Patrick Lee has taken the time and energy to respond to my essay concerning the Papal Allocution of March 20, 2004, “On the Care of Persons in a Vegetative State.” With consideration and acuity, he states correctly that my concerns are expressed with a view to following the norms set forth for response to papal teaching, as outlined in the document *Donum Sapientiae*, of the Congregation for Doctrine and Faith in 1990. For this reason, my essay, written two years ago and sent to the proper Vatican dicastery, appears for the first time in a volume considering this topic.

Moreover, in expressing his specific disagreements with the reasoning set forth in my essay, Lee evidences a grasp of my thinking and a calm response to it. He does not ask me to read once again the statement of Pope John Paul II, as did one person responding to my thoughts on this matter. Perhaps he realizes that I have read the Papal Allocution at least one hundred times, and in five different languages. In an effort to respond to Dr. Lee’s thoughts, I shall be as brief as possible, hoping to maintain the calm and respectful manner which he has initiated.

Certainly, there are many particular statements in regard to care for the dying upon which Dr. Lee and I would agree. We agree that upon occasion, life support in the form of artificial nutrition and hydration (ANH), may be withdrawn from patients in a permanent vegetative state (PVS). He states correctly that because the Papal Allocution uses the term “in principle,” (or as the French version has it, “as a general rule”) that there are exceptions to the proposition that ANH is ordinary and proportionate care.

Our disagreement concerns the conditions that justify these exceptions. Following the traditional teaching of the Church, stated for example in the ERD, D. 56 and 57, many persons with the same interpretation as I, maintain that life support may be withheld or withdrawn if a patient (or the proxy) determines that it offers no hope of benefit or imposes an excessive burden. Moreover in accord with D. 58, we agree that there should be a presumption to use ANH for patients who need it, but that the presumption ceases when the burden for the patient outweighs the

Kevin O’Rourke, O.P.
Neiswanger Institute of Bioethics and Health Policy; Stritch School of Medicine, Loyola University, Chicago, IL
Email: korourk@lumc.edu
benefit. According to our position, maintaining the life of a person in a permanent vegetative condition with ANH, when there is no hope of recovery, is not of benefit for the patient.

Dr. Lee, following the thought of Germain Grisez, would maintain that prolonging the life of a person in this condition, is of great benefit to the patient. This disagreement is the result of two different theological views of the goods of human life. Personally, I think the resolution of this disagreement depends upon an interpretation of the Thomistic concept of the purpose of human life, as discussed in my essay.

Moreover, Dr. Lee, is in agreement with some statements made by physicians at the conference in Rome which resulted in the papal allocution under discussion. Hence, he is reluctant to admit that the diagnosis of permanent vegetative state can be made with moral certainty, and thus he would agree that people often recover from this condition. On the other hand, basing my conviction on the findings of board certified neurologists, I believe that the condition of permanent vegetative state can be diagnosed with moral certitude. Note for example the case of Terri Schiavo; the autopsy more than confirmed the diagnosis made before her death by board certified neurologists. Clearly, my position admits the need for caution in making a PVS diagnosis, and allows that a Minimal Conscious State (MCS) might develop. But when there is moral certitude from clinical evidence that the patient is in a PVS condition, it is safe to say that ANH is no longer “in principle” an ordinary and proportionate care. Resolution of this disagreement is more within the realm of medical research than within the realm of theological investigation.

In the course of his considerations, Dr. Lee puts forth two arguments to which I would respond briefly in hopes that these arguments can be put in mothballs. First of all, following the thinking of Grisez and William E. May, he states that it is dualism to maintain that when there is moral certitude that a person will not recover or develop the potency to perform human acts, it is no longer necessary to seek to prolong that person’s life. This argument is inaccurate and fallacious. If anyone can be accused of dualism, it would be Grisez and followers because they make the “mere biological function of the body,” (Lee’s terminology) an absolute value, even when it is morally certain the person in this condition will not recover rational activity. All holding a position similar to mine would agree that biological function of the human body is vital for pursuing the purpose of life. But preserving “mere biological function” does not help the patient pursue this purpose. In response to the charge of dualism, I will repeat the thought of my colleague Benedict Ashley:

the human body is human precisely because it is a body made for and used by intelligence.
Why should it be dualism to unify the human body by subordinating the goods of the body to the good of immaterial and contemplative intelligence?” (Ashley, 1994, p. 73).

Secondly, Dr. Lee states that “the administration of nutrition and hydration is not expensive or terribly burdensome. Maintenance of the tube-feeding after its insertion does not require hospitalization and the nutrients are relatively inexpensive” (Lee, 2008, p. 188). The usual care for PVS patients is in hospital or a long term care facility, and it is very expensive. If it is so easy to care for permanently unconscious