

ASSISTED NUTRITION AND HYDRATION AND THE CATHOLIC TRADITION

THOMAS A. SHANNON AND JAMES J. WALTER

[Whether or not it is morally permissible to discontinue artificial nutrition and hydration in severely brain-damaged patients was hotly debated this year in the case of Terri Schiavo. Our article focuses on how the Catholic tradition has addressed this kind of dilemma over the last 25 years. It recognizes four unacknowledged shifts concerned with: (1) the method of reasoning about our moral obligations; (2) the general context of construing our obligations to seek medical interventions; (3) the presumption to use artificial nutrition and hydration (ANH); and (4) our normative obligation to use ANH.]

THE TERRI SCHIAVO CASE in Florida focused attention on a variety of issues related to the end of life: who is the decision maker, the status of advanced directives, the role of family members with respect to married adult children, and issues related to the removal of life support systems, particularly assisted nutrition and hydration. Terri Schiavo is now linked to two other young women who played a critical role in helping us to think through ethical issues at the end of life. Karen Ann Quinlan and her family raised the issue of the removal of a ventilator. In her case the physicians were reluctant to do this because they feared legal repercussions. The legal and ethical analysis concurred that such removal was justified because it constituted extraordinary means of treatment. Nancy Cruzan and her family focused attention on the removal of artificial nutrition and hydration

THOMAS A. SHANNON received his Ph.D. from Boston University. He is now Professor Emeritus of Religion and Social Ethics in the Department of Humanities and Arts, Worcester Polytechnic Institute, Worcester, Mass. In the last seven years he has published seven books on various aspects of Christian ethics, including *Health Care Policy* (Sheed and Ward, 2004) and *Genetics: Science, Ethics, and Public Policy* (Sheed and Ward, 2005). Together with James Walter he is currently completing *Contemporary Issues in Bioethics: A Catholic Perspective* (Sheed and Ward, 2005).

JAMES J. WALTER received his Ph.D. from the Katholieke Universiteit, Leuven. He is the Austin and Ann O'Malley Professor of Bioethics, and chair of the Bioethics Institute, Loyola Marymount University, Los Angeles. He has published widely in the field of bioethics. Besides his collaborative volume with Thomas Shannon in preparation, he has prepared a study on the "Consistent Ethic of Life" in a volume under that title edited by Thomas Nairn (Sheed and Ward, 2006).

(ANH). Again law and ethics concurred that such removal was justified, particularly because people testified that being maintained in such circumstances were not her wishes.

On February 25, 1990, Terri Schiavo had suffered a heart attack, possibly brought on as a result of chemical imbalances from an eating disorder. She suffered loss of oxygen to her brain and was eventually diagnosed as being in a persistent vegetative state. A decade later, in February 2000, her husband Michael Schiavo requested that her feeding tube be removed. The Circuit Court judge agreed and this set off a lengthy appeal and counter-appeal process, including attempted legislative initiatives from the state of Florida and the United States Congress and 37 court reviews, that was complicated by increasing family acrimony and public commentary from a variety of sources: religious, political, ethical, and legal. After a five-year legal battle, the feeding tube was removed, and Terri Schiavo died on March 31, 2005, at the age of 41.

A critical element in the debate was the ethics of the use of feeding tubes for patients in a persistent vegetative state. Several bishops, particularly in light of the papal allocation on feeding tubes in March 2004, argued that their use was morally obligatory. Thus Bishop Vaga of Baker, Oregon: "She may well die in the future from an inability to digest food but it would be murder to cause her death by denying her the food she still has the ability to digest and which continues to provide for her a definite benefit—life itself."¹ That sentiment was echoed by Representative Thomas DeLay of Texas who said: "That act of barbarism can be and must be prevented."² A comment on the ethical issue underlying the provision of ANH was offered by Bishop Loverde of Arlington, Virginia, who said: "If Mrs. Schiavo were facing imminent death, or were unable to receive food and water without harm, then removing nutrition and hydration would be morally permissible. It is however never permissible to remove food and water to *cause* death. Food and water are basic human needs, and therefore basic human rights."³ And Richard Doerflinger of the United States Catholic Conference of Bishops was reported to have articulated the normative nature of this position in an interview with the *Washington Post*:

Before the pope made his statement about feeding-tube cases at a conference last year there was enough uncertainty about the church's position that Catholics could

¹ <http://www.catholicmediacoalition.org/bishops%20on%20terri.htm#BishopVasa> (accessed April 15, 2005).

² <http://www.cnsnews.com/ViewPolitics.asp?Page=%5CPolitics%5Carchive%5C200503%5CPOL20050318c.html> (accessed April 15, 2005).

³ <http://www.catholicmediacoalition.org/bishops%20on%20terri.htm>. Emphasis in the original.

remove feeding tubes without fear of committing a sin. No one could fairly have said to you that you were dissenting from clear Catholic teaching. Now you would have to say, "Yes, you are."⁴

The issue on which we focus in this note is the state of the question in the Catholic tradition regarding the use of assisted nutrition and hydration, an issue that became central in the media and in public debate.

Our position is that there have been four unacknowledged shifts within the last 25 years from the traditional method of analyzing our moral obligations during illness and the dying process. The first of these is a shift in the very method itself: from proportionate reasoning as in the "Declaration on Euthanasia" from the Congregation for the Doctrine of the Faith in 1980 to a deontological reasoning as in the March 2004 papal allocution "Care for Patients in a 'Permanent' Vegetative State." Second, there is a shift in applying the ordinary-extraordinary distinction from the general context of obligations to oneself while ill to restricting the application to the context of imminent dying. Third, there has been a shift from making a determination of whether or not to use an intervention such as chemotherapy or assisted nutrition and hydration to a presumption in favor of using such interventions. Finally, following John Paul II's allocution, there is a shift from a presumption to use to an obligation to use. Thus, in a series of statements from various ecclesial commissions and magisterial authorities, the tradition has been moved recently from both a patient-centered focus and obligations determined through the use of proportionate reason to a technology and intervention-centered focus with obligations being determined by deontological principles. We call this more recent position the revisionist position.

THE DEVELOPMENT OF THE REVISIONIST POSITION

Methodological Shift

Many moral theologians argue that there are two different ethical methodologies operating in Roman Catholicism. The first is deontological or a principle-based ethic and is used primarily in the areas of sexual morality and in medical morality where sexual morality is the content, e.g., assisted reproduction. The resolutions of ethical issues are deducted from the principles and there are no exceptions to the principles and no parity of matter in sexual issues. The principles bind absolutely and are not qualified by circumstances. The other method is the one used in the area of social justice, for example in the analysis of the morality of war or economic

⁴ Manuel Roig-Franzia, "Catholic Stance on Tube-Feeding Is Evolving," *Washington Post*, March 27, 2005.

policy. This method, used in the two pastoral letters of the United States bishops *The Challenge of Peace* in 1983 and *Economic Justice for All* in 1986, includes scriptural and philosophical perspectives, empirical analysis, expert testimony, and an examination of a variety of contexts and circumstances. The conclusions drawn are recognized to be provisional in that new data can reshape the conclusion, and there is a recognition that one can come to different conclusions that are in harmony with one's starting principles.

Historically, the method of analysis of issues related to end-of-life issues has mostly utilized the second method. This ethic has traditionally been patient-centered and focused on an evaluation of benefits and burdens or on whether the intervention was proportionate or disproportionate. This is the method of, for example, the 1980 "Declaration on Euthanasia" from the Congregation for the Doctrine of the Faith.

First the Congregation notes that it "pertains to the conscience either of the sick person, or of those qualified to speak in the sick person's name, or of the doctors, to decide, in the light of moral obligation and of the various aspects of the case" (IV). The "Declaration" says that the patient can make a correct decision about whether a treatment is proportionate or disproportionate by "studying the type of treatment to be used, its degree of complexity or risk, its cost and the possibilities of using it, and comparing these elements with the result that can be expected, taking into account the state of the sick person and his or her physical and moral resources." (IV). Finally, the "Declaration" notes that one can refuse treatments based on a "desire not to impose excessive expense on the family or the community" (IV).

This position is essentially supported by the Pontifical Council Cor Unum when it says:

The fundamental point is that the decision should be made according to rational arguments that have taken well into account the many and various aspects of the situation, including what effect will be had upon the family. The principle to follow is, therefore, that no moral obligation to have recourse to extraordinary measures exists; and that, incidentally, a doctor must follow the wishes of a sick person who refuses such measures.⁵

The "Declaration on Euthanasia" is a clear and articulate summary of the moral teaching of the Catholic Church on end-of-life issues from about the 16th century to the present. Many of these teaching are summarized in the doctoral dissertation by now Bishop Daniel Cronin.⁶ The constant theme of the moralists is that the patient needs to determine what is ex-

⁵ Pontifical Council Cor Unum, *Questions of Ethics Regarding the Fatally Ill and the Dying* (Vatican City: Vatican Press, 1981) 8-9.

⁶ This dissertation is now included as part I of the book *Conserving Human Life*

traordinary in light of his or her medical circumstances, financial situation, and values. If the effects of the intervention are disproportionate to the desired outcome, they need not be used.

However, a shift seems to be occurring in this tradition and in the method over the past two and half decades. When one reads the 2004 allocution by John Paul II on assisted nutrition and hydration, there is a methodological shift to deontology and determination of principles by definition or stipulation. Briefly, the pope stated that such tubes were “not a medical act” and their use “always represents a natural means of preserving life” and is part of “normal care.” Therefore, their use is to be considered in principle ordinary and obligatory. “If done knowingly and willingly” the removal of such feeding tubes is “euthanasia by omission.” The 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—“nourishment to the patient and alleviation of his suffering.”⁷

What is interesting about this papal allocution is that it seems to represent a significant departure from the Roman Catholic bioethical tradition with respect to both the method and the basis upon which such decisions are made. Historically, the method for making a determination about the use of a medical intervention was the proportion between the benefits of the intervention and its harms or burdens to the individual, family, and community. The method is a teleological balancing of the impact of the intervention. This has been the central teaching of the tradition from the mid-1600s through Pope Pius XII and the 1980 “Declaration on Euthanasia” by the Congregation for the Doctrine of the Faith.⁸ The method announced by Pope John Paul II appears to be deontological in nature. The use of feeding tubes to deliver artificial nutrition and hydration is stipulated as in principle ordinary, and such an intervention apparently must not be forgone or withdrawn unless or until the body cannot assimilate the nutrients or they do not alleviate the suffering of the patient.⁹

(Braintree, Mass.: The Pope John XXIII Medical-Moral Research and Educational Center, 1989).

⁷ John Paul II, “Care for Patients in a ‘Permanent’ Vegetative State.” This allocution can be found on the Vatican website: http://www.vatican.va/holy_father/john_paul_ii/speeches/2004/march/documents/hf_jp-ii_spe_20040320_congress-fiamc_en.html (accessed April 13, 2005); also in *Origins* 33 (April 8, 2004) 737 and 739–40.

⁸ Congregation for the Doctrine of the Faith, “Declaration on Euthanasia,” *Origins* 10 (August 14, 1980) 154–57.

⁹ John Paul II, “Care for Patients in a ‘Permanent’ Vegetative State” 739.

The Shift from Illness to Imminent Dying

When one reads the manualist tradition on this question, the general framing of the question is in terms of preserving one's life during an illness. Historically, particularly up to about 1950, there was a coincidence of becoming ill and dying but that was because of the general lack of any genuinely useful medical interventions. Typically when one got seriously ill, one died. However, the moralists did not cast the teaching as applicable only in the context of dying. For example, when Francisco de Vitoria in the 16th century spoke of "protecting his life," of "employing all the means to conserve his life," he believed that "one is not held to lengthen his life."¹⁰ Thomas Sanchez, in the same century, says that, "it is inferred that one is not obliged to use medicines to prolong life even where there would be the probable danger of death, such as taking a drug for many years to avoid fevers."¹¹ Thus the obligation is cast in terms of the general context of illness and the prolongation of life.

Pius XII, in his 1957 address on "The Prolongation of Life," discusses the possibility of terminating attempts at resuscitation by not placing a patient on a mechanical ventilator. In this address the discussion of termination of life support occurs within the context of deep unconsciousness and hopelessness but not within the context of dying or of terminal illness. Additionally, Pius does not posit a presumption to resuscitate but rather uses the traditional burden-benefit method to determine whether or not there is an obligation to resuscitate.¹²

Finally, the "Declaration on Euthanasia" speaks in this vein as well. Section IV, as noted above, discusses the issue under the rubric of caring for one's health and how to determine what remedies to use. The last six sentences of section IV refer to the dying process but only in that one can refuse "means of treatment that would only secure a precarious and burdensome prolongation of life. . . ." (IV). The condition of dying or being terminally ill is not the general context for the application of the decision making process, but rather one more situation in which one can apply the method of analysis.

A shift in analysis seems to stem from *Evangelium vitae* in which John Paul II, in talking about aggressive medical therapies that are disproportional,

Though the Pope made an "in principled" argument here, some have not carefully articulated this in their remarks about the allocution. For example, see the published interview noted above with Richard Doerflinger in the *Washington Post*, March 27, 2005.

¹⁰ Cronin, *Conserving Human Life* 34–37.

¹¹ *Ibid.* 43.

¹² Pius XII, "The Prolongation of Life" (November 24, 1957), *The Pope Speaks* 4 (1958) 395–98.

tionate or too burdensome, says “in such situations, when death is clearly imminent and inevitable, one can in conscience” (65) refuse treatments. The footnote for this section is to the CDF “Declaration on Euthanasia,” but this seems to misrepresent what the document says. The “Declaration” does talk about imminent death in section IV, but it does not do it in the manner that *Evangelium vitae* suggests. *Evangelium vitae* restricts the application of the criteria of proportionality and burden to the situation of imminent and inevitable death. But this is not what the CDF document says. Rather the analysis of section IV is to identify the method of decision making and what is to be included in it as the patient makes decisions about his or her treatment. The context of dying is yet another time when this method can be brought to bear on the situations. The restriction of the application of the ordinary-extraordinary distinction to imminent death is new and has not been part of the general moral tradition nor of the CDF document.

From the Appropriateness of a Therapy to the Presumption of Its Use

Imbedded in the distinction between ordinary and extraordinary means of medical technology is the possibility of an equivocation on the term “ordinary.” When we discuss medical interventions, we frequently discuss some of them as routine, standard, the treatment of choice, standard of care, or ordinary. What is meant in this discussion is that for this particular situation, this is what is usually or ordinarily done. Such interventions can range from a blood transfusion, to chemotherapy, to cardiac bypass surgery, to dialysis, to the insertion of a feeding tube, etc. However, no determination has yet been made on the effect of such an intervention on the patient or on others. From the perspective of the tradition, this is where the moral evaluation begins. What is the impact on the patient, what benefits or burdens will it bring him or her, what is the likely outcome of the intervention, what is the cost, both psychological and economic for the patient and his or her family? The patient must determine whether there is a proportion between what is done ordinarily in medicine and the expected benefits, both short term and long term. What may be *medically* ordinary or routine may not in fact be *morally* ordinary because of a disproportion of the benefit-burden ratio for the patient. We must avoid the common equivocation on the word ordinary.

Another version of this equivocation concerns the distinction as a means of categorizing interventions. When one categorizes medical interventions in the abstract apart from the concrete circumstances of the patient, the basis of the classification itself determines the moral status of the intervention, not the effects of the intervention on the patient. Thus we look at the intervention and ask if this is routinely done. If the answer is yes, then

we must use it. Again the assumption is that, because an intervention is customarily used, it must be morally obligatory. And again the moral analysis is short-circuited because of the equivocation, and one attempts to draw an “ought” or moral obligation directly from an “is” or what is routinely done.

Another problem this equivocation sets up is that the terms ordinary and extraordinary are used as methods of classification or categorizations of interventions. If an intervention is categorized as ordinary—based on the observation that this is customary or ordinary medical practice—then it is morally obligatory. Fortunately, the tradition does not use the terms ordinary and extraordinary as a means of abstract classification but as the conclusion of an argument about the proportion or disproportion of benefits and burdens, as the CDF phrases it. This point was also nicely made by the founder of American Catholic bioethics, Gerald Kelly, S.J., who noted in 1950 that sometimes even “ordinary artificial means are not obligatory when relatively useless.”¹³ This conclusion led him to revise the definitions of the terms even more carefully, away from any sense of using them as means to categorize the intervention in the abstract to an evaluation of the impact on the patient.

The equivocation on the term ordinary and the use of the terms as means of categorizing interventions set the context for the presumption of use of assisted nutrition and hydration. For example, in 1986, the Committee for Pro-Life Activities of the then NCCB noted that food and water are necessities of life. And since they can be provided without risks and burdens associated with more aggressive life-supporting interventions, there should be a presumption in favor of their use. This idea of a presumption in favor of ANH was reiterated by the New Jersey Catholic Conference in 1987 when it argued against the removal of ANH in the case of Nancy Jobes. The New Jersey Bishops noted a positive duty to prolong human life and, since food and water are basic to human life, they should always be provided.¹⁴ This position was repeated in the *Ethical and Religious Directives for Catholic Health Care Services* issued in 1994 by the NCCB/USCC. After repeating the traditional means of determining burden and benefit, the document states:

There should be a presumption in favor of providing nutrition and hydration to all patients, including patients who require medically assisted nutrition and hydration,

¹³ Gerald Kelly, S.J., “The Duty of Using Artificial Means Of Preserving Life,” *Theological Studies* 11 (1950) 220. See also “Notes,” *Theological Studies* 12 (1951) 550–56 for the revised definitions of ordinary and extraordinary.

¹⁴ New Jersey Catholic Conference, “Providing Food and Fluids to Severely Brain Damaged Patients,” *Origins* 16 (January 22, 1987) 582–84.

as long as this is of sufficient benefit to outweigh the burdens involved to the patient.¹⁵

What is interesting is the structure of the sentence. The tradition would usually begin with an analysis of whether there is burden or benefit and then determine whether ANH is required or not. The revisionist position begins with a presumption and then moves to disprove the presumption. The problem with this comes from either an equivocation on the term ordinary or from using the term as a method of classification. The position of the long-standing tradition has been to evaluate the proposed intervention and then come to a moral conclusion.

A final difficulty with this shift concerns determining to what we have presumptive or prima facie obligations. In the tradition, one had a presumptive obligation to preserve one's life, not a presumptive obligation to accept or take any particular medical technology, e.g., mechanical ventilators, heart transplants, or assisted nutrition and hydration. In recent statements, however, patients have a presumptive obligation to take artificial nutrition and hydration. This presumptive obligation can be overridden if and when it can be shown from the circumstances, e.g., the body cannot assimilate the nutrients or the patient is imminently dying or they do not alleviate the suffering of the patient, that this obligation is not one's actual moral obligation.

From Presumption of Use to the Necessity of Use of Assisted Nutrition and Hydration

The first note of a shift away from considering the context of the sick person as morally relevant to decision making at any stage of the illness is in the previously cited Cor Unum document of 1981. This document states that:

There remains the strict obligation to apply under all circumstances those *therapeutic measures* which are called "minimal": that is, those which are normally and customarily used for the maintenance of life (*alimentation*, blood transfusions, injections, etc.). To interrupt these minimal measure would in practice, be equivalent to wishing to put an end to the patient's life.¹⁶

¹⁵ USCC, *Ethical and Religious Directives for Catholic Health Care Services*, (Washington: USCC, 1994), Directive # 58. Interestingly, in the latest version of the ERDs (2001), the introduction to Part V, in which directive # 58 is found, states: "These statements agree that hydration and nutrition are not morally obligatory either when they bring no comfort to a person who is imminently dying or when they cannot be assimilated by the person's body." Note here that a proportion between benefit and burden is not the criterion used.

¹⁶ Pontifical Council Cor Unum, 8–9 (emphases added).

Note here that feeding is defined as a medical intervention and that there is the presumption of benefit of this intervention.

The Pontifical Academy of Sciences in 1985 noted: "If the patient is in a permanent irreversible coma, as far as can be foreseen, treatment is not required, but all *care* should be lavished on him, *including feeding*."¹⁷ Note here that "feeding" is not placed within the category of "medical treatment" but is defined as "care," which indicates that such interventions are not subject to the normal moral criterion of proportionality between benefits and burdens.

This position is repeated in John Paul II's allocution on assisted nutrition and hydration in which the pope stated in March 2004 that such tubes were "not a medical act" and their use "always represents a natural means of preserving life" and is part of "normal care." Therefore, their use is to be morally considered in principle as ordinary and obligatory. "If done knowingly and willingly" the removal of such feeding tubes is "euthanasia by omission." Other than the inability of the body to absorb the nutrients or that the patient is imminently dying or that the patient's suffering cannot be alleviated, the person's medical condition is not relevant in making a determination about the use of feeding tubes because the food and water delivered through such tubes is ordinary care and provides a benefit—"nourishment to the patient and alleviation of his suffering."¹⁸ Such a shift to the requirement that assisted nutrition and hydration must be used essentially takes the decision about this intervention out of the patient-centered approach that has so characterized the historical tradition of the past.

CONCLUSIONS

The Terri Schiavo case provides an interesting insight into a major change in the methodology to determine whether or not an intervention is a benefit or a burden, whether or not it is proportionate or disproportionate. To our knowledge, no one in any of the discussions has argued that there is no moral obligation to provide cures or care for those who are ill or in medically compromised positions. At issue is how one determines that obligation. Our observation is that the tradition from at least the 16th century through Pius XII, the Congregation for the Doctrine of the Faith in 1980, and the vast majority of moral theologians has determined this obligation by having the patient consider the benefits and burdens of the

¹⁷ The Pontifical Academy of Sciences, "The Artificial Prolongation of Life," *Origins* 15 (December 5, 1985) 415 (emphases added).

¹⁸ John Paul II, "Care for Patients in a 'Permanent' Vegetative State" 739.

intervention to determine if they were proportionate or disproportionate. The tradition did not start with assumptions about interventions, nor did it categorize interventions.

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.

The shift seems to be motivated by two moves: one ethical and the other political. The ethical move seems to emerge out of an eliding of two distinct but related elements that make up a moral judgment. The axiological element, which is concerned with the determination of value, affirms the value or sanctity of life of the patient. This assessment opposes, correctly, efforts to devalue life lived under difficult circumstances or problematic medical conditions, such as permanent coma. Thus the axiological element of the moral judgment in the Catholic tradition opposes any use of the phrase "quality of life" as a shorthand way of arguing that a patient's life is not worth preserving. The second and distinct element, the normative, is a determination of what obligations I have in the concrete to maintaining this *valued* life. This normative element has traditionally been resolved by determining the burden-benefit ratio of the proposed intervention. Failure to make this important and traditional ethical distinction between axiology and normativity leads one to affirm wrongly that the affirmation of the value or sanctity of life of the patient in and of itself imposes normative obligations with respect to medical interventions. In addition to being the fallacy of deriving an "ought" from an "is," the failure also implicitly may signify a form of vitalism that affirms that biological life is the only or most important value. Finally, the failure to make the distinction leads to a form of a "medical indications policy" as the moral criterion that mandates that particular interventions necessarily must follow from the diagnosis.

The political move both incorporates the failure to make the distinction between the axiological and the normative and incorporates this into the rhetoric of the right to life movement. Thus the rhetoric of the right to life movement focuses on the obligation to maintain biological life under virtually any and all conditions and in the more excessive strands of the movement comes close to committing idolatry by making biological life the only value to be considered. This is certainly not the traditional Catholic "sanctity of life" position, and, in fact, it begins to move this rhetoric into materialism in that biological life is the only or most important value under consideration. There is no doubt that recent magisterial attempts to protect the dignity of unconscious patients are important and utterly necessary, but the movement to require the use of technologies that sustain biological life

may in fact have the opposite effect on a society that is prone to devaluing life.¹⁹

In an earlier article we developed the following position, and we continue to argue that it will serve as an appropriate basis on which to make decisions about the morality of the use of assisted nutrition and hydration.

[W]hen a proposed intervention cannot offer the patient any reasonable hope of pursuing life's purposes at all or can offer the patient a condition where the pursuit of life's purposes will be filled with profound frustration or with utter neglect of these purposes because of the energy needed merely to sustain physical life, then any medical intervention (1) can only offer burden to the life treated, (2) is contrary to the best interests of the patient, (3) can cause iatrogenic harm or risk of such harm, and (4) has reached its limit based on medicine's own principal reason for existence, and thus treatment should not be given except to palliate or to comfort.²⁰

The more recent revisionist perspective approaches end-of-life judgments by defining and categorizing particular interventions in the abstract as ordinary, and, on the basis of this maneuver, mandating these interventions. This method that appears to have entered magisterial statements by stipulation undercuts the traditional benefit-burden method and risks imposing great hardship on patients and families at a time of great crisis. We can think of no greater burden to impose on people at this time than to have them feel abandoned by the Church when they are in greatest need of its benefits. Bluntly stated, the Catholic tradition on end-of-life issues has never mandated doing useless or inane things to people in the name of morality. We should not start doing this now.

¹⁹ See Thomas A. Shannon and James J. Walter, "Implications of the Papal Allocation on Feeding Tubes," *Hastings Center Report* 34 (July-August 2004) 18–20.

²⁰ Thomas A. Shannon and James J. Walter, "The PVS Patient and the Forgoing/Withdrawing of Medical Nutrition and Hydration," *Theological Studies* 49 (1988) 645.