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CONTENTS

Different Viewpoints

Should Nutrition and Hydration Be Provided to Permanently Unconscious and Other Mentally Disabled Persons?

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The title of this article can be understood either as a legal or as an ethical question. It is treated only insofar as it is an ethical question—that is, a moral issue.[1] But it is the author's hope that this discussion will contribute to the current debate about what law ought to require in this matter, for, of course, questions about what law *should* require are, at least in large part, moral questions.

In its reflection on moral questions, ethics has a task very different from that of legal studies, which focus on the making and application of social rules. Ethics tries to discover what is good and right for persons and groups of persons, considered insofar as they are agents. In other words, ethics tries to learn the truth about what ways of acting will make persons and communities truly flourish. Thus, the aim of this article is not to try to use ideas and words to channel anyone's behavior, but to articulate the author's own effort to arrive at a sound view on the question, in the hope that doing so will help others who want to know what they ought to do about it.

"Permanently comatose" is understood to refer to all who are in fact permanently unconscious, no matter what their specific condition

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[1]The purpose here is to try to clarify certain philosophical issues underlying the moral norm articulated in a previous collective statement: May, Barry, Griese, Grisez, Johnstone, Marzen, McHugh, Meilaender, Siegler & Smith, *Feeding and Hydrating the Permanently Unconscious and Other Vulnerable Persons*, 3 ISSUES IN LAW & MED. 203 (1987).

is or its underlying cause.[2] The author presupposes that even comatose human individuals are persons.[3] For brevity's sake, the single word *comatose* shall be used to refer to the permanently unconscious, and the single word *food* to refer to nutrition and hydration.

For the purpose of this article, two types of cases are excluded from the discussion: First, sometimes a choice is made to kill someone, and that choice is carried out by withholding food. It seems that this is exactly what has been done in some of the widely publicized cases. Now, if food is withheld precisely in order to kill someone, that calculated omission is homicide and cannot be morally justified. The author has argued this view elsewhere and shall not repeat those arguments here.[4]

Second, sometimes a comatose or other mentally disabled person is dying, and providing food will not prolong life or give the person comfort, but perhaps even will increase discomfort. The author agrees with the general consensus that in such cases food should not be provided. Just as is true of any other sort of care or treatment, the reason for providing food is to benefit the person being cared for; therefore, when doing so is no benefit, and perhaps is a burden, it is not reasonable to continue trying to provide food.

Also set aside is the method of feeding called "total parenteral feeding" or "hyperalimentation."[5] It differs significantly in its burdens from other methods of feeding and is used in few if any cases to sustain comatose persons. So, it is not considered relevant to the general question to be treated here.

Thus, this article concerns only cases of the following sort: no choice is made to kill the comatose or otherwise mentally disabled person, the person is not dying, but the burdens of care and its limited benefits make some or all of those concerned wonder whether it is right to continue providing food.

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[2]Even within medical circles, the language used in referring to permanently unconscious persons is bewilderingly complex, partly because the subject matter itself is not simple, partly because of the difficulties of diagnosis and prognosis, and partly because the medical community has no established tradition in the matter. On this linguistic-factual problem, *see* Cranford, *The Persistent Vegetative State: The Medical Reality (Getting the Facts Straight)*, HASTINGS CENTER REP., Feb.–Mar. 1988, at 27.

[3]Concerning this presupposition, *see* G. GRISEZ & J. BOYLE, JR., LIFE AND DEATH WITH LIBERTY AND JUSTICE: A CONTRIBUTION TO THE EUTHANASIA DEBATE 229–38 (1979).

[4]*See id.* at 414–22 in the context of 336–414; *cf.* Connery, *The Ethical Standards for Withholding/Withdrawing Nutrition and Hydration*, 2 ISSUES IN LAW & MED. 87 (1986).

[5]*See* Major, *The Medical Procedures for Providing Food and Water: Indications and Effects*, in BY NO EXTRAORDINARY MEANS: THE CHOICE TO FORGO LIFE-SUSTAINING FOOD AND WATER 21, 24–25 (J. Lynn ed. 1986).

A Change of Mind

In 1986, the author published a lecture which dealt with the issue of feeding persons who are comatose. That lecture stated:

> If a patient is not in imminent danger of death but is in an irreversible coma, as the late Miss Karen Quinlan was, life-support care more sophisticated than ordinary nursing care is very costly. It seems to me that such costly care exceeds a permanently comatose person's fair share of available facilities and services. Thus, I believe that when Miss Quinlan was removed from intensive care, she ought not to have been placed in a special care facility, but should instead have been sent home or cared for in the hospital with only the sorts of equipment and services available in an ordinary household. These do not include feeding by tube, and Miss Quinlan could not be fed otherwise. Thus, if I am right, she should not have been fed. Not feeding patients in irreversible coma would cause their early death, and it would be wrong to omit feeding them to hasten their death. But a proxy could decide against care in a special nursing facility out of fairness to others, and accept the patient's death as a side effect.
>
> Does it follow that no one is entitled to a lifetime of care, including feeding by tube, at the level Miss Quinlan received? No, because the same principle of fairness by which the cost of that level of care is excessive for people in irreversible coma will require as much or more care for many other patients. This can be seen by applying the Golden Rule, which expresses what fairness demands, to various cases. We all know that each of us might sometime be in irreversible coma, might sometime need public funding of long-term treatment for some other condition, and must always pay taxes. I think we can honestly say that we are willing to limit treatment of ourselves and those we love, if ever in irreversible coma, to ordinary nursing care, without feeding by tube. By setting this limit, we will keep publicly funded special care facilities free for other patients, and avoid increasing taxes to provide additional facilities of this sort. But if we or someone we loved were conscious and able to do some good things and have some good experiences, we would want a lifetime of care at or even above the level Miss Quinlan received, including feeding by tube, if necessary, and we would want public funds to be available for what was needed. Hence, we cannot fairly limit others' care if they are in this condition. Nor can we reject the taxation required to provide facilities for such people.[6]

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[6]Grisez, *A Christian Ethics of Limiting Medical Treatment*, in 2 POPE JOHN PAUL II LECTURE SERIES IN BIOETHICS 35, 49–50 (F. Lescoe & D. Liptak eds. 1986).

The author continued to hold this view until quite recently, and thought that it was not reasonable to provide food to persons who are comatose. However, the author's present position is that in our society food should be provided as a rule even to such persons. Six considerations led the author to change his mind on this matter.

First, it was assumed that the class of comatose persons is well defined and that members of the class usually can be picked out easily and with certainty. But there is conflicting testimony by various experts in some of the widely publicized cases. The author has discussed the problem with specialists in neurology, and as a consequence, it now seems that *comatose* refers not to a clear-cut type of case but to a spectrum of cases, in which damage to the nervous system has resulted from various causes and varies considerably in degree. Thus, serious difficulties arise in the attempt to make a diagnosis.

Second, it was assumed that feeding a comatose person by tube is in itself complicated and difficult, so that such a person could be cared for only in a special care facility. But in personal conversations, nurses experienced in home health care have stated that this is not so. Some families care for comatose family members at home.

Third, it was also assumed that feeding a comatose person by tube is in itself expensive. But there is a distinction between the cost of feeding such a person and the total cost of caring for that person. Most of the cost is for other elements of care: providing a room with suitable furnishings and equipment, keeping it warm, having someone present to do everything that must be done (not only to provide food), and so forth. The food itself costs very little, and those who care for persons who are comatose spend only a small part of their time in feeding them.

Fourth, it was believed that once a person is comatose, the only human good at stake is his or her life. But, in talking with people about family experiences in caring for persons with mental disabilities, the author realized that a family has personal reason to care for its members and not abandon them. People find it hard to articulate this personal reason, but it amounts to something like this: Caring for people—especially providing food and other elemental forms of care—affirms their dignity as persons, expresses benevolence toward them, and maintains the bond of human communion with them. Therefore, if even a comatose individual is a person, feeding that person also serves this personal good, which shall be referred to as the good of human solidarity.

Fifth, it was assumed that tube feeding is used only to sustain persons who cannot ingest food in the normal way. But physicians and nurses who are directly acquainted with current practices in institu-

tions where the severely retarded and very senile are maintained state that uncooperative persons sometimes are fed by tube simply because pouring a formula down a tube is easier, faster, and thus cheaper than patiently feeding such people by mouth. It was then realized that the criteria which the author had suggested—namely, being conscious and able to do some good things and have some good experiences—excludes not only the persons who are comatose but many people who, although conscious, are mentally disabled to such an extent that, by standards of nondisabled persons, they never have been (or likely never will be) able to do any "good thing" or have any "good experience."

Sixth, it was believed that not caring for the comatose would make special care facilities available for other persons without increasing taxes. But the economics of the health care system are such that savings at one point are likely to be lost to the always increasing costs of health care rather than to be put to better use at some other point. So, the author is now far less optimistic about the likely economic consequences of withholding or withdrawing care from persons who are comatose.

Food Should Be Provided to Persons Who Are Comatose?

In view of these considerations, food ordinarily should be provided even for persons who are comatose, and a fortiori, for other persons who are mentally disabled. But the limits of this position should be noticed. It leaves two kinds of cases in which it would be right to withhold or withdraw food from comatose persons and perhaps from some other people.

First, in a community which, unlike our affluent society, is so poor that caring for comatose and other mentally disabled persons would deprive others, such as healthy children, of necessities, it would be reasonable to use the limited available resources to feed and care for those likely to receive greater benefits from them.

Second, fairness does not always require what it ordinarily requires. Fairness does not require us to feed someone now comatose who, when formerly competent, envisaged the future situation and clearly and freely rejected food in that situation, should it ever come about. This reference to advance directives regarding the rejection of food does not include offhand remarks made casually by persons who are now comatose. Rather, it refers to the decisions of people who were competent and who carefully considered the possibility of a future situation in which they would be certifiably comatose. In this context, the "rejection of food" means that the persons made it perfectly clear that, should they ever be in the condition which they envisaged, they

wanted to forgo care, including food. Such people are not trying to commit suicide and have the moral right to concede their own claim upon others for care.

Of course, it does not follow that anyone is entitled to make such a concession on behalf of someone else. For while one often may set aside one's own rights in a spirit of self-sacrifice, one may never set aside the rights of others.

Within its limits, this position concerning feeding comatose and other mentally disabled persons is in agreement with the Golden Rule, which requires us to feed even the comatose if we would reasonably want others to feed us or those we hold near and dear if ever comatose. And if providing food to comatose persons significantly benefits them and concerned others without significantly burdening either comatose persons themselves or concerned others, then we could reasonably want others to feed us or those we love, even if we or they were in a comatose condition.

The Burdens and Benefits of Feeding Comatose Persons

Burdens of care or treatment are those negative aspects which can be good reasons for forgoing, withholding, or withdrawing food. Among such negative aspects are organic side effects, cost, painfulness, psychological repugnance, and interference with worthwhile outward behavior or mental function.[7]

Persons who envisage a situation in which they would be comatose might reasonably decide to forgo care, should that situation arise, because of its cost and perhaps because of psychological repugnance toward being fed by tube. But these aspects of care are not burdens for persons who did not earlier forgo care and who have now become comatose. These comatose persons neither bear the costs of their own care nor, presumably, experience any of its negative aspects. If they do experience any burdens of the care they are receiving, they cannot be called "comatose" and might also experience the pain of dying from hunger and thirst.

Of course, persons can have imposed upon them burdens that they do not experience. There are burdens which can be imposed upon a comatose person. For example, a comatose person could be used as a sex object or dumped into the garbage. These indignities are violations implying denial of their status as persons. But caring for comatose persons, including feeding them by tube, does not in itself constitute an indignity. Rather, to say that being fed by tube is an indignity is merely

[7] *See id.* at 43–44.

to express an observer's feeling of repugnance. Moreover, feeding the comatose does not impose any other burden on them.

What about burdens to others? Admittedly, others must bear the cost of feeding the comatose. But many will argue that a far more important burden is experienced by a comatose person's loved ones because their joy in living and peace of mind are damaged or even destroyed by having someone they care about maintained in a hopeless condition with no resolution in sight.

This argument is emotionally moving but fallacious. Plainly, being comatose is, from an observer's point of view, a miserable state, and neither option—to maintain people in that state or to stop maintaining them—is attractive. The situation is similar in this respect to many others which are inescapable in the human condition: nothing one can do feels "right." So, as a comatose person's loved ones watch what is done to provide food and other care, they experience a negative aspect of the situation—in other words, they experience a great and undeniably real burden. But it is not a burden of the comatose person's feeding or other care. Rather, it is the burden of that person's extreme disability. Of course, this burden will be eliminated if food is withheld, but only because the comatose person will be eliminated. Thus, to decide not to feed a comatose person in order to end the burden that his or her loved ones experience is to choose to kill that person in order to end the miserable state in which he or she now lives.

As stated above, when the distinction is noted between the cost of feeding persons who are comatose and the total cost of caring for them, the cost of feeding is comparatively insignificant. For example, providing the bed and services for Miss Quinlan to live out her days cost the public a good deal, but her formula and the work of feeding it to her made up only a small part of the total cost of caring for her. Yet those who oppose providing food for the comatose on the ground of cost invariably seem to have in mind the total cost of caring for such persons, not the small cost of feeding them.

This fact leads to a dilemma for anyone who uses cost to justify a decision not to feed a comatose person. Either food is withheld precisely as a means of saving the total cost of care, or, at least, food is withheld as part of a more inclusive decision to save that total cost. If food is withheld precisely as a means of saving the total cost of care, the choice is to kill the comatose person, since the means achieves its end only by starving the person to death and rendering unnecessary any further care. But, the choice to kill the person would be homicidal and, therefore, morally unjustifiable. If, however, food is withheld as part of a more inclusive decision to save the total cost of care, the issue no

longer is whether comatose persons should be fed or not, but whether they should be cared for or abandoned. The choice to abandon comatose persons bears on every element of their care, and so it cannot be justified by considerations which concern only either the technique by which they are fed or the appropriateness of medical treatment for persons in their situation. So the real but hidden issue emerges: In our affluent society, can we justify abandoning the comatose in order to save the cost of caring for them as we care for others who cannot care for themselves?

Although the issue thus shifts, it remains necessary to discuss the benefits of caring for comatose persons. For some will hold that even if individuals who are comatose remain persons, caring for them neither benefits them nor anyone else. Against that view, caring for the comatose and other less severely mentally disabled persons carries with it two important benefits: it keeps them alive and it maintains human solidarity with them.

Many deny that keeping people alive benefits them when there is no prospect that they will ever gain or regain the use of their specifically human capacities. For example, Kevin O'Rourke, O.P., focusing on the tube feeding of comatose persons, argues that it is useless to sustain life unless doing so helps a person to pursue "the purpose of life" and writes: "In order to pursue the purpose of life, one needs some degree of cognitive-affective function."[8] Richard A. McCormick, S.J., makes a more general assertion along similar lines: "Life is a value to be preserved precisely as providing the condition for other values and therefore in so far as these other values remain attainable. To say anything else is, I submit, to make an idol of mere physical existence."[9]

In denying that "mere physical existence" is inherently good, O'Rourke, McCormick, and all who share their views presuppose that a person's life has only the status of an instrumental good—something which human persons have and use for their specifically human purposes, but, nevertheless, something which remains really distinct from what human persons are. For if O'Rourke and McCormick did not presuppose that human life is only an instrumental good, they could not hold that it is pointless to preserve a person's life unless "some degree of cognitive-affective function" can be restored or "other values remain attainable." But a person's life is not merely an instrumental good. It is the very actuality of his or her living body, and—although human persons also have spiritual powers and acts which

[8]O'Rourke, *The A.M.A. Statement on Tube Feeding: An Ethical Analysis*, 155 AMERICA 321, 322 (1986).

[9]McCormick, *The Defective Infant (2): Practical Considerations*, 238 THE TABLET (London) 690, 691 (1984).

cannot be reduced to bodily capacities and functions—a human being's living body *is* the bodily person. To deny this is to accept a position which requires some sort of dualistic theory of human persons—that is, a theory according to which human beings are inherently disembodied realities who only have, inhabit, and use their bodies.[10]

No form of dualism is rationally defensible. For every dualism sets out to be a theory of one's personal identity as a unitary and subsisting self—a self always organically living, but only discontinuously conscious, and now and then inquiring, choice-making, and using means to achieve purposes. But every form of dualism renders inexplicable the unity in complexity which we experience in every conscious act. For instance, as I write this, I am the unitary subject of my fingers hitting the keys, the sensations I feel in them, the thought I am expressing, my commitment to write this article, and my use of the computer to express myself. So, within the one reality that I am, consciousness and bodily behavior coexist, and dualism starts out to explain me. But every dualism ends by denying that there is any *one* something of which to be the theory. It does not explain me; it tells me about two things, one a nonbodily person and the other a nonpersonal body, neither of which I can recognize as myself.[11]

It follows that, whatever persons are, they cannot be essentially disembodied realities. So a human person includes a body; one's living body is an intrinsic part of one's personal reality; one does not merely possess, inhabit, and use one's body as an instrument. Human life, which is the very actuality of a person's body, is a good intrinsic to the person, not a merely instrumental good for the person. Therefore, contrary to what O'Rourke, McCormick, and others think, human life is inherently good, so it does not cease to be good when one no longer can enjoy a degree of cognitive-affective function or attain other values.

There are two further implications—which are often overlooked or unmentioned by its proponents—of the thesis that human life is merely an instrumental good to be sustained only so long as it is an

[10]For a fuller philosophical and Catholic theological development of this line of argument: J. FINNIS, J. BOYLE & G. GRISEZ, NUCLEAR DETERRENCE, MORALITY AND REALISM, 304–09 (1987); and, Grisez, *Dualism and the New Morality,* in 5 ATTI DEL CONGRESSO INTERNAZIONALE TOMMASO D'AQUINO NEL SUO SETTIMO CENTENARIO 323, 323–30 (Edizioni Dominicane Italiane-Napoli, 1977); and, LINACRE CENTRE, EUTHANASIA AND CLINICAL PRACTICE: TRENDS, PRINCIPLES AND ALTERNATIVES 37–43 (1982).

[11]Some other articulations of the argument against dualism: G. MARCEL, THE MYSTERY OF BEING: I. REFLECTION AND MYSTERY, 127–153 (1960); Williams, *Are Persons Bodies?* in THE PHILOSOPHY OF THE BODY: REJECTIONS OF CARTESIAN DUALISM 137 (S. Spicker ed. 1970); Cameron, *Bodily Existence,* in 53 PROCEEDINGS OF THE AMERICAN CATHOLIC PHILOSOPHICAL ASSOCIATION 59 (1979).

effective condition for attaining other goods inherent in human persons. First, if life is not a good inherent in persons, then the choice to kill a person is wrong, not in itself, but only insofar as it undermines the attainment of other goods which are inherent in persons. In other words, since O'Rourke, McCormick, and others who share their view see no benefit whatsoever to certain persons in keeping them alive, they would, if they were consistent, see no harm to those same persons in killing them. But that view clearly would be contrary to the Judeo-Christian tradition.

Second, if life were worth sustaining only for those who could attain further goods, then the lives of many permanently and severely mentally disabled people would hardly be more worth sustaining than the lives of the comatose. For many such disabled persons are no more able than the comatose—according to my own earlier formulation—"to do some good things and have some good experiences." Hence, the denial that human life is a good inherent in persons logically points to killing not only the comatose but many conscious people who live, often quite wretchedly, in public institutions or private nursing homes.

At this point, some will think that this is a so-called slippery slope argument, and they may suppose that it vitiates the whole argument being articulated in this article. These suppositions certainly would be false. The main line of argument is complete in itself and does not require this and the two previous paragraphs. What is more, this incidental argument differs from a slippery slope argument. For the argument brings out logical implications of the assumption that human life is only an instrumental good, while a slippery slope argument would point to the psychosocial dynamics which do not logically imply but which in fact might lead from killing the comatose to killing other mentally disabled persons.

Does it follow from this argument that one must "make an idol of mere physical existence" and treat human life as an "absolute good," which must be preserved at all costs, regardless of the burdens of doing so and the benefits which might be gained by using available means to pursue other human goods? Not at all. But two things do follow from the fact that life is an intrinsic good to the person. First, any choice to kill a person is a choice contrary to his or her good, and so is a choice inconsistent with rational love (though, perhaps, consistent with a feeling of affection) toward that person. Thus, one cannot love any neighbor, even a comatose person, and at the same time choose to kill that person. Second, acts which effect nothing more than keeping a person alive, no matter what that person's condition, do really benefit the person, even if only in a small way, and so, if not done for some ulterior reason, do express love toward the person.

This brings us to the second benefit of caring for comatose persons rather than abandoning them: caring for them maintains human solidarity with them—that is, it affirms their dignity as persons, expresses benevolence toward them, and maintains the bond of human communion with them. This personalistic good is realized both in those who receive care and in those who provide it.

Some will deny that maintaining human solidarity with a comatose person benefits him or her in any way, for they will deny that this or any other personal good can be realized in a person who is permanently unconscious. However, as noted above, permanently unconscious people plainly can be burdened in that they can suffer indignities; by the same token, such persons can be benefited by being cared for out of a love which respects their dignity. Moreover, one can maintain the bond of human communion with permanently unconscious persons, even though they cannot enjoy the good experiences normally characteristic of this bond as it exists among conscious persons. This bond is a moral reality, which is maintained essentially by fidelity of will and action. For example, a husband who is faithful to his comatose wife maintains marital communion with her, and so truly benefits not only himself (by continuing to be a good husband) but her, although she cannot consciously enjoy this benefit. Similarly and generally, families and larger communities that faithfully care for their comatose members maintain human communion with them and thereby benefit not only themselves (by continuing to be loving families and genuine communities) but their comatose members.

Some, of course, will reply that a husband who is faithful to his comatose wife is a sentimental fool, whose perseverance is pointless because it benefits nobody, and whose refusal to adjust to the realities of his situation only prevents him from getting on with his life. The questions such a reply opens up are so profound that, within the limits of this article, they can only be sketched out. Underlying the reply are modern conceptions of the human person, of human community, and even of morality itself which are very different from those of the Judeo-Christian tradition. According to that tradition, human individuals become good persons and form community by loving one another. They effectively love one another by freely making and faithfully fulfilling self-determining commitments to use their gifts and resources in the service of meeting common needs and pursuing common ideals.

According to the modern view which underlies the denial of the worth of a husband's fidelity to his comatose wife, human individuals become good persons by working to satisfy their desires as a whole and in the long run; they form community inasmuch as those desires include some which are based on sympathy and others which arise

from the inescapable dependence of human beings on one another; and practical choices are either rationally determined by these goals and the means available for pursuing them or are foolish—that is, uninformed by the realities, short sighted, and emotionally motivated. Because the Judeo-Christian tradition locates human goodness in the free and mutual self-gift which transcends every given desire, it presupposes and affirms freedom of choice. Because the modern view locates human goodness in the rational satisfaction of given desires, it has no need for freedom of choice and leads to its denial (although the modern view exalts the liberty of individuals and groups to use available means in the rational pursuit of the goals which will satisfy their desires). Although the argument is a long one, it can be shown philosophically, without assuming premises from religion or morality, that human persons can make free choices and, from this, that the modern view of human goodness oversimplifies human possibilities and so provides a foreshortened, distorted view of what human life is all about.[12]

Burdens and Benefits Compared

Having considered both the burdens and the benefits of caring for comatose persons, the two are now compared. The only real burden is the cost; the benefits are both in keeping these persons alive and in maintaining human solidarity with them. The latter good is at the heart of the moral truth about this question. If we understand human solidarity and the precise way in which it is at stake in the question of caring for persons who are comatose, we shall see both why in general we should care for them and why under certain conditions we need not care for them.

Competent persons who envisage the situation of being comatose, and who clearly and freely reject food in that situation should it ever come about, need not be choosing to kill themselves. They can, instead, be choosing both to avoid being kept alive by a method toward which they feel psychological repugnance and to free others of the burden of the cost of caring for them. If people who have made and adequately communicated such a decision become comatose, others can comply with their choice without in any way violating human solidarity with them. Under these conditions, not caring for the comatose person is not abandonment. Rather, by respecting the comatose person's

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[12]For an argument for free choice: J. BOYLE, G. GRISEZ & O. TOLLEFSEN, FREE CHOICE: A SELF-REFERENTIAL ARGUMENT (1976). For a philosophical articulation of an ethics in accord with the Judeo-Christian tradition: G. GRISEZ & R. SHAW, BEYOND THE NEW MORALITY: THE RESPONSIBILITIES OF FREEDOM (3rd ed. 1988).

wishes, others express their benevolence, affirm that person's dignity, and maintain the bond of human communion with him or her.

Again, other grave obligations could take priority over the duty to care for the comatose or other mentally disabled members of a family or larger community. When other obligations do take priority, withholding care does not have the significance of elective abandonment, namely, the breaking off of human solidarity. That is why an impoverished society need not deprive other members of necessities to care for those who are comatose. But in our affluent society, to abandon comatose persons who never clearly communicated to others a personal decision to forgo care would be to break off human communion with them and to deny their personhood. Abandoning them would be tantamount to dumping them into the garbage.

Arguments and Objections Answered

This conclusion can be defended by answering some arguments and objections from the opposing point of view. Many who oppose feeding persons who are comatose argue that artificial feeding is a form of medical treatment and so must be evaluated precisely as therapy. They claim it is useless treatment, for comatose persons, by definition, cannot be restored to health. Others have answered this argument by pointing out both that even artificial feeding is an elemental form of care, which has great human significance, and that medical treatment which preserves whatever remains of human life and functioning is not entirely pointless even if it is impossible to restore health.[13]

The main thrust of these answers is sound, but they err both insofar as they focus on feeding the comatose and insofar as they see the significance of feeding as merely expressive or symbolic. So the answer to the argument that feeding the comatose is a form of medical treatment is clarified and strengthened by two of the points made earlier: that the real issue is not whether to feed comatose persons, but whether to care for them or to abandon them; and that faithfully caring for comatose persons benefits them not only by sustaining their lives but by maintaining a moral bond, which is far more than mere experience and feelings, of human solidarity with them.

Sometimes those who oppose caring for the comatose invoke the authority of Pius XII, who said that gravely burdensome means of pre-

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[13]For fuller formulations (in some ways overstated) of these lines of argument: Meilaender, *On Removing Food and Water: Against the Stream,* HASTINGS CENTER REP., Dec. 1984, at 11; Derr, *Nutrition and Hydration as Elective Therapy: Brophy and Jobes From an Ethical and Historical Perspective,* 2 ISSUES IN LAW & MED. 25, 33–36 (1986).

serving life need not be used, since a strict obligation to use them "would render the attainment of the higher, more important good too difficult. Life, health, and all temporal activities are in fact subordinated to spiritual ends."[14] But these statements of Pius XII do not support the position of those who oppose care for persons who are comatose. For, whatever the burdens of caring for them, doing so in no way interferes with their (or, as a rule, with anyone else's) attaining any spiritual end. And Pius XII spoke only of situations in which the benefit of preserving life would somehow generate some burden with respect to a higher, spiritual good. By contrast, those who oppose caring for persons who are comatose think that preserving the life of a comatose person offers no benefit at all and thus cannot justify the cost of his or her care. The premises requisite to that view are: (1) bodily goods are not inherent goods of persons and (2) that keeping faith with the comatose is pointless. But Pius XII does not supply these premises, for he was not a dualist and he held the traditional, Judeo-Christian view of the human person and community and of morality itself.

Some argue that comatose persons are suffering from a fatal pathology, and so, if deprived of food, die because of this antecedent pathology, not because those who could provide food fail to provide it. However, this argument only shows that the decision not to feed a comatose person need not be a choice to kill him or her. It by no means shows that those who can feed comatose persons have no moral obligation to do so. This point may become clearer by considering that those who have acquired immunodeficiency syndrome (AIDS) also are suffering from a fatal pathology, and without care they will die rather quickly because of it. But it does not follow that such persons may be abandoned. Similarly, the fact that comatose persons are suffering from a fatal pathology does not show that they may be abandoned, and the preceding argument, based on comparing benefits and burdens, indicates that we should not abandon them (although, of course, the benefits are less than and the burdens are different from those involved in caring for persons with AIDS).

Some assert that if it is wrong to withhold food from comatose persons, it is also wrong to withdraw or withhold from them any sort of medical treatment available to other persons. Since, they argue, the latter is false, so is the former. This argument can be exemplified in a form the author formerly accepted with reference to Miss Karen Quinlan. Nearly everyone agrees that it was morally right to remove the respirator on which her life was thought to depend. Why, then, when the

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[14]Pius XII, *The Prolongation of Life*, 4 POPE SPEAKS 393, 396 (1958) (allocution to the International Congress of Anesthesiologists Nov. 24, 1957).

respirator was removed and she did not die, would it have been wrong to discontinue feeding her?

The answer to this challenging question can be drawn from the preceding argument: a decision not to feed Miss Quinlan (which her father rejected with horror) would have differed greatly from the decision to remove the respirator. A decision not to feed her could have had only one of two possible meanings, neither of which is morally admissible. It would have been either a choice to resolve the situation by killing her (and so would have been homicidal) or a choice to abandon her (and so, in our affluent society, it would have been contrary to human solidarity with her). The decision to remove her respirator might have had one of those two meanings, but in fact did not. It could and did have another, and morally admissible, meaning: it was a choice to end the burden of intensive care, but not to abandon her. The choice could focus exclusively on intensive care because that care by itself was both expensive and psychologically burdensome to her family who thought that she struggled against the respirator. In general, even an affluent society such as ours must establish limits to medical treatment and need not provide every possible treatment for persons of every condition. It is reasonable, for instance, to decide that nobody should be sustained indefinitely in an intensive care unit. Moreover, even if they are not dying, comatose and other severely mentally disabled persons stand to benefit far less from many sorts of treatment than do most other people, and it is reasonable to provide those sorts of treatment only to persons who will benefit more from them.

Admittedly, this answer does not resolve the difficult question about precisely what sorts of medical treatment should be provided to persons who are comatose and what sorts should be withheld. However, this question is not really different from the question of how far to go in treating all those who are permanently and so severely mentally disabled that they will never (or never again) be able to do any good thing or have any good experience. For persons severely mentally disabled benefit from care and treatment in the same way as persons who are comatose do: it keeps them alive and maintains human solidarity with them.