching. Similarly, Rev. Norman Ford stated: “His address would have the same moral standing as comparable speeches of Pope Pius XII on bioethics in the 1950s. Father Maurizio Faggioni, O.F.M., a theological expert on life issues and a consultor to the Vatican’s Congregation for the Doctrine of the Faith, said this teaching is ‘authoritative without being definitive.’” In: Rev. Norman M. Ford, S.D.B., S.T.L., Ph.D., “Thoughts on the Papal Address and MANH,” Ethics & Medics, 30(2), February 2005, 3.
the two years since it was issued.”

Others including John J. Paris, S.J., absolutely refused to acknowledge that the pope’s statement contained any authoritative weight whatsoever. Paris basically claimed that, far from being a serious contribution to the body of theological debate on the issue, the 2004 papal allocution was actually nothing more than an occasion speech that the pope used to pander to pro-life physicians and the other conservative Catholics who attended the 2004 International Congress. Unsurprisingly, critics of the papal allocution found numerous reasons to diminish the moral authority of the document. Upon further reflection, however, while hindsight clearly shows that the allocution did not accomplish the task of clarifying and unifying Catholic moral thought on this issue, given the degree of animosity for the pope’s position, one could begin to wonder what level of doctrinal weight would have made a difference.

The third response critical of the Holy Father’s assertion concerning ANH was by far both the most controversial, and the greatest source of confusion for those hoping to grasp the Church’s teaching on this issue. Stated concisely, critics claimed that the Holy Father’s conclusion regarding ANH delivery to patients in the PVS was such a significant departure from the Church’s centuries-year-old moral tradition that it completely changed the basis for determining the moral obligation to preserve one’s life in a

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252 Brian Braiker, “A Jesuit Bioethicist on Schiavo’s Right to Die,” at 1. Father Paris ultimately claimed that the driving force behind the 2004 allocution was not Pope John Paul II at all, but, Bishop Elio Sgreccia, the head of the Pontifical Academy for Life. In his statement Father Paris suggested that somehow Bishop Sgreccia was able to get the pope to deliver the speech and then draw everyone’s attention to the fact that the pope said it. See: Jim DeFede, “Priest Disputes Governor’s Role in Schiavo Case,” at 1. Here O’Rourke opined that, “I know it is wrapped up in the pro-life, antiabortion activity...” See also: Thomas A. Shannon and James J. Walter, “Assisted Nutrition and Hydration and the Catholic Tradition,” at 661.

given circumstance. They argued that the recent revision of the Catholic moral tradition embodied by the 2004 allocution severely restricted the individual’s right to direct the course of his own medical treatment. And further, that the revision would make the duty to preserve his life far too rigorous, and in the extreme, even an idolatry of biological existence.

At the heart, they charged that by declaring ANH to be, in principle, an ordinary and proportionate means of conserving life, the Holy Father had circumvented the patient’s right to personally assess the benefits and burdens of medical care, to state his own treatment preferences, and to direct his own health care. Drawing from Directives #32, #56 and #57 of the ERD, opponents of the allocation rested their opposition on the Church’s traditional teaching which stated that the benefit or burden of a particular treatment could only be assessed by the patient; e.g., what might appear to be beneficial to one person could seem excessively difficult and burdensome to another. Thus, in their estimation, Pope John Paul II’s conclusion regarding the delivery of ANH for patients in the PVS was in error because it objectified the “benefit” of ANH apart from the subjective judgment of the individual patient. In essence they argued that however well intentioned they believed the Pope’s allocation to be, his interpretation ultimately neglected the will of the patient in favor of a narrow principle protecting the good of physiological life. Although other commentators, e.g., Ronald Hamel and Michael Panicola, offered an alternative.

Shannon and Walter claim that the 2004 allocution contains a methodological shift away from the individual patient’s right to assess a particular form of medical care to a deontological approach that gives moral principles the greatest weight in determining a medical decision. They argue that: “Since the early- to mid-1980s, though, a revisionist position has been emerging in the statements from the pope, Pontifical Academies, Commissions, and Committees that radically change the methodology. These statements categorize interventions and stipulate obligations. The method shifts from proportionality of effects on the patient (teleology) to deontology.” See: Thomas A. Shannon and James J. Walter, “Assisted Nutrition and Hydration and the Catholic Tradition,” at 655 and 661.


Thomas A. Shannon and James J. Walter, “Assisted Nutrition and Hydration and the Catholic Tradition,” at 655. Here, Shannon and Walter offer their interpretation of the crux of the 2004 allocution: “[t]he person’s medical condition is not really relevant in making a determination about the use of feeding tubes, except if the body cannot assimilate the fluids or the intervention does not alleviate the suffering of the patient, because the food and water delivered through such tubes is ordinary care and provides a benefit.” See also: Kevin D. O’Rourke, O.P., “The Catholic Tradition on Forgoing Life Support,” at 546.
interpretation (that if correct), partially diminished the indictment against the Holy Father’s classification of ANH, they nonetheless could not help but leave the impression that in the long-run, his narrow analysis of the Catholic moral tradition might cause more harm than good.

On the opposite side of the spectrum, the Holy Father’s clarification of, and emphasis upon, the nature of ANH gelled much more easily with the perspective of other moral theologians, in part, because it was consistent with their own reasoned views on the application of the Catholic moral tradition to the care of patients in the PVS. Unlike their counterparts who received the allocution warily, the document’s supporters regarded the Holy Father’s statement as a clear reaffirmation of the value of human life (even one marked by persistent unconsciousness), as well as an authoritative recognition of the benefit offered by ANH in sustaining the fundamental good of human life. Thus in contrast to the document’s critics who questioned its moral authority, supporters of the allocution believed it to possess significant moral weight and to contain recommendations that should be seriously and prayerfully considered. Because this group

257 Hamel and Panicola speculated that, “an alterative reading is also possible. Although the pope definitely narrows traditional teaching by claiming that nutrition and hydration are ordinary, apart from relative factors, he does not radically and completely depart from traditional understanding or his own previous teachings by making their use an absolute requirement with no exceptions.” In: Ronald Hamel and Michael Panicola, “Must We Preserve Life?” at 12.

258 Ibid., at 13. They argued: “Undoubtedly, forgoing life-sustaining treatment, including artificial nutrition and hydration, can be abused. It can take the form of euthanasia. The possibility that this will happen is perhaps greater than ever today with physician-assisted suicide (PAS) gaining wider support and our collective appreciation for life eroding. But we must all carefully consider whether a narrow revision and application of the tradition is the most effective response to this threat. Instead of limiting abuse, such a narrowing could have the opposite effect.”

259 One theologian speculated that the reason why the 2004 allocution was received so poorly in certain theological circles was because they had already declared themselves in favor of withdrawing ANH from patients in the PVS, and as a result, found it difficult to recant their position. In: Br. Adam J. Hildebrand, “On ‘Vegetative’ Human Beings,” at 1.

260 Tom Harmon, “Ethicists Go Against Pope on Feeding-Tube Removal,” Our Sunday Visitor, 93(18), August 29, 2004, 3. Similarly, Dr. Eugene Diamond remarked that, “[t]he statement by Pope John Paul II was not a throw-away line. It was delivered solemnly at the end of the convention in the Papal Audience Chamber. As a delegate to the convention it was clear to me that the Pope was addressing one of the most important issues of the convention as the meeting closed.” In: Eugene F. Diamond, M.D., “Catholic Medical Reflection,” Catholic Medical Association, (newsletter), July 2005, at 6.
generally accepted and welcomed the papal clarification on the provision of ANH to patients in the PVS, from the outset they found themselves defending it against the sudden and often heated reactions opposed to it.

Like their counterparts, supporters based their moral assessment of ANH delivery on Catholic moral principle that governed the balance between an appropriate respect for the good of a person’s earthly life, and an acknowledgment of his ultimate destiny. Despite the clear distinction between these two goods, the distressing circumstances embodied by patients in the PVS made the proper balance between the two difficult to determine for some. A fixation upon the “low quality of life” possessed by patients in the PVS caused many to conclude that patients so afflicted would be better off dead. Beyond the surface, however, supporters recognized in such patients a seriously injured person who required, as any sick person would, some measure of care and assistance. Far from being a vitalistic worship of biological life or a practical lack of faith in life after death, the decision to provide nourishment to patients in the PVS focused on basic moral questions intended to ascertain its morally obligatory or optional status: “Is the patient, regardless of intervention, imminently dying?” “Will ANH sustain the life of this particular patient without undue burden, inconvenience, or expense?” Contrary to the opinion of some critics who argued that patients in the PVS suffered from a fatal pathology, supporters of the allocution concluded that such patients were not imminently dying and that ANH delivery would sustain their lives without undue burden, inconvenience or expense.

261 Joseph Torchia, O.P., Artificial Hydration and Nutrition and the PVS Patient,” at 724. Theologians from both sides of the debate acknowledged the principle of the Catholic moral tradition that human life constitutes a fundamental good of the person, but not an absolute good that must be preserved at all costs.

262 O’Rourke remarked that “solidarity (charity) is better demonstrated through prayers for the dead than it is by prolonging life that does not benefit the patient.” In: Kevin D. O’Rourke, O.P., “Artificial Nutrition and Hydration and the Catholic Tradition,” at 52.

263 Ibid., at 719. Torchia remarked: “The problematic nature of this issue proceeds from the fact that the PVS patient provides the paradigmatic example of human life reduced to its most basic constituents. The phenomenon of PVS…prompts us to assess the clinical situation on the basis of the patient’s very humanity, rather than upon considerations of what he or she is capable of doing or expressing.” See also: William E. May, Catholic Bioethics and the Gift of Human Life, at 268.

264 The view that persons in the PVS are not considered dying patients is supported by the conclusions of respected medical professionals. In 1989 the American Academy of
quality of life speculations or dire pronouncements of a “fate worse than death,” supporters simply conducted a straight-forward assessment the benefits and burdens of ANH in relation to the condition of patients in the PVS. Since for decades ANH has proved to be an effective, relatively painless, and only marginally costly life-sustaining measure for patients unable to nourish themselves, supporters discerned no moral reason to deny it to patients in the PVS. Thus, it was because the Catholic tradition was followed and not circumvented that supporters of the allocution agreed with the Holy Father that the provision of ANH generally constituted an ordinary means of conserving life that, consequently, was owed to such patients as long as they could assimilate the nutrients supplied them.

Critics countered with the argument that, although ANH itself might not be cost prohibitive, the total burdens associated with maintaining the life of persistently unconscious patients made the provision of ANH an extraordinary means of conserving life;265 others disputed this claim. Peter Cataldo responded that the Catholic moral tradition did not primarily base the ordinary or extraordinary nature of a particular treatment or form of care upon the broad context of a patient’s total condition. Instead, he continued, the extraordinary/optional nature of a particular means was grounded upon the acute factors that directly affected the patient’s life, e.g., poor physical condition, excessive pain, intense horror, insufficient finances or imminent death.266 It was these factors and not an extensive account of the burdens

Neurology explicitly stated that patients in the PVS were not terminally ill. Similarly, the 1994 MSTF document on the PVS devoted a significant amount of space to discuss the possibilities of survival and recovery from the PVS. It is doubtful that such a discussion would be devoted to a group of patients that the major medical organizations considered imminently dying. 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 (1989) 125; and MSTF, “Medical Aspects of the Persistent Vegetative State,” The New England Journal of Medicine, 330(22), June 2, 1994, 1572-1579.

265Kevin O’Rourke argued that the financial burden of maintaining life in the PVS went well beyond the price of plastic tubing and a couple of cans of Ensure. To further his point, he also raised the question of the burdens assumed by the family of a seriously debilitated patient, as well as the burden thrust upon society itself. In: Kevin D. O’Rourke, O.P., J.C.D., S.T.M., “The Catholic Tradition on Forgoing Life Support,” at 546-547, 552-553.

266Peter Cataldo, “Pope John Paul II on Nutrition and Hydration,” at 526-527. This idea is also raised in the 1992 NCCB Committee for Pro-Life Activities document “Nutrition and Hydration: Moral and Pastoral Reflections.” At the end of question #4 the Committee stated: “In the context of official church teaching, it is not yet clear to what extent we may
associated with the patient’s overall situation that traditionally determined the extraordinary status of a given treatment or aspect of care. As a result, a correct moral assessment of ANH could only be achieved through a dispassionate examination of the benefits or burdens that it offered to a particular patient, not through a compilation of the total burdens associated with continued existence. Further, others contended that the attempt to avoid the total burdens of patient care by denying food and fluids was in itself a fatally flawed argument. Because the expense associated with caring for a patient in the PVS could only be relieved by the patient’s death and not by the simple removal of ANH, the death of the patient and not the cessation of ANH became the true cost-saver. In this case, the intention to spare the expense of caring for a seriously debilitated loved one by removing ANH could only be achieved by an act that inevitably involved the death of the patient.

Tangential to the classification of ANH as, in principle, an ordinary and proportionate means of conserving life, lay the subject of patient autonomy and its role in the decision making process. From the broad perspective of Catholic principles, theologians on both sides of the debate rested on common ground. Both recognized the application of Catholic morality that assess the burden of a patient’s total care rather than the burden of a particular treatment when we seek to refuse ‘burdensome’ life support. On a practical level, those seeking to make good decisions might assure themselves of their own intentions by asking: Does my decision aim at relieving the patient of a particularly grave burden imposed by medically assisted nutrition and hydration? Or does it aim to avoid the total burden of caring for the patient? If so, does it achieve this aim by deliberately bringing about his or her death?"

Neither the Holy Father, nor supporters of the 2004 allocution blithely dismissed the total burdens of care incurred by caregivers of patients in the PVS. In section 6 of the allocution he directed society, the Church, etc… to support families who care for such seriously debilitated loved ones. In addition he directed society to provide sufficient means to care for such patients and to assist in their recovery. In: Pope John Paul II, “Life-Sustaining Treatments and Vegetative State,” at 6. See also: William E. May, Catholic Bioethics and the Gift of Human Life, at 269-270.

William E. May, Catholic Bioethics and the Gift of Human Life, at 268. May further argued that since our affluent society assists other persons with serious disabilities, it would be a discriminatory practice to exclude patients in the PVS from receiving their fair share. See: William E. May, Tube Feeding and the ‘Vegetative State,’ Ethics & Medics, 24(1), January 1999, 4.

Pope John Paul II, “Life-Sustaining Treatments and Vegetative State,” at 5 § 2. Here, the Holy Father strongly contended that an evaluation of costs could not outweigh the fundamental good of a person’s life.
a proper respect for the dignity of the person necessarily included a right to accept or refuse proposed medical treatments. In theory, both acknowledged the Church’s teaching stated in Directive #32 of the ERD that patients were bound to employ all ordinary means to preserve their lives, but no one could be forced to accept a treatment that they judged to entail excessive risks or burdens. In practice, however, differences in interpretation and application resulted in serious divisions among Catholic theologians that were more clearly revealed by the 2004 allocution.

Critics of the allocution charged that the Holy Father had circumvented the individual’s right to gauge ANH as a treatment option in the event of persistent unconsciousness when he declared that ANH should be considered, in principle, an ordinary and proportionate means of conserving life. Consequently, many likewise argued that the Holy Father had endorsed an extreme view of the level of care owed to seriously debilitated patients that significantly changed the Catholic moral tradition regarding the ordinary and extraordinary means of conserving life.270 For critics, the patient’s right to refuse a treatment he judged to be excessively burdensome was of paramount importance to the decision making process. For example, an often raised rhetorical question asked: “Would you tell your loved ones to continue keeping you alive in this fashion?”271 The heavily implied response to this question of course was “Definitely not, I wouldn’t want to live like that!” or “No, I wouldn’t want to burden my family.” The deeper and more serious implication, however, was the underlying assertion that, because I have concluded that I wouldn’t want to live in such a fashion, I possess the undisputed right to refuse any measure sustaining my life. In a similar emotionally charged manner another commentator argued:

Let me give you a test that I’ve done 100 times to audiences. And I guarantee you can do the same thing. Go and find the first 12 people you meet and say to them, “If you were to suffer a cerebral aneurysm, and we were able to diagnose with a PET-scan immediately, would you want to be put on a feeding tube, knowing that you can be sustained in existence?” I have asked that question in medical audiences, legal audiences, and audiences of judges. I’ll bet I have put that question before

271Jim DeFede, “Priest Disputes Governor’s Role in Schiavo Case,” at 1.
several thousand people. How many people do you think have said they wanted to be maintained that way? Zero. Not one person.272

From this perspective it appeared that the most crucial factor needed to ascertain the morally optional nature of a particular form of care was the answer to the question “What does the person want?” Even contributors to the events surrounding Terri Schiavo’s life and death regularly lamented the fact that she had left behind no indisputable indication of her desire to refuse life-sustaining ANH before she collapsed and ultimately descended into the PVS. Further, playing upon a person’s natural fears of serious disability and dependence, a decision to refuse life-sustaining ANH was almost a foregone conclusion.273 Whether in theory or in practice, this argument basically assumes that the supreme authority regarding the decision to refuse ANH in the event of PVS is the patient’s will. In effect, rather than constituting one important factor in the decision making process, the fruit of the patient’s will seemed to be an absolute moral trump that must be accepted at face value and carried out accordingly. In terms of a surrogate decision maker’s request to remove the ANH sustaining the life of a persistently unconscious loved one, (e.g., the Schiavo situation) or an individual’s unequivocal refusal to accept ANH on a written advance directive, this argument appears to profess that such wishes be honored without question.274

Conversely, supporters of the allocution steered a more cautious approach that more closely adhered to the Catholic moral tradition. On the one hand, while they did not question a person’s right to direct his own

272 Andrew Leonard, “This Has Nothing to Do with the Sanctity of Life,” at 3.
273 Some authors question whether or not a person can actually make a fair assessment of the burdens and treatment preferences associated with a future disability from a current condition of health. In this vein Cohen and Kass remarked, “[b]ut he is assuredly mistaken in believing that he can control every detail of his own future care with a voice from the past – or that he can rightly assess the worth of a diminished future life from the height of his own flourishing.” In: Eric Cohen and Leon Kass, “Cast Me Not Off in Old Age,” Commentary, 121(1), January 2006, 35.
274 Based upon their insistence that patients in the PVS possess no cognitive-affective capacity and, consequently, do not have to be provided with ANH in order to sustain their lives, one could ask whether O’Rourke’s and his colleagues would demonstrate the same insistence on respecting the wishes of the patient who desired ANH provision in the event of persistent unconsciousness that they do for those who refuse it?
health care preferences, they also never forgot that within the bounds of the Catholic moral tradition, patient autonomy was never considered to be an unlimited right. Unlike the critics of the allocution who appeared to focus exclusively on the patient’s right to refuse a treatment he deemed to be an extraordinary means of conserving life, the understanding of its supporters was tempered by the patient’s obligation to employ all ordinary means to preserve his life. When considering the circumstances of patients in the PVS, the question that primarily governed their assessment of the obligatory or optional nature of ANH was not, “What do I want?” but rather, “Does this proposed treatment offer me a reasonable hope of benefit without causing me excessive burden, inconvenience or cost?” From this perspective, a decision to forego ANH in the event of unconsciousness involved a serious deliberative process that was much more reflective and based upon the advantages and disadvantages of the treatment than a simple emotion-driven reaction to be taken at face value. In addition, this deliberative process also helped a person distinguish a suicidal decision to forego a treatment in order to end a debilitated life from a decision to refuse a useless treatment or burdensome prolongation of life.\footnote{William E. May, \textit{Catholic Bioethics and the Gift of Human Life}, at 270.}

By contrast, the almost unquestioned acceptance a decision to refuse life-sustaining ANH in the event of persistent unconsciousness represents a puzzling response to a culture that already idolizes control and abhors any form of dependence. It also appears to grant far greater weight to a person’s unfettered choice to refuse ANH than it does a rational assessment of the benefits and burdens it offers to patients in the PVS. At the bottom line, the vocal insistence of some commentators to automatically acquiesce to a person’s desires to reject ANH in the event of persistent unconsciousness appears to over-step the guiding parameters of the Catholic moral tradition largely because it practically recognizes few if any limits to patient self-determination.\footnote{Nancy Valko stated, “Like many people, these patients and families have bought the ‘right to die’ myth that ‘I wouldn’t want to live like that!’ is a compassionate and logical rationale for deliberately terminating lives including their own….While there is the traditional ethical principle that a person can ethically refuse treatment that is futile or excessively burdensome, the definitions of futile and burdensome have been redefined by many ethicists over the past few decades in an attempt to justify withdrawal of basic medical care.” In: Nancy Guilfoy Valko, R.N., “A Study in Contrasts,” at 3. Similarly, Dr.} In this regard, it is possible to question where the true shift in the Catholic moral tradition lies.
Conclusion

Even though the decision to provide or withdraw ANH from patients in the PVS continues to divide many in the Catholic arena, the 2004 papal allocution was a positive contribution to the debate for several reasons. First, the document served to clarify earlier American hierarchical and Vatican statements on the level of care owed to patients in the PVS.\textsuperscript{277} For decades a common, but ambiguous health care directive recommended a presumption in favor of providing ANH for all patients who could benefit from its use. While various documents and letters promulgated by the U.S. bishops and the Vatican attempted to affirm and shed light on the presumption in favor of ANH, in practice, however, it appeared that the opposite presumption had actually prevailed.\textsuperscript{278} In this instance, the 2004 allocution, while not establishing an absolute obligation to provide ANH to patients in the PVS, did more robustly insist upon the provision of ANH as a general rule for all seriously debilitated patients.\textsuperscript{279} Despite questions that remain over the Holy Father’s decision to use the vehicle of a papal allocution to deliver such an important message, his statement does represent the reasoned conclusions of the Church’s most authoritative figure on the level of care owed to patients in the PVS.

The second positive contribution of the allocution centered upon the Holy Father’s recognition of humanity of patients in the PVS and his acknowledgment of their inherent dignity even when marked by serious debility. Notable in this regard was his strong disapproval of the term

\textsuperscript{277}Janet Smith commented: “There is such a desire for autonomy that the value of life is being obscured. Life is a more important legal right than autonomy.” In: Tom Harmon, “Ethicists Go Against Pope on Feeding-Tube Removal,” at 3.
\textsuperscript{278}One commentator remarked, “His teaching then, was completely consistent with prior Magisterial documents when examined in detail, in context and in totality. The 2004 Papal teaching specifically addressed the issue of PVS and the moral necessity of providing sustenance as a part of basic supportive and humane care, not extraordinary medical intervention. In so doing, Pope John Paul II was removing all doubt about the way in which to properly interpret magisterial documents/teaching.” See J.P. Hubert, M.D., “Fr. Richard McBrien and Others Mislead Catholic Public,” at 3.
\textsuperscript{279}Lisa Sowle Cahill stated that “pluralism persists both in moral-theological interpretation and – equally if not more importantly – in health care practice, where one even finds a practical bias toward allowing ANH to be declined as not in the best interests of certain patients. See: Lisa Sowle Cahill, “Bioethics,” at 131.
“vegetative” to describe patients suffering from persistent unconsciousness and his insistence that such patients will always be human beings and never become a vegetable or an animal. More important, however, was the Holy Father’s insistence that certain individuals (e.g., health care professionals, family etc…), society, and the Church have a duty towards such patients, even to the point of providing basic health care, rehabilitative measures, and effective monitoring for clinical signs of recovery. In the opinion of this contributor, such a response is more consistent with the Church’s moral tradition because it clearly acknowledges the dignity of the human person and the good of human life, while at the same time backing it up with a concrete action in favor of that life. In the final analysis, even though the good intentions of the allocution’s critics are undeniable, the position that favors the withdrawal of ANH seems less focused upon benefiting the patient’s life than it does engineering an acceptable reason to allow a life with low quality to depart.

Finally, the allocution served to reaffirm the proper relationship between the patient’s right to refuse unwanted treatments and the principles of the Catholic moral tradition. In the 2004 allocution, Pope John Paul II did not classify ANH as an ordinary means of conserving life without exception, nor did its supporters interpret his conclusion in such a manner.\textsuperscript{280} Supporters of the allocution agreed that the classification of ANH as, in principle, an ordinary and proportionate means of conserving life was not indifferent to the relative aspects of the individual patient’s medical condition, nor was it closed to a patient’s right to make legitimate treatment preferences.\textsuperscript{281} On the other hand, the message of the allocution firmly upheld the Church’s consistent teaching that not every self-determined choice to forego ANH in the event of persistent unconsciousness necessarily constituted a morally correct one. Personal wishes aside, the Catholic moral tradition has always taught that no one has the right to knowingly and willingly forego an ordinary means of conserving life and


\textsuperscript{281} Rev. Ford commented, “The Pope’s teaching applies in principle, but doctors and healthcare providers still need to make clinical assessments to correctly determine when patients are being truly nourished and their sufferings alleviated, or when complications or other medical counter-indications arise.” In: Rev. Norman M. Ford, “Thoughts on the Papal Address and MANH,” at 4.
still remain engaged in a moral act. Rather, it taught that personal treatment preferences must always be considered within the moral parameters of that tradition. Thus, at a time when a patient’s right to refuse life-sustaining treatments has started to heavily overshadow any other consideration, and the refusal of life-sustaining treatments has increasingly evolved into the default position for anyone considering life with disabilities, the Holy Father’s reaffirmation of the proper relationship between patient autonomy and the moral parameters within which that right can be exercised was a vital contribution to the debate.

282 Joseph Torchia, O.P remarked that advance directives focus too heavily upon one’s right to refuse life-sustaining treatment with a corresponding neglect of alternative options. See: Joseph Torchia, O.P., “Artificial Nutrition and Hydration for the PVS Patient,” at 728.