

Grace at the End of Life: Rethinking Ordinary and Extraordinary Means in a Global Context Conor Kelly

IN THE CATHOLIC CONTEXT, health care is a true work of grace. The healing, accompaniment, and caring at the heart of health care all show the imprint of a God whose love is incarnate in the world.¹ One essential task for Catholic health care ethics, then, is to promote a form of ethical discernment that not only allows people to weigh the concrete choices before them but also invites them to be attentive to the unfolding of grace in their lives. While every issue in contemporary health care is potentially open to this kind of twofold analysis, decisions about care at the end of life are especially poignant from this point of view because two simultaneous movements of grace always need to be held in tension. On the one hand, temporal life needs to be recognized and respected as a gift from God. On the other hand, the good of eternal life must be acknowledged as an even greater gift of grace.

Traditionally, Catholic health care ethics has used the principle of ordinary and extraordinary means to navigate this tension, since the distinction ensures that the gift of life is neither dismissed too cavalierly nor esteemed too absolutely. In theory, this approach recognizes and affirms the work of grace in both the fight to preserve life and the willingness to forgo certain treatments, but, in practice, the division has been used to suggest that the true path of grace lies only at one end of the spectrum. This reduction does serious theological damage both speculatively—by preemptively narrowing the space in which one conceives of grace at work in the world—and practically—by restraining ordinary Catholics’ abilities to cooperate with grace in their own lives. Furthermore, in an environment of significant global health disparities, this narrowing tendency has the power to exacerbate some of today’s worst health-related injustices. Catholic health care ethics must respond to this contemporary trend or else it will fail in its service to the people of God. The purpose of this article, then, is to analyze

¹ For a nice explanation of how grace functions in Catholic health care, see Neil Ormerod, “Health Care and the Response of the Triune God,” in *Incarnate Grace: Perspectives on the Ministry of Catholic Health Care*, ed. Charles Bouchard (St. Louis: CHA USA, 2017), 22–36.

the developments reinforcing a narrow view of grace at the end of life and to propose solutions that will counteract their force so that Catholic health care ethics might more thoroughly respect the Catholic community's faith in the continual prospects of grace at all stages of life.

In pursuit of this end, the article has three parts. The first part reexamines the well-known distinction between ordinary and extraordinary means, illustrating how both elements of this division originally facilitated a proper respect for life as a gift of grace and then explaining how recent trends have transformed the principle into a tool that restricts the work of grace all but exclusively to the fight to preserve life. Next, the second part of the paper argues that this ballooning of the category of ordinary means cannot be justified in a world of dramatic health care inequities. In response, part two builds on the growing scholarly insistence that Catholic health care ethics needs to be in closer contact with social ethics, arguing specifically that the line between ordinary and extraordinary means needs to be interpreted in a global and not just a local context. The main result of this reconceptualization is to remove the onus of moral obligation from some of the costlier routine procedures whose burden levels seem reasonable in a United States context but truly extraordinary when viewed from a global perspective. Finally, the third, concluding section of the article discusses some of the structural changes that will be necessary to make this new approach to ordinary and extraordinary means a more realistic option for more of the faithful today.² Together, the three parts present a challenge to the current approach to end-of-life care while also offering a unique set of resources for the church to employ as it seeks to support and to encourage the faithful to work in good conscience to discern how God is calling them and their family members to respond to the complexities of grace at the end of life.

² The focus on structural changes stems from the assumption that social structures have the power to exert a causal, but not deterministic, effect on moral agents, variously making certain decisions easier or harder to make. As a result, structural forces must be considered when a new approach to moral discernment is countenanced because the incentives embedded in social structures affect both the likelihood that an agent will entertain a new form of discernment (e.g., discern ordinary and extraordinary means in light of a larger social consciousness) and the likelihood that he or she will act in a way that is consistent with the results of that discernment. See Daniel K. Finn, "What is a Sinful Social Structure?" *Theological Studies* 77, no. 1 (2016): 136–164.

ORDINARY AND EXTRAORDINARY MEANS AND THE WORK OF GRACE

In Catholic health care ethics, the distinction between ordinary and extraordinary means is a fundamental resource for moral discernment. Historically-conscious ethicists note some version of the distinction as early as the sixteenth century, and the patron saint of moral theology, Alphonsus Liguori, advanced the idea explicitly.³ In its original iterations, the principle of distinguishing ordinary and extraordinary means was not about health care per se but about one's personal moral obligations for self-care more generally.⁴ Of course, the means in question were always means of preserving life, but the context for this reflection was not bioethics as it is conceived today but something more like meta-ethics. In particular, these moralists accepted Thomas Aquinas's assertion that "whatever is a means of preserving human life, and of warding off its obstacles, belongs to the natural law" (ST I-II, q. 94, a. 2, c). Their main concern was therefore to determine how far one's natural law obligation to preserve his or her own life might extend. For example, the sixteenth century Dominican Francisco de Vitoria framed the question around "the specific obligation of the human person to eat food and thus sustain life," asserting that one ought to distinguish between the positive obligation to attain nourishment and the permissible, but not obligatory, effort to secure better quality foods as part of that endeavor.⁵ Other moralists reflected on similar concerns, and the eventual conclusion of their debates was that a person only had to exhaust his or her energy and resources to procure the ordinary means of sustaining human life, including, in the words of Gerald Kelly's twentieth century review of the earlier tradition, "the use of reasonably available food, drink, medicines and medical care; the wearing of sufficient clothing; the taking of necessary recreation; and so forth."⁶ One's natural law obligations did not, however, extend to the extraordinary means of preserving life—that is, "everything which

³ James F. Keenan, S.J., "A 400-Year-Old Logic," *Boston College Magazine*, Spring 2005, bcm.bc.edu/issues/spring_2005/ft_endoflife.html#keenan; in "When Burdens of Feeding Outweigh Benefits," *Hastings Center Report* 16, no. 1 (1986): 30–32, John Paris points to the Dominican Domingo Bañez as the originator of the term in 1583. Alphonsus Liguori quoted in Scott M. Sullivan, "The Development and Nature of the Ordinary/Extraordinary Means Distinction in the Roman Catholic Tradition," *Bioethics* 21, no. 7 (2007): 386–397.

⁴ Donald E. Henke, "A History of Ordinary and Extraordinary Means," in *Artificial Nutrition and Hydration and the Permanently Unconscious Patient: The Catholic Debate*, ed. Ronald P. Hamel and James J. Walter (Washington, DC: Georgetown University Press, 2007), 53–77.

⁵ Henke, "A History of Ordinary and Extraordinary Means," 55–56.

⁶ Gerald Kelly, S.J., "The Duty of Using Artificial Means of Preserving Life," *Theological Studies* 11, no. 2 (1950): 203–220, 204.

involves excessive difficulty by reason of physical pain, repugnance, expense, and so forth.”⁷

Notably, these extraordinary means involved a number of medical treatments, so it is not surprising that the larger idea of distinguishing ordinary and extraordinary means of preserving life has become intimately connected with health care ethics today. Indeed, such a development is a logical extension of the tradition, since health care is the primary field in which humans have to adjudicate various means of preserving life. Nevertheless, it is important to remember that the roots of this distinction go beyond health care to larger matters concerning one’s general moral obligation. Significantly, this broader focus on moral responsibility, and not just health care decision-making, allows one to see the relationship between the classic distinction and the work of grace more clearly in two ways.

First, the distinction presumes grace in its conclusion that certain means will be obligatory. The reason there is a *duty* to preserve life is that life is a gift from God. This is a direct conclusion from Aquinas’s description of this duty as a universally binding precept of the natural law, for he averred as a matter of definition that the “natural law is nothing else than the rational creature’s participation of the eternal law” (ST I-II, q. 91, a. 2, c). Insofar as the duty to preserve life was an evident principle of the natural law, it was also in alignment with God’s eternal law and therefore an affirmation both of God’s role as the author of life and, by extension, the giftedness of life itself.⁸ The subsequent specification of this duty through the concept of ordinary means begins with this assumption and underscores it, ensuring a proper appreciation of the magnanimity of life as a gift of grace.

Second, the distinction between ordinary and extraordinary means also creates space for grace in the decision to forgo extraordinary means of preserving life. The major premise behind this distinction was the belief that the preservation of life is a general precept of the natural law. Against this background, the novelty of the distinction is not that humans would need to use ordinary means to preserve life but that some means might actually be extraordinary and for that reason not obligatory. Arriving at this conclusion required some alternative—or at least additional—understanding of grace’s operation at the end of life, such that the termination of a gift of grace (i.e., life) might nevertheless serve as its own source of (new) grace. As one might imagine, Christian faith in the resurrection provided the basis for this interpretation, for hope in the afterlife implies, as David Kelly has put

⁷ Kelly, “The Duty of Using Artificial Means,” 204.

⁸ William May makes this point rather explicitly in *Catholic Bioethics and the Gift of Human Life*, Second Edition (Huntington: Our Sunday Visitor, 2008), 276.

it, that “the present life is to be treasured, but it is not all there is.”⁹ Such was the clear conclusion of Pope Pius XII in his influential statement on the “Prolongation of Life,” which defended the non-obligatory nature of extraordinary means by arguing that “life, health, all temporal activities are in fact subordinated to spiritual ends.”¹⁰ This position takes nothing away from the sanctity of life as a gift of grace; instead, it adds another level of appreciation for the next life as a wonderful gift of grace as well.

For the field of Catholic health care ethics, with its keen interest in the work of grace in the world, these two observations point to one fundamental reality about the traditional distinction between ordinary and extraordinary means: both sides of this distinction serve to call attention to the role of grace amidst serious illness. Consequently, Catholic health care ethics should be rightly concerned when the narrative begins to suggest that grace is primarily—or worse, exclusively—found at only one end of the division. Unfortunately, the popular use of this principle in recent years, at least in the U.S. context, has begun to suggest exactly this idea. The clearest way to see this is in the interpretation and application of Pope John Paul II’s 2004 allocution on “Life Sustaining Treatments and Vegetative State.”

In that allocution, John Paul II stressed the inherent dignity of the human person, criticizing the trend to dehumanize patients in a “persistent vegetative state” on the basis of their reduced functionalities and instead emphasizing the intrinsic worth of every human life. In order to ensure the protection of life even in this vulnerable state, John Paul II addressed the issue of obligatory care for those in a persistent vegetative state, and professed, “The administration of water and food, even when provided by artificial means, always represents a *natural means* of preserving life, not a *medical act*. Its use, furthermore, should be considered, in principle, *ordinary* and *proportionate*, and as such is morally obligatory.”¹¹ Although the language “in principle” left some room for discernment in specific cases, the force of this allocution was almost immediately evident as moral theologians began to debate how authoritatively and definitively a papal allocution could assign artificial nutrition and hydration to the category of ordinary

⁹ David Kelly, *Medical Care at the End of Life: A Catholic Perspective* (Washington, DC: Georgetown University Press, 2006), 5.

¹⁰ Pope Pius XII, “The Prolongation of Life,” in Ronald P. Hamel and James J. Walter, *Artificial Nutrition and Hydration* (Washington, DC: Georgetown University Press, 2007), 91–97.

¹¹ Pope John Paul II, “Address to the Participants in the International Congress on ‘Life-Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas,’” March 20, 2004, w2.vatican.va/content/john-paul-ii/en/speeches/2004/march/documents/hf_jp-ii_spe_20040320_congress-fiamc.html. Emphasis in original.

means.¹² Additionally, the Congregation for the Doctrine of the Faith (CDF) eventually responded to a request for clarification about this allocation, further elevating the significance of the teaching and prompting renewed discussions about this proposal among those actively engaged in health care ministry.¹³ The impact of this papal address was especially pronounced in the United States, where it played into the ongoing culture war battle over the fate of Terri Schiavo, a Florida woman in a persistent vegetative state whose Catholic parents were locked in a legal battle with her husband over whether to remove her feeding tube.¹⁴ As that subtext makes clear, the effect of the allocation was to cement the idea that artificial nutrition and hydration ought to be identified *prima facie* as an ordinary means of preserving life, despite the fact that a compelling case can be made for the interpretation that this is precisely not what the allocation meant in practical terms.¹⁵ Whatever the authoritative status of the allocation and its interpretation, the *prima facie* reading certainly had a lot of influence, particularly in the context of Schiavo's case and its aftermath. This

¹² For one illustration of this debate, see Thomas A. Shannon and James J. Walter, "Assisted Nutrition and Hydration and the Catholic Tradition," *Theological Studies* 66, no. 3 (2005): 651–662; John J. Paris, James F. Keenan, and Kenneth R. Himes, "Quaestio Disputata: Did John Paul II's Allocation on Life-Sustaining Treatments Revise Tradition?" *Theological Studies* 67, no. 1 (2006): 163–168; Thomas A. Shannon and James J. Walter, "A Reply to Professors Paris, Keenan, and Himes," *Theological Studies* 67, no. 1 (2006): 169–174. See also Kevin O'Rourke, "Reflections on the Papal Allocation Concerning Care for Persistent Vegetative State Patients," *Christian Bioethics* 12, no. 1 (2006): 83–97. For a thorough account of how this debated question was treated before the papal allocation, see Michael R. Panicola, "Withdrawing Nutrition and Hydration," *Health Progress* 82, no. 6 (2001): 28–33.

¹³ Congregation for the Doctrine of the Faith, "Responses to Certain Questions of the United States Conference of Catholic Bishops Concerning Artificial Nutrition and Hydration," September 16, 2007, www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20070801_risposte-usa_en.html; Congregation for the Doctrine of the Faith, "Commentary on Responses to Questions Presented by His Excellency the Most Reverend William S. Skylstad," August 1, 2007, www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20070801_nota-commento_en.html. See also Ron Hamel, "The CDF Statement on Artificial Nutrition and Hydration: What Should We Make of It?," *Health Care Ethics USA* 15, no. 4 (2007): 5–7; Kevin D. O'Rourke and John J. Hardt, "Nutrition and Hydration: The CDF Response, in Perspective," *Health Progress* 88, no. 6 (2007): 44–47; Justin F. Rigali and William E. Lori, "On Basic Care for Patients in the 'Vegetative State': A Response to Dr. Hardt and Fr. O'Rourke," *Health Progress* 89, no. 3 (2008): 70–72.

¹⁴ For an overview of the way this case unfolded in the culture wars, see Cathleen Kaveny, *Prophecy without Contempt: Religious Discourse in the Public Square* (Cambridge: Harvard University Press, 2016), 65–74.

¹⁵ James T. Bretzke, "A Burden of Means: Interpreting Recent Catholic Magisterial Teaching on End-of-Life Issues," *Journal of the Society of Christian Ethics* 26, no. 2 (2006): 183–200.

result is especially troubling because, as the debate over Schiavo's case illustrates, an abstract determination of a particular treatment as an ordinary means restricts the work of grace to the attempt to prolong temporal life.

Admittedly, few of the people discussing Schiavo's case appealed to the work of grace, but the public discourse from Catholic leaders at the time reveals implicit assumptions about the place of grace at the end of life. The best example is a statement from Archbishop Charles Chaput, then head of the Archdiocese of Denver, who condemned the removal of Schiavo's feeding tube as "a form of murder...[that] attack[s] the sanctity of human life...[and] reject[s] any redemptive meaning to suffering."¹⁶ By appealing to the affront to the sanctity of human life, Chaput's statement implied that the grace of life was not appropriately recognized and honored in Schiavo's case. At the same time, by lamenting the dismissal of suffering's redemptive meaning, his statement also suggested that the removal of Schiavo's feeding tube was a missed opportunity for grace, leaving one to infer that the real place to search for grace at the end of life is in the divine assistance necessary to persevere in the face of exceptionally challenging medical conditions, no matter how debilitating. Other Catholic leaders, including Cardinal Renato Martino, the head of the Pontifical Council for Justice and Peace at the time, made similarly strong statements.¹⁷

Of course, there are a number of unique issues in Schiavo's case, and the discussion here is not meant to gloss over the complexities involved, but it is important to appeal to this example nonetheless because the very public debate about Schiavo's treatment ensured that a certain interpretation of Catholic teaching on end-of-life care managed to shape the narrative of the day.¹⁸ Reflecting on the case and the larger duty to preserve life, the senior ethicist for the Catholic Health Association at the time, Ron Hamel, noted that

Two standards for making decisions about nutrition and hydration have emerged and now exist side by side. One is a more holistic standard based on the traditional teaching, in which benefits and burdens

¹⁶ Charles J. Chaput, "Statement by Archbishop Chaput on Terri Schiavo," *Catholic News Agency*, March 22, 2005, www.catholicnewsagency.com/document/statement-by-archbishop-chaput-on-terri-schiavo-252.

¹⁷ Renato R. Martino, "Statement of Cardinal Renato Martino on Behalf of Terri Schiavo," *Catholic Culture*, March 7, 2005, www.catholicculture.org/culture/library/view.cfm?recnum=6374.

¹⁸ Kaveny makes the point that the contributions of leading Catholics to the popular debate were mainly in the form of prophetic rhetoric and as such presumed that their interpretation of the moral obligations in the case was the only possible interpretation that could be sustained by people who shared their same religious and moral commitments, see Kaveny, *Prophecy without Contempt*, 71–72.

are understood broadly relative to the person, and any means of preserving life is subject to a benefit-burden analysis. The other is a more restrictive standard based on recent revisions of the traditional teaching, in which benefits and burdens are understood narrowly, apart from relative factors, and nutrition and hydration are given a special moral classification.¹⁹

Although Hamel demurred on which of these two standards was taking hold (notably, he wrote while Schiavo's case was still unfolding), Thomas Shannon and James Walter were more insistent after witnessing the concerted Catholic response to Schiavo's situation, offering, "we remain persuaded that there is... a shift to deontological reasoning in the area of death and dying, complemented by categorizing interventions as ordinary or extraordinary [in isolation]."²⁰ They pointed directly to John Paul II's 2004 allocution as the tipping point.

There is much to suggest that Shannon and Walter are right: there has been a shift toward deontological thinking in the approach to death and dying. On the one hand, there were a number of cultural factors that encouraged this shift, most notably concerns about the contemporaneous movement seeking to legalize euthanasia and physician assisted suicide.²¹ Against this background, the impulse is certainly understandable. On the other hand, there are real costs to this development. The greatest cost is in the growing assumption among ordinary Catholics that they must do everything in their power to fight death for themselves and their loved ones or else they risk turning into unconscious pawns in the culture of death, actively involved in violating the sanctity of human life as a gift from God. However dramatic this may sound, personal anecdotal evidence reveals there are people facing these sorts of end-of-life decisions who earnestly feel this way. Often, many of them are led to this conclusion by their well-meaning parish priests who have followed the public battles over end-of-life care for Catholics but have not had the opportunity to delve into the particulars of the church's long tradition.²²

¹⁹ Ronald Hamel, "Must We Preserve Life?," *America*, April 19, 2004, www.americamagazine.org/issue/482/article/must-we-preserve-life.

²⁰ Shannon and Walter, "A Reply," 173.

²¹ See Michael D. Place, "Thoughts on the Papal Allocution," *Health Progress* 85, no. 4 (2004): 6, 60.

²² In recognition of precisely this challenge, Catholic Health Association USA has launched a series of workshops for clergy to familiarize them with the details of the church's position on end-of-life care. One part of the workshop is dedicated to "dispelling myths," specifically the "misconception that the Catholic Church requires Catholics to say yes to all medical interventions." Julie Minda, "Clergy Gain Insights on Assisting in End-of-Life Care Choices," *Catholic Health World*, May 15, 2018, www.chausa.org/publications/catholic-health-world/archives/issues/may-15-2018/clergy-gain-insights-on-assisting-in-end-of-life-care-choices.

If all this led to merely a presumption in favor of something like artificial nutrition and hydration—which the USCCB’s *Ethical and Religious Directives* (ERDs) affirms—then one might be tempted to say no harm, no foul.²³ The problem, however, is that this logic is not restricted to artificial nutrition and hydration but is instead applied to interventions more broadly. People begin to think that the only way to cooperate with grace at the end of life is to fight for life and to hope for the grace to persevere through suffering in that fight.

Of course, this is not to say that people only come to this conclusion as a result of Catholic involvement in the culture wars. There are other cultural influences at work, especially the “idolatry of health” and the growing assumption that the purpose of modern medicine is to eliminate suffering and, ideally, counteract the effects of mortality.²⁴ The net effect of these developments, though, is that questions of the proportionate and disproportionate nature of certain means have begun to disappear, except for the most well-informed patient, and Catholics have instead defaulted in favor of intervention. Given the history of the principle of ordinary and extraordinary means, this is a theological problem because of what it says about our appreciation of grace, and it is also a pastoral problem for the stress it adds to families at an especially trying time. Just as importantly, this change is also a theological problem because of what it does to the distribution of scarce medical resources.

THE EXTRAORDINARY NATURE OF ORDINARY MEANS IN A GLOBAL CONTEXT

The narrowing of options for faithful Catholics and the implicit restriction of grace to the active fight to preserve life presents poignant problems in light of contemporary health care disparities. As the physician and reformer Paul Farmer is quick to point out, the story of medicine in the contemporary world is a story of radical disparities, all of which revolve around one feature: poverty. “Surveys have shown,” Farmer notes in an article with his colleague Nicole Gastineau Campos, “that in the world’s poorest countries, the affluent have ready access to [expensive modern medical treatments like]...antiretroviral agents...therapy for renal insufficiency...[and] NICUs.... At the same time, the world’s poor, even those living in wealthy nations, do not have reliable access to good medical care or to the fruits

²³ United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 5th ed. (Washington, DC: United States Conference of Catholic Bishops, 2009), no. 58; cf. Shannon and Walter, “A Reply,” 172.

²⁴ George Khushf, “Illness, the Problem of Evil, and the Analogical Structure of Healing: On the Difference Christianity Makes in Bioethics,” *Christian Bioethics* 1, no. 1 (1995): 102–120; Stanley Hauerwas, *Naming the Silences: God, Medicine, and the Problem of Suffering* (London: T&T Clark, 2004), 101.

of medical science.”²⁵ This truth is readily apparent to anyone who has seen understaffed inner-city trauma centers in the United States or who has traveled abroad to oppressed areas of the global south.

Nevertheless, Catholic health care ethics has not grappled with this reality effectively. As Daniel Daly observed in his own work contextualizing the ethics of end-of-life care in a world of radical health inequities, “While the suffering and premature death that is commonplace in the global south has emerged as a central topic within Catholic medical ethics, few moral conclusions have changed as a result. The diminished and shortened lives of the global poor are lamented but have not concretely altered moral analysis or conclusions.”²⁶ Undoubtedly, this reality is something that end-of-life ethics needs to take more seriously, and the application of the principle of ordinary and extraordinary means should not be immune to this global reality.

To give a quick sense of the problem in more concrete terms, consider just a few sobering statistics. Less than a decade ago, the World Health Organization reported that OECD countries consumed 86 percent of all health dollars spent globally while encompassing only 18 percent of the population.²⁷ Unsurprisingly, this translates into significant disparities in access to health care services, and the WHO estimates that even today “at least half of the world’s population cannot obtain essential health services.”²⁸ A number of examples reveal very clearly that this half of the world’s population is defined by poverty and, by extension, geography since truly abject poverty is concentrated in the so-called developing nations of the global south. First, a 2010 review of trends in maternal mortality found that 99% of all women who died from complications related to their pregnancy lived in developing nations.²⁹ Second, the leading cause of “lost life years” (i.e., early death) in the global north and BRICS nations (Brazil, Russia, India, China, and South Africa) is almost universally heart disease, a tricky medical problem to address. The leading cause of lost life

²⁵ Paul Farmer and Nicole Gastineau Campos, “Rethinking Medical Ethics: A View from Below,” *Developing World Bioethics* 4, no. 1 (2004): 17–41.

²⁶ Daniel J. Daly, “Unreasonable Means: Proposing a New Category for Catholic End-of-Life Ethics,” *Christian Bioethics* 19, no. 1 (2013): 46.

²⁷ World Health Organization, *The World Health Report: Health Systems Financing: The Path to Universal Coverage* (Geneva: WHO Press, 2010), 4. Available online at www.who.int/whr/2010/en/.

²⁸ World Health Organization, “World Bank and WHO: Half the World Lacks Access to Essential Health Services, 100 Million Still Pushed into Extreme Poverty because of Health Expenses,” December 13, 2017, www.who.int/en/news-room/detail/13-12-2017-world-bank-and-who-half-the-world-lacks-access-to-essential-health-services-100-million-still-pushed-into-extreme-poverty-because-of-health-expenses.

²⁹ World Health Organization, *Trends in Maternal Mortality: 1990 to 2010* (Geneva: WHO Press, 2012), 22. Available online at apps.who.int/iris/bitstream/handle/10665/44874/9789241503631_eng.pdf?sequence=1.

years in the global south, however, runs the gamut from HIV/AIDS (similarly tricky to tackle, yet with a clearer management plan than heart disease) to malaria, diarrhea, and pneumonia-type illnesses, which have much less costly solutions.³⁰ Third, as Paul Farmer helpfully illustrated in the midst of the 2013–2016 Ebola outbreak, most health care disparities today come down to the distribution of “staff, space, stuff, and systems.” The varying availability (or unavailability) of these four things explains why Ebola mortality rates hovered at 75% in Western African nations but plateaued at 25% in Germany during a rare outbreak there *nearly half a century earlier*.³¹ This gets to the heart of the problem, revealing that global health care disparities are chiefly about access to care and that the worst of these disparities reflects the lack of access to even basic medical care that the WHO has ascribed to at least one half of the world’s population.

In a world where the majority of people cannot reliably hope to receive everyday health care treatments like vaccines, prenatal monitoring, and safe drinking water, surely one has to reconsider what constitutes an ordinary means of preserving life. Admittedly, this is not an easy thing to do. The traditional approach to ordinary and extraordinary means has presumed that these categories need to accommodate local variation, since the means in question have to be available to a given patient in his or her particular situation.³² The CDF’s initial interpretation of John Paul II’s allocution follows this logic in asserting a permissible exception to the obligation to provide artificial nutrition and hydration “in very remote places or in situations of extreme poverty...[where] the artificial provision of food and water may be physically impossible.”³³ The prevailing norm, however, is that treatments normally accessible in one part of the world ought to be identified as ordinary means—and thus obligatory interventions, all things being equal—for all patients in the same locale, except when medical futility arises in particular cases. There are good reasons for this norm because it militates against disparate treatment of similar patients in the same context and bolsters the argument for providing an equally rigorous standard of care to all patients as a matter of justice.

Unfortunately, this approach also masks and exacerbates global health inequities because it encourages people to take a local view of their place in an increasingly interconnected health care infrastructure.

³⁰ Dylan Matthews, “The #1 Reason People Die Early, in Each Country,” *Vox*, March 13, 2015, www.vox.com/2015/1/2/7474995/map-years-lost-life.

³¹ Jonathan Hiskes, “Stopping Infectious Disease Requires ‘Staff, Space, Stuff, and Systems,’ Paul Farmer Argues,” *Medium*, February 20, 2018, medium.com/@simpsoncenter/stopping-infectious-disease-requires-staff-space-stuff-and-systems-paul-farmer-argues-with-8f59e5ad79d4.

³² Pope Pius XII, “The Prolongation of Life,” 94.

³³ Congregation for the Doctrine of the Faith, “Commentary.”

When people evaluate the benefits and burdens of a proposed treatment in the narrow context of their place in the United States, for instance, they can quickly overlook the fact that this treatment might be very costly, contributing to the disproportionate use of health care resources in the global north and thereby undermining the expansion of access to basic care in the global south. Granted, this is not strictly the result of a direct causal chain, although in a globalized world with finite health care resources, overuse by some still does result in underuse by others. The strongest impact arises from the creation of misaligned incentives, such as the way that the rich health care markets of the global north prompt a “brain drain” from the global south as trained medical professionals seek higher paying jobs and better working conditions in wealthier countries, creating shortages of health care workers in their homelands.³⁴ In light of these challenges, it is necessary to encourage a greater sense of (global) solidarity in the ethical discernment surrounding end-of-life care.

Of course, this is not exactly a novel suggestion. In the early 2000s, Lisa Sowle Cahill made the case for a theological approach to health care ethics that would distinguish itself, in part, from its secular counterparts by its explicit emphasis on evaluating bioethics as a social ethics issue.³⁵ One of the ways she illustrated this approach was with a powerful critique of the tendency to use a concern for the vulnerable as an excuse to ignore the impact of end-of-life care on the common good. Pointing toward the implications of a more globally-conscious perspective, Cahill argued that “specific allocations of health care resources need to be made...in awareness of the need for redistributive justice in meeting basic needs of persons in less advantaged societies before providing relatively expensive or exotic life-prolonging technologies to those in more privileged circumstances.”³⁶ The present effort to reexamine ordinary and extraordinary means adds specificity to some of Cahill’s critiques and extends her concerns, many of which have only been amplified by the global rise in inequality that has been

³⁴ Daly, “Unreasonable Means,” 48. This can also be seen in the way that the outsized scope of the U.S. drug market orients research and development toward the inconveniences of an aging population (e.g., erectile dysfunction) and away from the life-threatening problems of the global population (e.g., malaria). Conor M. Kelly, “Pharmaceutical Development and Structural Sin: Diagnosing and Confronting Global Health Care Disparities,” presented at the Catholic Theology Society of America Annual Convention, Milwaukee, WI, June 11–14, 2015.

³⁵ Lisa Sowle Cahill, *Theological Bioethics: Participation, Justice, Change* (Washington, DC: Georgetown University Press, 2005), 1–3.

³⁶ Cahill, *Theological Bioethics*, 110.

a defining feature of the last thirteen years since her book was published.³⁷

While Cahill set the stage, in many ways, for a more globally conscious approach to health care ethics in general, another theological ethicist has followed her lead to address end-of-life care specifically from the perspective of social ethics. Writing with an acute awareness of global health disparities, the aforementioned Daniel Daly proposed a solution to the disproportionate use of health care resources for end-of-life care in developed countries by championing the addition of a new category to the principle of ordinary and extraordinary means that would create “an upper moral limit on medical treatment at the end of life.”³⁸ His concept of “unreasonable means” (a term borrowed from David Kelly) prohibits the use of treatments “when the burdens to the patient and community far outpace the benefits to the patient...and when [their] use...directly or indirectly limits another patient’s access to ordinary means.”³⁹ This is an important development that goes a long way in addressing the myopia that the culturally variable account of ordinary and extraordinary means promotes. It highlights the inter-related nature of health care decisions in a world of finite health care resources, and it invites the cultivation of solidarity as a patient or a patient’s family begins to consider personal medical decisions in relation to the common good. Precisely for these reasons, Daly’s solution serves an essential function in contemporary health care ethics, and it represents a necessary addition to Catholic end-of-life ethics in particular. However necessary, though, Daly’s category of unreasonable means is not sufficient alone. Given the recent developments in assumptions regarding the principle of ordinary and extraordinary means, the problem of inordinate uses of health care resources cannot be solved solely by adding to the distinction in order to expand its force. Instead, the distinction itself needs reevaluation.

The solution proposed here, then, is to take Daly’s instincts and apply them to the other end of the spectrum of care. Daly offers a terminus at one end by arguing that unreasonable means are morally prohibited. This leaves ordinary means as the morally obligatory way to prolong life and extraordinary means as the morally supererogatory (i.e., optional) way to prolong life. If one considers things in these terms, it is easy to see how the distinction itself contributes to the problem, especially when the category of ordinary means begins to balloon to encompass more interventions less critically. To be more precise, the rapid expansion of the category of ordinary means has facilitated

³⁷ For more on the increasing prevalence of inequality worldwide and its ethical implications, see Kate Ward and Kenneth R. Himes, “‘Growing Apart’: The Rise of Inequality,” *Theological Studies* 75, no. 1 (2014): 118–132.

³⁸ Daly, “Unreasonable Means,” 52.

³⁹ Daly, “Unreasonable Means,” 52–53.

broader trends, like the medicalization of human health and the expanding vision of medicine's proper purpose, which lead to the disproportionate use of health care resources in developed nations like the United States, because the category tells Catholics that they must use certain treatment options at the end of life. Given that end-of-life care is one of the most expensive categories of care, this perspective certainly has the potential to exacerbate the current global health inequities.⁴⁰ In response, Catholic health care ethics needs to find a way to give greater latitude to the interpretation of ordinary means, thereby counteracting the implicit narrowing of the space for grace in end-of-life care that has accompanied the rise of deontological thinking in the application of the principle of ordinary and extraordinary means.

In concrete terms, this solution entails an expansion of the factors that ought to be evaluated when one employs the principle of ordinary and extraordinary means to discern appropriate end-of-life care. Currently, "places, times, and culture" are a factor in the determination of ordinary means, and this is quite appropriate for the reasons outlined above. Yet, in a world of global health care disparities, it is not enough to see the distinction between ordinary and extraordinary means in a local context alone. As a matter of solidarity, which involves "a firm and persevering commitment to the common good; that is to say to the good of all and of each individual, because we are all really responsible for all" (*Sollicitudo Rei Socialis*, no. 38), Catholics ought also to consider the ways that access to care affects the determination of ordinary means. More specifically, they need to account for the fact that what is ordinary in a U.S. context might be deemed quite extraordinary in much of the rest of the world. The best way to do this is to discern the burdens of a proposed treatment not simply in one's immediate circumstances but also according to a broader global perspective.

Something along these lines is already presumed in the work of discerning ordinary and extraordinary means, for as the ERDs summarize that long tradition, ordinary means "are those that in the judgment of the patient offer a reasonable hope of benefit and do not entail an excessive burden or impose excessive expense on the family or the community."⁴¹ By highlighting the need to consider not simply the burdens to the patient himself or herself but also to the larger circles of family and community, the ERDs present the principle of ordinary

⁴⁰ Studies of the U.S. Medicare system indicate that nearly one-third of all Medicare expenditures go to the five percent of patients who die in a given year. Amber E. Barnato, Mark B. McClellan, Christopher R. Kagay, and Alan M. Garber, "Trends in Inpatient Treatment Intensity among Beneficiaries at the End of Life," *Health Services Research* 39, no. 2 (2004): 364.

⁴¹ United States Conference of Catholic Bishops, *Ethical and Religious Directives*, no. 56.

and extraordinary means as a potential tool of solidarity insofar as it invites the patient to see herself or himself as a person in relationship with others whose wellbeing is also a concern. The challenge, though, is that this broader sense of burden is often hard to gauge, especially since each person is a constituent of multiple communities. The point of this proposal, then, is to invite patients to recognize themselves as members of the global community and to encourage them to account for the burdens their treatment(s) might impose on that community as well. Given the disproportionate use of health care resources by the global north and the misaligned incentives that this reality creates, patients in a U.S. context should address their global accountability by assessing the extent to which a proposed treatment reinforces international disparities by using resources to provide a form of care in the global north that is inaccessible to the majority of the population in the global south.

In practical terms, one can envision this type of discernment as a twofold process. First, a patient would evaluate the benefits and burdens of a treatment according to her or his immediate circumstances. Then, the patient would try to imagine how he or she would evaluate the benefits and burdens of the same treatment if he or she were in another part of the world, like the global south, focusing on the additional burdens and new obstacles that might stand in the way of treatment when one can no longer count on the advantages of a well-established health care system. In many instances, this twofold process would likely generate some degree of dissonance, for the unjust distribution of health care resources, which results in lower standards of care in the global south, could very well lead to the conclusion that what a patient discerns as an ordinary treatment in the United States is deemed extraordinary by the majority of the world's population. The obvious question is what a patient ought to do with this dissonance, and this is where the Catholic moral tradition's insistence that the determination of an ordinary or extraordinary means can only occur in the concrete situation of a patient's particular course of treatment becomes especially important, for it indicates that the resolution of this dissonance is a matter of conscience.⁴² While this may seem flippant or dismissive, it is not. As "the most secret core and sanctuary of a [human person where one]...is alone with God, Whose voice echoes in his [or her] depths" (*Gaudium et Spes*, no. 16), conscience is precisely where this decision should take place, for the final determination of whether one's end-of-life care represents an ordinary or extraordinary means comes down to discerning how one is called to cooperate with God's grace.

⁴² James T. Bretzke, "Ordinary and Extraordinary Means," in *A Handbook of Roman Catholic Moral Terms* (Washington, DC: Georgetown University Press, 2013), 167–168.

While the ultimate decision remains a matter of conscience, which always operates in the concrete and cannot be predetermined,⁴³ attention to the work of grace at the end of life suggests that certain outcomes might be more common than others. Specifically, one can imagine that in most cases the twofold discernment process would still lead patients to accept treatment as an ordinary means according to their local context. This is because adequate respect for the sanctity of life as a gift of grace justifies deference to a more expansive definition of ordinary means, which is typically going to arise from the local rather than the global analysis. Even in these instances, though, it will still be helpful for patients to have examined their decision from a global perspective, for this can promote an appropriate sense of global awareness that better enables one to appreciate both the fragility of life as a gift of grace and the privilege of cooperating with grace in its preservation. In some unique cases, though, the disconnect between local and global understandings of ordinary means might prompt a particular patient to forgo a treatment that he or she initially discerned to be an ordinary means of prolonging life in his or her locale, as long as he or she did so under narrow circumstances and for the right reasons. This, of course, is where the greatest impact of this twofold discernment process comes to light, for it represents a departure from the typical assumptions surrounding the principle of ordinary and extraordinary means. Currently, the local decision is the one that creates the force of moral obligation, for that which a patient discerns to be an ordinary means according to his or her time, place, and culture must, for that very reason, be used to prolong the patient's life. With the addition of a global perspective, however, the obligation can give way to a concern for global justice, which is consistent with both the Christian understanding of the practical implications of faith in Jesus Christ as the Son of God and, as outlined below, the belief that God's grace is at work in the world, even at the end of life.⁴⁴

Before addressing the opportunities for grace inherent in this new approach to ordinary and extraordinary means, it seems prudent to offer a bit more detail about the unique areas where a patient's judgment of conscience might prompt them to defer to the discernment of extraordinary means according to the global rather than local perspective. While it is tempting to try to articulate a set of criteria that would restrict this situation in advance, such an approach would merely perpetuate some of the problems that have given rise to the need for a

⁴³ Timothy O'Connell, *Principles for a Catholic Morality*, Revised Edition (New York: Harper Collins, 1990), 112.

⁴⁴ For a robust defense of the compatibility of a commitment to global justice with Christian faith, see Lisa Sowle Cahill, *Global Justice, Christology, and Christian Ethics* (Cambridge: Cambridge University Press, 2003).

new interpretation of ordinary and extraordinary means in the first place. After all, the twofold process proposed here is designed, in part, to counteract the tendency to view ordinary means as a deontological category. Fortunately, the well-established tradition of moral discernment through casuistry offers a way to develop some additional specificity without devolving into a deontological calculus. Consider, then, the case of patients in a persistent vegetative state, which is, of course, the question that has been at the heart of the very deontological shift that needs more critical evaluation.

In this case, the twofold discernment process articulated above entails that a Catholic could, in good conscience, instruct his or her health care proxy to discontinue artificial nutrition and hydration if he or she were diagnosed in a persistent vegetative state (and had been in that state for a sufficiently prolonged period virtually to eliminate the possibility of eventual recovery). In this situation, the Catholic in question would need to settle on these instructions not out of a fear of being stuck in this life in this condition but out of a desire to avoid excessively taxing the health care system in a way that perpetuates the disproportionate use of medical resources in the global north (as a whole) and encourages the persistence of the global health care system's perverse incentives. In a word, this would have to be a selfless decision, motivated by the recognition that in many—in fact, most—parts of the world this diagnosis would be an almost immediate death sentence because even the relatively rudimentary care of continual nursing and artificial nutrition and hydration is inaccessible. Out of solidarity with the majority of the population in this situation and out of a desire to combat the very inequities that make this lack of access a reality, one in this context could opt out of the active interventions of the modern health care system and instead ask for hospice care so that there might be additional resources available for more basic (or perhaps similarly basic) care for more people in the world. Granted, the act would likely be one of prophetic resistance to a large-scale structural problem rather than a direct solution to it, but the example of Jesus clearly shows that there is value—and more importantly, grace—in these kinds of actions. While this discernment might seem to contradict the official magisterial interpretation of artificial nutrition and hydration, observers who are attuned to the intricacies of magisterial authority and papal pronouncements note that the Magisterium's "official" position on artificial nutrition and hydration (even for patients in a persistent vegetative state) is not so clear cut.⁴⁵ Consequently, the effect of the twofold discernment process advocated here is not to contradict magisterial teaching but to nuance its interpretation and application, so that an isolated reading of one papal address does not undercut the Catholic community's fidelity to its core

⁴⁵ Bretzke, "A Burden of Means," 195.

convictions like hope for the resurrection or a commitment to the preferential option for the poor.

Naturally, there are likely to be concerns with an approach like this, especially since one of the factors motivating the shift toward a deontological interpretation of ordinary and extraordinary means was a desire to protect life at all of its vulnerable stages. While this is a laudable goal, it is important to recognize that expanding the notion of ordinary means in a *prima facie* fashion does not serve this end directly. Certainly, as suggested above, a tendency to categorize a specific medical treatment as an ordinary means of prolonging life can aid the effort to insist that every patient should, as a matter of justice, have access to that treatment, but the notion of ordinary means does not directly entail this conclusion. The real moral implication of defining something as an ordinary means is not that everyone should have access to this means of preserving life but that anyone who does have access must use it. On its own, the principle of ordinary and extraordinary means is not about access to care, which is why patients and their families need to be encouraged to incorporate a broader perspective when they apply this principle. The global perspective presented here as part of a twofold discernment process does this by creating more space for the exercise of conscience in the adjudication of ordinary means. Thus, the notion of a broader process that compares local determinations with global realities prompts a question of justice and might lead to different choices, which, collectively, could have the power to undo some of the injustices plaguing health care today. Of course, this appeal to conscience carries risks of relativism alongside the risk that a patient or his or her family might make a morally bad decision, but such is the nature of conscience in fallible human beings. The Catholic community ought to be willing to accept these risks in order to honor the high dignity of conscience. Furthermore, the Catholic community ought to tolerate these risks out of a respect for the dynamism of grace because the incorporation of a global perspective in end-of-life discernment invites a new openness to all the possibilities of grace at the end of life.

At the moment, as explained above, the common interpretation of grace at the end of life is limited. Despite the fact that the principle of ordinary and extraordinary means points to grace at both of its poles, the application of this principle has led to the assumption that the proper place to search for grace is with the patient who insists on fighting to the end, despite any suffering, so that she or he can enjoy the grace of a purely “natural death.” In this model, there is little space for grace in the patient who chooses to forgo or to cease treatments that could prolong life but not change the inevitable. Such a person seems to be giving up at precisely the moment he or she is called to be

ramping up for battle instead. Yet surely grace is not so restrictive. The very gratuity of grace suggests that God's love cannot be confined in advance. Fortunately, the introduction of a global perspective provides a theological explanation of the ways that grace can be operative not only in the choice to battle for one's life but also in the decision to accept one's finitude in a way that springs from a concern for others. Here a Rahnerian notion of grace is especially informative, for Karl Rahner described grace as God's self-communication, or agapic gift of self, to the world.⁴⁶ Hence, he identified the experience of grace as self-transcendence, specifically the form of transcendence that allows one to move beyond self-concern to a selfless concern for others.⁴⁷ Insofar as a patient chooses, after an appropriately careful discernment process, to forgo what they discern to be a locally ordinary but globally extraordinary treatment out of a selfless concern for others' ability to access care—especially a selfless concern for the poor's ability to access care—then that patient is necessarily a recipient and a conduit of grace in the world, for there is in Rahnerian terms no other explanation for this agapic gift of self than the gift of God's very essence, *agape*, grace. If Catholic health care ethics has no way to countenance this decision, then Catholics might very well be led astray in their search for grace at the end of life.

To be clear, no part of this defense of a twofold approach to ordinary and extraordinary means is meant to suggest that every person should use this perspective to forgo any and all end of life treatments. The point, instead, is to carve out room for Catholic ethics to acknowledge more explicitly that a Catholic in good conscience *could* take this route, at least under certain circumstances. With its greater flexibility for consciences, the twofold discernment process outlined here allows the principle of ordinary and extraordinary means to account better for the pitfalls of this present, imperfect world and also to acknowledge more readily the multifaceted nature of grace's forays into that same present, imperfect world.

This approach will not, however, solve everything. In fact, the introduction of a global perspective is much more of a bandage than a cure. The end goal must be to expand access to care so that there would be less need for a twofold discernment process because the burdens of receiving the same treatment will be distributed less unevenly across the globe. A process of double discernment serves this goal by raising awareness about the problem and by reminding people of the ways that their seemingly private decisions always have social ramifications

⁴⁶ Karl Rahner, *Foundations of the Christian Faith: An Introduction to the Idea of Christianity*, trans. William V. Dych (New York: Seabury Press, 1978), 116–117.

⁴⁷ Karl Rahner, "Reflections on the Experience of Grace," in *Theological Investigations, Volume Three*, trans. Karl-H. Kruger and Boniface Kruger (Baltimore: Helicon, 1965), 89.

in a world of finite resources. Still, individual recognition of this interconnectedness will not suddenly fix the unjust distribution of health care goods. Real change will only come as a result of reforms in the social, political, and economic structures that constrain choices and perpetuate injustices—that is, through transformation of the structures of sin underlying the global health care system today.⁴⁸

Such structural changes are, however, impossible to imagine without a committed group of personal moral agents whose consciences are attuned to the magnitude of the problem at hand. Hence, the global approach to end-of-life care defended here might best be described as a necessary but not sufficient condition for the rectification of the global injustices in access to health care. Significantly, even this small step in the right direction will be difficult to achieve because there are other structural pressures that militate against even a limited conscientization like this. Additional changes will surely be necessary before more people can make the globally-conscious discernment of ordinary and extraordinary means envisioned here. By way of conclusion, then, this paper closes with a brief discussion of two of the changes that might set the stage for a better embrace of the global approach to ordinary and extraordinary means.

MAKING GLOBAL EVALUATION A REALITY

Certainly, there are obstacles that stand in the way of greater global awareness in health care, especially in the United States. There are many forms of moral inertia, both personal and institutional, that are already working to frustrate this more nuanced form of moral discernment. Among the many examples one might imagine, two are prominent enough to merit attention as a fitting conclusion to the argument for the global approach to end-of-life care.

The first illustration of the inertia standing in the way of a global approach to ordinary and extraordinary means is personal. People have been primed to view health care as an eminently personal choice, and they are encouraged to make their health care decisions with their own self-interest in mind. People want the best care possible for themselves, and they will positively insist upon it for their family members (especially if those family members are minors). This is a natural instinct, and morally speaking it is also a healthy one, for it respects the Thomistic ordering of charity, which acknowledges responsibilities for one's own well-being (ST II-II, q. 26, a. 4) and also delineates varying degrees of obligation to one's neighbor according to familial

⁴⁸ For more on structures of sin and their effects, see Finn, "What is a Sinful Social Structure?" 136–164. Pope Francis also points specifically to the role of "unjust social structures" in the perpetuation of inequality (*Evangelii Gaudium*, no. 59).

bonds, among other things (ST II-II, q. 26, a. 7–8).⁴⁹ Furthermore, there are virtuous interpretations of this instinct, especially when one thinks of James Keenan’s relational account of the cardinal virtues, which promotes both self-care and fidelity as good dispositions for the moral life.⁵⁰ Nevertheless, this instinct must not become absolute. Christianity has, for millennia, used the words and example of Jesus to criticize an exclusive prioritization of kin responsibilities, insisting instead that the sphere of moral responsibility cannot be limited to ties of blood alone.⁵¹ Keenan’s system of virtues, meanwhile, notes that the obligations of self-care and fidelity have to be weighed, with the assistance of prudence, against the demands of justice.⁵² Unfortunately, as the struggle to incorporate both of these insights into ordinary moral discernment illustrates, there is a considerable gap between admitting this moral responsibility and actually living it out in practice. Before a global approach to ordinary and extraordinary means can hope to have any impact, it will need to address this gap.

The best way to challenge the gap, and thereby to make the global perspective more influential in ethical discernment at the end of life, is to promote the cultivation of solidarity throughout the entirety of one’s life. As both the descriptive fact of human interconnectedness and the spirit of moral obligation that flows from that fact, solidarity has the potential to impact ethical discernment in a profound and encompassing way.⁵³ As Pope Francis explained, solidarity “refers to something more than a few sporadic acts of generosity. It presumes the creation of a new mindset which thinks in terms of community and the priority of the life of all over the appropriation of goods by a few” (*Evangelii Gaudium*, no. 187). In an individualistic society like the United States, though, this is far from a natural instinct.⁵⁴ Consequently, if the ultimate aim is to have more Catholics engaging in the twofold discernment process proposed here as an act of solidarity then Catholics first need to be encouraged to practice solidarity in more

⁴⁹ Strikingly, kinship bonds are so important in Aquinas’ conception of the ordering of charity that he dedicates a series of articles to adjudicating one’s responsibilities to various family members (ST II-II, q. 26, a. 9–11).

⁵⁰ James F. Keenan, S.J., “Proposing Cardinal Virtues,” *Theological Studies* 56, no. 4 (1995): 709–729.

⁵¹ See Julie Hanlon Rubio, *A Christian Theology of Marriage and Family* (New York: Paulist Press, 2003), 49–54.

⁵² Keenan, “Proposing Cardinal Virtues,” 724, 728.

⁵³ Gerald J. Beyer, “The Meaning of Solidarity in Catholic Social Teaching,” *Political Theology* 15, no. 1 (2014): 7–25.

⁵⁴ By virtually any measure, the United States is one of the most individualistic countries in the world. A famous study of “culture and organizations” by Dutch psychologist and anthropologist Geert Hofstede placed the United States at the top of the list of individualistic cultures. Geert Hofstede, Gert Jan Hofstede, Michael Minkov, *Cultures and Organizations: Software of the Mind; Intercultural Cooperation and Its Importance for Survival*, Third Edition (New York: McGraw Hill, 2010), 93–95.

routine matters of ethical discernment. Then, they will be prepared to use solidarity as a central guiding feature in their major ethical decisions, like the discernment of ordinary and extraordinary forms of end-of-life care.

To give just a few examples of how this cultivation of an everyday form of solidarity might occur, a parish could organize a talk on *Laudato Si'* and then hand out shower timers at the end as a way of prompting the faithful to recognize that water is a finite resource in the world, even if it is not in their local community. People could be encouraged to put their phones away during their free time so that they might build relationships rather than feed into the isolating tendencies of an increasingly technology-saturated culture.⁵⁵ This could occur by championing public goods, like city parks, over private ones, like country clubs, so that people might build connections to their community as a whole and not just to individual friends in isolation.⁵⁶

These examples, though, are merely the beginning. The message needs to be that the work of solidarity never ends, and, therefore, that every ethical choice should be made with an awareness of its impact on others. In this way, the local church can work to ensure that the valorization of individualism and personal autonomy might not hold the same sway on the faithful Catholic that it holds on people in the United States more generally. Given the force of individualism as a cultural value, the everyday development of solidarity is the only way that Catholics in the United States can be expected to see the global perspective on ordinary and extraordinary means as a genuine invitation to explore the role of grace in their lives and not as an external imposition encroaching on their individual rights.

In the absence of this development, a global consciousness will be an unrealistic ideal, especially for the majority of U.S. Catholics. The appropriate pastoral response, then, would not be to give up on the twofold process of discernment entirely but rather to underscore the importance of evaluating community burdens in the assessment of ordinary and extraordinary means and to encourage patients to think of their social responsibilities in progressively larger senses. This might allow them to imagine how the burdens of their treatment would look different if they were in a less well-connected area of the United States or if they had fewer economic resources but were in the same location. In this way, the twofold discernment process could still promote a sense of solidarity with those in need, and it could still call attention

⁵⁵ See Sherry Turkle, *Alone Together: Why We Expect More from Technology and Less from Each Other* (New York: Basic Books, 2011), especially Part II, “Networked: In Intimacy, New Solitudes,” 151–305.

⁵⁶ The dangers of the opposite trend are alluded to in Ward and Himes, “‘Growing Apart’: The Rise of Inequality,” 122.

to health care disparities in those instances where a global accountability represents too ambitious a goal. Of course, this concern reflects the need to inculcate solidarity as a more regular part of the moral life through the kinds of practices just detailed, but, in the interim, making this kind of accommodation is perfectly reasonable given that so much remains to be done to promote solidarity more effectively.

Beyond the narrow sense of autonomy that necessitates greater training in solidarity, there is also a second, institutional form of inertia standing in the way of a more globally-conscious approach to end-of-life care, this one lodged in the structures of Catholic health care itself. This is quite significant because, as a key provider of care, especially long-term care, Catholic health care creates a key institutional context within which many of the end-of-life decisions envisioned here occur. Yet Catholic health care is not always structured to promote a twofold discernment process that examines both local and global realities. Consider again the case of a patient in a persistent vegetative state who has chosen, after the twofold discernment process outlined above, to issue an advance directive requesting the discontinuation of artificial nutrition and hydration after this diagnosis has become effectively irreversible. Unfortunately, the structures of a Catholic hospital could end up preventing a patient's care team from honoring precisely this kind of request, for at least two reasons.

First, although health care teams are committed to honoring the autonomy of their patients, a certain kind of institutional inertia can complicate the decision-making process, especially with incapacitated patients, like those in a persistent vegetative state. For a variety of reasons, including fear of litigation, health care teams often cede power to surrogates in these situations, but the surrogate decision-maker is not always held accountable to the patient's wishes, even when those wishes have been expressed in an advance directive. As a result, physicians have observed that advance directives "have been disappointingly ineffective...because of barriers that are conceptual (general reluctance to explore death and dying), structural (inadequate clinical training, etc.) and procedural (restrictions on who can serve as a health care agent or proxy)."⁵⁷ Some of this can be addressed by encouraging patients to develop advanced planning for end-of-life decisions in a process that emphasizes more than just advance directives, but a complete solution must attend to the fact that there is "an organizational and professional failure to empower clinicians to support the patient's documented moral discernment" even in Catholic hospitals.⁵⁸

⁵⁷ Angelo E. Volandes and Aretha Delight Davis, "Advance Care Planning Leads to Wished-For Care," *Health Progress* 98, no. 6 (2017), 43.

⁵⁸ Volandes and Davis, "Advance Care Planning Leads to Wished-For Care"; quote from Rachelle Barina, email to author, September 30, 2018.

Second, another structural issue stems from a combination of the ERDs' approach to advance directives and the developing tradition on artificial nutrition and hydration for patients in a persistent vegetative state. Directive 24 indicates that a Catholic health care institution "will not honor an advance directive that is contrary to Catholic teaching." Similarly, Directive 59 proclaims, "The free and informed judgment made by a competent adult patient [and by extension a legally designated proxy] concerning the use or withdrawal of life-sustaining procedures should always be respected and morally complied with, unless it is contrary to Catholic moral teaching." When this guidance is coupled with John Paul II's papal allocution and the CDF's clarification of that speech, the result is an ambiguity surrounding advance directives requesting the cessation of artificial nutrition and hydration when one is diagnosed in a persistent vegetative state.⁵⁹ In fact, when the United States bishops revised Directive 58 in 2009 to account for the magisterial developments concerning patients in a persistent vegetative state, Ron Hamel and Thomas Nairn provided guidance about the revisions for people working in Catholic health care ministry and explicitly acknowledged that "there may be the occasional situation, such as some patients in a persistent vegetative state, when what the patient is requesting through his or her advance directive is not consistent with the moral teachings of the Church. In these few cases, the Catholic health care facility would not be able to comply."⁶⁰ Now, in practice, Catholic health care facilities are not routinely intervening to object to a patient's advance directives, even in cases like this, out of a respect for the consciences and discernment processes of patients and their families. Nevertheless, the fact remains that the language of the ERDs at least creates an ambiguity on this matter, meaning that if the proverbial winds were to change, the structures would be in place to undermine a patient who employed the twofold discernment process in this situation. Consequently, it would be helpful to clarify this issue so that patients might, in good conscience, accept their invitation to cooperate with grace at the end of life in the way that befits their situation before God.

CONCLUSION

The two obstacles just described illustrate that getting the faithful to adopt a twofold discernment process for end-of-life care will likely be an uphill battle, especially in the United States. The Catholic community ought to commit itself to this battle, however, because so much

⁵⁹ Hamel, "The CDF Document," 6.

⁶⁰ Ron Hamel and Thomas Nairn, "The New Directive 58: What Does It Mean?" *Health Progress* 91, no. 1 (2010): 70–72.

is at stake. The twofold process of discerning ordinary and extraordinary means in both a local and a global context has a real potential to combat some of the most dangerous tendencies of the recent ballooning of ordinary means. Moreover, this approach reflects the best of the Catholic Church's long commitment to a transformative concern for the poor, and it suggests a way that Catholic health care ethics might embrace Pope Francis's vision for a "Church which is poor and for the poor."⁶¹ Just as importantly, a twofold discernment process promotes a greater openness to grace, counteracting the recent tendency to preemptively restrict grace at the end of life. The road to making this global approach to end-of-life care a reality may be challenging, and it may be fraught with the frictions of sin both personal and structural, but insofar as this approach springs from the conviction that grace is at work in the world, it has every reason to hope that grace will be provided for all the steps along the way. **M**

⁶¹ Pope Francis, "Address to Representatives of the Communications Media," March 16, 2013, w2.vatican.va/content/francesco/en/speeches/2013/march/documents/papa-francesco_20130316_rappresentanti-media.html.