

The Ethics of End-of-Life Issues

Fr. O'Rourke Has Made Wide-Ranging Contributions to Thinking on the Topic



BY FR. PATRICK NORRIS, OP

Fr. Norris is pastor, Blessed Sacrament Parish, Madison, WI.

In Rome, the Franciscan Church of Santa Maria della Concezione is also known as the “Church of the Bones.” The bones of over 4,000 Franciscan friars decorate the walls of the crypt of the church. There is, near some mummies in the church, a sign that reminds pilgrims that “what you are now, we used to be; what we are now, you will be.” The church seems macabre at first, but, on the day I visited it, one of the friars indicated that the decor actually represents a way to laugh, if not rejoice, in the face of death.

My colleague and fellow Dominican friar, Fr. Kevin O'Rourke, OP, would often take the same tack by inserting several humorous remarks in his talks on end-of-life issues. One of my favorites, and one that Fr. O'Rourke loves to tell, is about a talk he once gave. Concerned about the length of his presentation, he stopped to ask the moderator, “How much time do I have left?” “I don't know,” replied the moderator. “How old are you?”

Although laughing about death might be seen by some as a form of denial, the laughter of these two friars, Franciscan and Dominican, expresses a faith articulated by St. Paul in his first letter to the Corinthians: “Where, O death, is your victory? Where, O death, is your sting?” (1 Cor. 15:55).

To analyze Fr. O'Rourke's contribution to the topic of end-of-life issues in the field of Catholic health care ethics, one must begin by recognizing that his magnificent opus in the field is primarily a theological one, an expression of faith in the resurrection: Where, O death, is your victory? Where, O death, is your sting?

THE THEOLOGICAL ENTERPRISE

Fr. O'Rourke's thought on end-of-life issues successfully integrates the essential sources of Catholic moral decision making: Scripture, reason, magisterial teaching, and the expertise of theologians, medical science, and patient experience. From the Scriptures, Fr. O'Rourke, influenced by St. Thomas Aquinas, draws an essential element for the norms that he develops for the use of life support: the purpose or mission of life. From the Scriptures, we discern our purpose in life—to respond to God's love by knowing, loving, and serving God in this life and being happy with him in the next. Consequently, any decision in the moral realm must ask the teleologically (or goal-based related question): How is this action going to help me pursue the purpose of life or achieve my goal of loving, knowing, and serving God in an integrated fashion?

Furthermore, Fr. O'Rourke points out that “although human life is a great good upon which many other goods depend, sacred Scripture indicates it is not the ultimate good.”¹ These scriptural insights allow for a middle ground position between vitalism and ethical relativism. That is, Scripture recognizes the sanctity of life—hence the exceptionless prohibition against euthanasia and assisted suicide—but, at the same time, does not provide a context that would mandate preserving life at all costs in light of the Christian belief in the Resurrection and the subordination of other goods to spiritual goods. That is, there is a strong presumption in favor of using life support because it generally allows those involved to love and be loved without unreasonable burden; but it is not an absolute presumption.

NORMS FOR USING LIFE SUPPORT

For Fr. O'Rourke, the norms for end-of-life care flow directly from this scriptural foundation.

Logically, it follows that any life-sustaining intervention should be evaluated according to how well it helps an individual to pursue the purpose of life. Any use of treatment must, first, be effective in helping the individual in pursuing his or her purpose in life. Second, if it is effective, the treatment must not impose grave burdens in comparison with the benefits it offers. Because of the integrated nature of the human person, such burdens and benefits can be of a physical, emotional, social, or directly spiritual nature. Burdens and benefits for the patient can at times involve effects on family and society as a whole.

When life support is withheld or withdrawn because it is either ineffective or gravely burdensome, the cause of death resulting from that action is the underlying fatal pathology that seemed to necessitate the intervention in the first place. A fatal pathology is understood to be "any disease, illness, or injury which will cause death if allowed to run its course."² A fatal pathology differs from a terminal illness, which has traditionally been understood to be an illness or condition that will result in death in six months, regardless of the treatment used. In allowing the patient to die when the treatment is either ineffective or gravely burdensome, the moral cause of death is understood to be the underlying pathology, which one no longer had a duty to circumvent.

For Fr. O'Rourke, end-of-life decisions exemplify the principle of double effect, wherein the withholding/withdrawing of life support is either morally good or neutral, the intention of the act being to remove either an ineffective or gravely burdensome treatment. The evil effect of the death is not a means to achieving the good effect (avoiding an inappropriate treatment), and, given appropriate circumstances, the good achieved is commensurate with the harm that occurs as a foreseen but unintended effect of a good action. The invocation of the principle of double effect in these cases properly distinguishes between physical causality and moral culpability.

INTEGRATING SOURCES

A central tenet of Fr. O'Rourke's theological work is that it must portray the medical realities accurately and take into account people's actual

conditions. When he founded the Center for Health Care Ethics at Saint Louis University in the late 1970s, he spent many hours on rounds with the physicians and also attended other medical conferences learning about the practicalities of medicine. As a priest, he was also privy to the realities of human experience in his interactions with patients and their families. This practical knowledge has given Fr. O'Rourke's conclusions a greater credibility. The recent disputes and discord regarding Terri Schiavo's condition and her actual capabilities point to the need always to have sound medical data.

Another important aspect of Fr. O'Rourke's work as a theologian is his integration of the historical tradition into his theological appraisal of end-of-life care.³ His analysis of the issue is enhanced by his knowledge of the historical developments flowing from the first theologians to discuss the issue, Francisco de Vitoria and Domingo Banez of the Dominican school in Salamanca, Spain, in the 16th century. But he also incorporates the thinking of modern scholars, such as Daniel Cronin, John Connery, and Gerald Kelly. Most importantly, in accord with the Second Vatican Council, Fr. O'Rourke carefully integrates magisterial teachings from Pope Pius XII onwards, paying attention to the character of the teaching, the frequency of the teaching, and its manner of expression.⁴ In doing so, he has worked to avoid the extremes of attributing too much authority to a text, on one hand, and, on the other hand, seeing a magisterial teaching as just one opinion among a variety of others in the formation of conscience.

A CRITIQUE OF THE O'ROURKE SYNTHESIS

Over time, Fr. O'Rourke evolved into one of the major spokespersons for end-of-life care in the United States; and, in particular, for the claim that for patients in a permanent vegetative state (PVS), artificial nutrition and hydration (ANH) is a treatment that is ineffective and, for many individuals, also burdensome in terms of the effects on the family and society. Although not a terminal illness, PVS is a fatal pathology because, if left untreated, it would result in the death of the patient. Therefore, the use or discontinuation of

**Fr. O'Rourke insists that life is an intrinsic good—
hence his stalwart defense against euthanasia and assisted suicide.**

ANH (or any other treatment) can be considered for patients in PVS.

However, this position has met with resistance. For instance, in a presentation accompanying the publication of the papal allocution on "Care for Patients in a 'Permanent' Vegetative State,"⁵ Fr. Kevin McMahon singles out "the O'Rourke position."⁶ The critique of this specific application of Fr. O'Rourke's theory raises some legitimate as well as unfounded concerns.

One concern is that Fr. O'Rourke's theory reduces *bodily life to an instrumental good* as opposed to an intrinsic good, thereby creating a type of dualism. Yet Fr. O'Rourke clearly insists that life is an intrinsic good—hence his stalwart defense against euthanasia and assisted suicide. At the same time, he also sees life as an instrumental good that allows us to love and to express emotion and affection, and the use of life support principally deals with the concerns of pursuing instrumental goods. From the point of view of moral theology, this would be the difference between a negative precept which always binds (acting against life through euthanasia and assisted suicide) and a positive precept that usually binds (the duty to preserve life).

A second concern with Fr. O'Rourke's position is that it does not embrace the idea that the provision of ANH for people in PVS demonstrates a type of human solidarity with those who are severely impaired. Certainly the care that family members have provided for people in PVS is heroic. Yet it need not be seen as morally obligatory, lest the patient be treated as a means to an end rather than an end in himself or herself. That is, the first question is not how the treatment benefits the family or community, but, rather, how it benefits the patient.

A third general concern with Fr. O'Rourke's position involves the accuracy of diagnosis of PVS and/or the permanency of the condition, given isolated incidents of people seeming to emerge from PVS. Once again, to make a moral decision, the church does not demand metaphysical certitude; but it does demand moral certitude in making a health care decision. Medicine currently provides moral certitude; the church has never sanctioned the position in which the safest course of action had to be taken, especially when it

would be difficult to resolve a doubt of fact.

A fourth concern is that Fr. O'Rourke's position does not account for the idea that removal of ANH from PVS patients results in dehydration that can result in pain or suffering for the patient. The diagnosis of PVS presumably excludes such an ability to suffer, because of the nature of the pathology, although it must be admitted that there is no way to verify this absolutely.

A fifth concern has been that Fr. O'Rourke's position does not hold that food and water are always *ordinary treatment*, two of *life's basic necessities*. But the same can be said of oxygen, and yet people do not object to removing a ventilator from a person in PVS, even though it is equally if not more important to immediate survival and is not directly burdensome to the patient because he/she has no awareness of its use.

These five critiques can thus be overcome in a straightforward manner.

However, there are legitimate concerns about the O'Rourke position of both a theoretical and practical nature. When one looks back at the tradition, from the early authors through Pope Pius XII, one sees that the criterion surrounding the removal of life support centered on the treatment or action being gravely burdensome in comparison with the benefit offered. The introduction of the other O'Rourke criterion—that the treatment must be effective in terms of pursuing the purpose in life—can be considered a nuance. The tradition certainly has affirmed that the treatment must offer the patient a "reasonable hope of benefit."⁷

One could interpret the tradition to mean that "hope of benefit" could include solely physiological benefit (i.e., determining whether ANH can be physically assimilated by the body). Thus it is not absolutely clear that when Pius XII indicated that "life, health, all temporal activities are in fact subordinated to spiritual ends,"⁸ he necessarily implied the presupposition that if a treatment does not achieve a spiritual purpose, it can be forgone (presuming that it is not gravely burdensome as well). Therefore, although Fr. O'Rourke's position seems to make sense, it does represent a potential development in the tradition, depending on what is understood as constituting "benefit."

On the practical level, moreover, the concept of

**Fr. O'Rourke has helped change the culture of Catholic health care,
so that it can now accept death not as a failure but as a natural part of life.**

the spiritual purpose of life suggests some practical questions raised by theologians such as William May.⁹ Specifically, where does one draw the line in terms of a person's ability to pursue a spiritual purpose in life? Should ANH be provided to neonates with severe brain damage who may never be able to know, love, or serve God? How should this be interpreted for people in the end stages of diseases, such as Alzheimer's, who develop dysphagia? Has a slippery slope developed wherein the potential for inappropriate quality-of-life decisions emerges, as in the Baby Doe case? Care should be taken here to avoid interpreting Fr. O'Rourke's notion of benefit too narrowly, because AHN can benefit a patient on a cognitive/affective level even when it does not provide direct spiritual benefit. Undergirding this debate is the question whether it is appropriate to say that one of the burdens of treatment is that it preserves an already burdened life. Certainly, an individual's own assessment of his or her quality of life should be considered in making the decision whether to use treatment, because one's underlying condition alters the assessment of the benefit of the treatment provided. Nevertheless, this should remain an important point of future discussion.¹⁰

**THE CONTRIBUTION TO THE
FIELD OF CATHOLIC HEALTH CARE ETHICS**

Clearly Fr. O'Rourke's contribution to the discussion surrounding end-of-life issues has been significant for several reasons.

Terminology First, he has provided important terminology that has advanced the discussion. His introduction of the term "fatal pathology" moved the discussion about the use of life support beyond questions of terminal illnesses alone, broadening the scope of dialogue to include illnesses such as diabetes, AIDS, end-stage renal disease, Alzheimer's, and others. In doing so, he has helped people to ask the all-important question: Why am I doing this? The question is truly at the heart of Catholic conscience formation. Moreover, the overall teleological method that Fr. O'Rourke developed with Fr. Benedict Ashley, OP, "prudential personalism," has also moved people away from a deontological approach to ethics—the "Just-tell-me-what-to-do" method of ethical decision making.¹¹ In

doing this, Fr. O'Rourke has helped countless people focus on what is ethically correct, putting aside the overemphasis on the law that has saturated decisions surrounding end-of-life issues in the United States.

Fr. O'Rourke's use of the term "spiritual purpose or mission in life" has provided a helpful (if at times controversial) means of focusing Catholic health care's attention on the purpose of medicine in light of our understanding of the Resurrection. Medicine is not meant to keep people alive indefinitely but, rather, to keep them alive to strive for goals in life.

Message Secondly, by way of the myriad number of books, articles, and pamphlets he has published, the countless number of talks he has given at international and national conferences, the lectures he has given for hospital systems and individual facilities, the classes he has taught in the field of health care, the presentations he has made in individual parishes, and the counseling he has done with families and individuals involved in making decisions—Fr. O'Rourke has gotten his message *out*. The Jesuits remind us that repetition is the mother of study. Through his dogged repetition of the message, Fr. O'Rourke has helped change the culture of Catholic health care, so that it can now accept death not as a failure but as a natural part of life. In addition, by coauthoring and promoting *Advance Directive for Future Health Care Decisions: A Christian Perspective*,¹² he has helped provide people with a vehicle for thinking about such a hard topic ahead of time and, moreover, for doing so in a Christian way that goes beyond some of the legalese associated with secular documents.

Influence Third, he has influenced teachers, pastors, authors, and others, who have continued to preach a similar message. An example of this influence is a recent article, appearing in a popular Catholic magazine, entitled "End-of-Life Ethics: Preparing Now for the Hour of Death."¹³ Although the author does not mention Fr. O'Rourke, the terminology he uses clearly articulates the O'Rourke position. Fr. O'Rourke's language—"purpose of life" and "fatal pathology," for example—has become mainstream.

Methods Fourth, Fr. O'Rourke's goal-based assessment of the use of technology associated

**Fr. O'Rourke has reminded us of the Aristotelian maxim:
Virtue stands in the middle.**

with end-of-life issues can be used to assess other technologies in health care—including advances in areas such as stem cell research and reproductive technologies—vis-à-vis other goods in health care and society as a whole.

Balance Fifth, his approach to magisterial teachings has always been balanced, making the appropriate distinctions as to their weight and importance, neither overemphasizing nor underemphasizing their importance. In doing so, he distinguishes between the magisterium teaching on the level of principle (which has a greater certitude) and concrete applications (which admit of less certitude). This methodological aspect would be critical in all areas of Catholic health care.

Against Assisted Suicide Sixth, by avoiding vitalism, on one hand, while clearly condemning euthanasia and assisted suicide, on the other, Fr. O'Rourke has offered an approach that has not only worked in the best interests of patients but also helped impede calls for assisted suicide and euthanasia that surface when individuals feel they will be caught in medical limbo because of overly restrictive ethical or legal norms surrounding end-of-life issues.

Compassionate Care for the Dying Seventh, although the influences here have been many, certainly Fr. O'Rourke's concern with the ethical decisions about the use of life support has helped to focus attention on compassionate care for the dying. Because of the growing acceptance of allowing people to die, Catholic facilities have shown a resurgence of interest in palliative care in cases that call for comfort treatment rather than aggressive treatment. Such care can happen precisely because, aided by an appropriate use of ethical norms at the end of life, people feel intellectually, emotionally, and morally comfortable with the decision to move away from aggressive therapy.

Beyond Catholic Health Care Finally, Fr. O'Rourke's work has made an impact beyond the scope of Catholic health care. He helped to instigate a "friend of the court" brief in the Cruzan case decided by the U.S. Supreme Court. Over the past three decades, he has taught health care workers from a variety of different religious backgrounds the natural law or philosophical foundations that undergird the Catholic theological tradition on end-of-life questions.

AN ARISTOTELIAN REMINDER

In any effort to appraise a scholar's contribution to a field, it is easy to exaggerate. Certainly, in the field of Catholic health care ethics, many people are making significant contributions. Nevertheless, Fr. O'Rourke has made (and continues to make) a substantial contribution to the discipline. As a theologian and ethicist, in his well-thought-out articulations and advancements of Catholic thought, he has reminded us of the Aristotelian maxim: Virtue stands in the middle. ■

NOTES

1. Kevin O'Rourke, *Development of Church Teaching on Prolonging Life*, Catholic Health Association, St. Louis, 1988, p. 1.
2. Jean deBlois, Mary McGrath, and Kevin O'Rourke, *Advance Directive for Future Health Care Decisions: A Christian Perspective*, Virginia Publishing Co., St. Louis, 1991, p. 24.
3. Kevin O'Rourke, "The Catholic Tradition on Forgoing Life Support," *The National Catholic Bioethics Quarterly*, vol. 5, Autumn 2005, pp. 537-553.
4. "Lumen Gentium," in Austin Flannery, ed., *Vatican Council II: The Conciliar and Post-Conciliar Documents*, vol. 1, Costello Publishing, Northport, NY, 1975, para. 25.
5. Pope John Paul II, "Care for Patients in a 'Permanent' Vegetative State," *Origins*, vol. 33, no. 43, 2004, pp. 737-740.
6. Kevin McMahon, "Should Nutrition and Hydration be Considered Medical Therapy?," *Origins*, vol. 33, no. 43, 2004, pp. 746-747.
7. See U.S. Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, Washington, DC, 2001, directive 56, p. 31.
8. Pope Pius XII, "The Prolongation of Life: Allocation to the International Congress of Anesthesiologists," *The Pope Speaks*, vol. 4, 1958, p. 396.
9. William May, "Tube Feeding and the 'Vegetative' State," *Ethics and Medics*, vol. 23, December 1998, p. 2.
10. Patrick Norris and Kevin O'Rourke, "Care of PVS Patients: Catholic Opinions in the United States," *Linacre Quarterly*, vol. 68, August 2001, pp. 201-217.
11. Benedict Ashley and Kevin O'Rourke, *Health Care Ethics: A Theological Analysis*, 4th ed., Georgetown University Press, Washington, DC, 1997, pp. 139-176.
12. deBlois, McGrath, and O'Rourke, pp. 13-26.
13. Kenneth Overberg, "End-of-Life Ethics: Preparing Now for the Hour of Death," *Catholic Update*, August 2006, pp. 1-4.

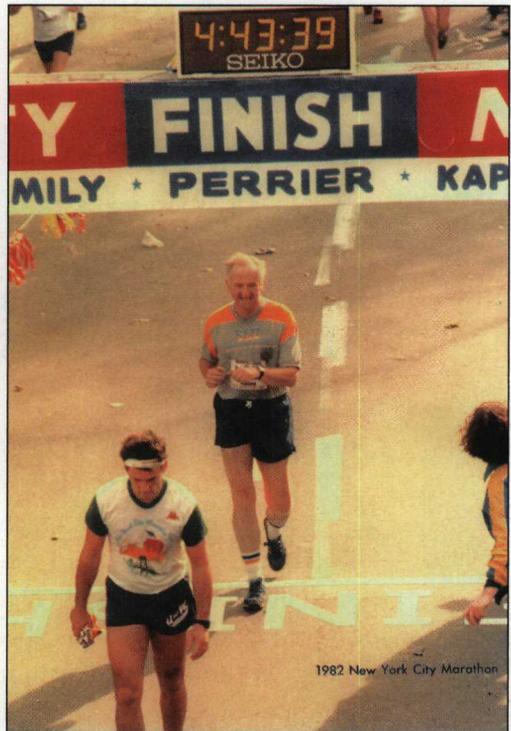
HONORING FR. O'ROURKE



1981, honorary PhD from Dominican University.



1994, honorary degree from Quincy University.



1982, New York City Marathon finish line!



1983, conferral of Dominican Master of Sacred Theology.

JOURNAL OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES

www.chausa.org

HEALTH PROGRESS®

Reprinted from *Health Progress*, March-April 2007
Copyright © 2007 by The Catholic Health Association of the United States
