Editors Note: In our March 14, 1992 issue, AMERICA published an article by Richard A. McConnick, S.I., entitled "Moral Considerations' III Considered." The article elicited many heated responses, both pro and con. The sampling of letters presented below is indicative of those varied responses.

Father McCormick Replies
Msgr. William Smith (Letters, 4118) writes about my reference to probabilism in analyzing P.Y.S. patients as follows: "Jesus, long defenders of honorable probabilism, should be among the first to point out the three areas to which probabilism does not and cannot apply among them 'rights' of innocent persons, especially the right not to be injured which is the case at point" (my emphasis).

It is always painful to point out another theologian’s error. But Monsignor Smith errs here. It is not the case in point. When theologians asserted that probabilism could not be applied in the area referred to by Monsignor Smith, they were speaking of doubts of fact. Doubts of fact must often mean doubtful obligations. But not here. The example commonly given: A hunter who doubts whether a man or an animal moves in the underbrush has a certain duty not to shoot. Clear enough so far.

But that is not the issue in the removal of nutrition and hydration from a P.Y.S. patient. It would be the issue if one had, for instance, factual doubts about whether the patient is truly in a P.Y.S. The whole debate is whether there is any genuine injury done to a certainly diagnosed P.Y.S. patient by removing artificial nutrition and hydration. Doubts about such matters are not "areas to which probabilism does not apply." That is why Bishop John Leibrecht (Springfield-Cape Girardeau) was absolutely correct when he referred to a "valid Catholic position which approves removal of Nancy Cruzan's tube." He could not have made such a statement had the issue of nutrition-hydration removal violated the principles of probabilism, as Monsignor Smith asserts.

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Doctors and Burdens
I strongly agree with Richard A. McCork-mick, S.I.‘s insightful and telling critique of the Pennsylvania Catholic bishops' statement, which forbids applying to medically engineered nutrition and hydration in care of the dying the traditional Catholic norm permitting refusal of "excessively burdensome" treatment. Two additional observations are called for.

First, the Pennsylvania statement misrepresents not only the content but also the spirit of traditional Catholic moral teaching. This does not only by advancing a single solution to a disputed concrete application of moral principle to the case at hand, as Father McCormick shows. But the statement also implies that Catholic moral teaching can have benign influence within and outside the Catholic community only by representing itself as having detailed answers to all such particular, complex moral perplexities. Vatican II said something very different: "This Council exhorts Christians as citizens of two cities to strive to discharge their earthly duties conscientiously and in response to the Gospel spirit..." Secular duties and activities belong properly although not exclusively to laymen... Laymen should also know that it is generally the function of their well-formed Christian conscience to see that the divine law is inscribed in the life of the earthly city. From priests they may look for spiritual light and nourishment. Let the layman not imagine that his pastors are always such experts, that to every problem which arises, however complex, they can readily give him a concrete solution, or even that such is their mission (Gaudium et Spes, No. 43). As Father McCormick points out, the Pennsylvania statement ignores the moral experience of the large majority of doctors, including Catholic doctors. This is a serious misrepresentation of the traditional way of proceeding in Catholic applied moral theology whereby people of good will experienced in practice were carefully consulted by the great casuists.

Second, the Pennsylvania bishops ignore, indeed appear ignorant of, a critical dimension of doctors' experiences with artificial nutrition and hydration (which was perfected originally to tide surgery patients through a difficult healing process). Many doctors, especially in geriatrics, by no means view artificial nutrition and hydration as inherently benign "ordinary care"! Rather, they find these measures used abusively and indiscriminately in prolonging dying, especially of the aging and vulnerable. Indeed, this often derives from a shockingly widespread use of these techniques on those not yet dying who are confined in nursing facilities— to deprive these persons who can still chew and swallow of the comfort of eating because they eat too slowly or require individual assistance. But, most alarming, nowhere do proponents of virtually universal mandatory use of these measures acknowledge that if a patient with a feeding tube remains at all capable of restless movement, the use of artificial nutrition and hydration entails, in practice, permanent use of "restraints" until death. Surely this is "excessively burdensome" treatment. To ignore such current medical realities and to deny that this is a medical treatment like others (e.g., ventilators) that should be judged morally mandatory if and only if it is not excessively burdensome relative to the particular patient's condition, is, I believe, to invite persons who know what is really going on both to reject as inadequate basic Catholic moral teaching on the right to reject excessively burdensome treatment and also to forestall good hospice-type care of the dying. Instead, many are led to embrace as a kind of pre-emptive "self-defense" proposals such as the recent State of Washington initiative, which would have legalized physician-assisted suicide and physician-effected euthanasia.

The Pennsylvania bishops, listening to fundamentalist Catholic moralists, thus strengthen the movement which they claim to oppose by this garde-fous.

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A Personal Reading of McCormick
I refer to Richard McCormick’s article from a very personal viewpoint. I read it while my mother, at 91 years of age, was hospitalized, in a P.Y.S. (permanently vegetative state). She had suffered two strokes and a heart attack. She was coma-

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tose and being sustained solely by intravenous (I.V.) injection of a dextrose solution. Eventually, owing to her advanced age and steadily deteriorating condition (collapsing veins, etc.), there were no more places to locate the I.V., and her physician suggested that a "subclavian" procedure would be the next alternative. This would have entailed surgery to insert the I.V. beneath her collarbone. At this point, the doctor requested the family's permission to proceed with it. The option was that discontinuance of the I.V. would result in dehydration and imminent death. Since my mother had previously made it clear that she did not want "extraordinary means" used to prolong her life, we, the family members, were suddenly face to face with the quite real and painful decision of what to do next.

As it happened, Father McCormick's article landed in my mailbox during the very time we were being confronted with these unsettling events. Naturally, I read it expectantly, hoping, I suppose, for (divine?) guidance.

I sat at the bedside of my unconscious and dying mother, holding her hand while I combed the article several times. On and on she breathed (apparently oblivious to this painful drama), as I endeavored to form a reasoned judgment, one that might, literally, determine the continuation, or the end, of her life.

As I pondered the pros and cons of the article, straining to reconcile the divergent views of the learnèd bishops, ethicists, bioethicists, physi.ians, etc., trying to decide whether to "kill the patient (my mother) or allow (her) to die," as Daniel Callahan put it, the answer, of course, gradually emerged: There simply was no clear or prevailing guidance to be had. These great minds obviously could not agree among themselves in their academic approach to an abstract moral question that to me had now become a vital issue: Whether to prolong our dear mother's life, or to let it end.

Their very confusion, then, became my answer, and I took it as my guidance. The subclavian procedure was declined. Soon thereafter she left us. Surely she had earned a heavenly reward for the suffering she endured while lying in that hospital bed those last six weeks of her life. What I learned was an even healthier skepticism for things institutional.

How sad that we have so convoluted the simple message Jesus gave us to live and die by.

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The Key Point
Regarding the issue of hydration and nourishment for patients in P.V.S., it seems to me that a key point, if not the key point, is barely alluded to in the concluding sentence. This point is that my sojourn on earth is only one phase of my life. The final phase is an eternity face to face with my Father, Jesus and the Holy Spirit. How can my choice to allow a pathology to follow its natural course, and thereby permit me to enter this second phase, be considered an insult to life? It seems to me that it is an insult to my life to prolong needlessly the first phase. It is also an insult of sorts to the lives of my family members who are burdened needlessly, emotionally, physically and financially. Put very simply, when my time comes to be face to face with the persons who love and care for me the most, please don't hinder me.

Donald S. Rampolla
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A Telling Omission
While I applaud the clear-sighted arguments of Richard A. McCormick, S.1, I cannot help but be disturbed by the omission of perhaps the most important consideration of all, the perspective of the common good, in his ethical discussion of artificial nutrition and hydration for patients in a persistent vegetative state.

As a Marynoll associate priest working among the poor of Peru, I am often asked by young mothers to bless infants who have died of dehydration resulting from common and preventable diseases. In a world where thousands of children are dying at any given moment for lack of basic health care and nutrition, we must consider the ethics of applying high cost and high tech medical care to the few versus providing basic low-cost life-giving services to the many.

Could it be that, 500 years after the arrival of Columbus to the Americas with sword and Bible in hand, we are experiencing yet another sort of oppression, an imperialism in the field of ethics?

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Unanswered Questions
Richard A. McCormick, S.1, makes some interesting points but also leaves unanswered important questions. Certainly the issue of nutrition and hydration for patients in a persistent vegetative state is significant, controverted and unresolved. The solution Father McCormick advocates raises further questions, however.

How persistent is the vegetative state? A recent issue of Life at Risk (12/91), quotes a study in the Archives of Neurology (6/91) that says that of 84 P.V.S. patients "41 percent became conscious by six months, 52 percent regained consciousness by one year and 58 percent recovered consciousness within the three-year follow-up interval."

What kind of comfort care should we provide any human being? My discussions as a member of the Ethics Committee at a local Catholic hospital led me to conclude that nutrition and hydration are what we provide as normal care. How is it that we are discussing nutrition and hydration as extraordinary means of preserving life? Furthermore, How does the P.V.S. patient die when disconnected? My understanding is that he or she slowly starves to death?

Finally: How will these considerations affect people with disabilities? If severely disabled persons can neither feed themselves nor "pursue life's goals," might not their nutrition and hydration logically be terminated as well? Such questions make me hesitate to adOPt the position Father McCormick believes is held by the majority of philosophers, theologians and courts.

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'Moral Considerations'
III Considered

By RICHARD A. McCORMICK

CONTROVERSIES ARE at times like house pests: Just when you think they have died out, they reappear. So it is with the ethical discussion of artificial nutrition and hydration for patients in a persistent vegetative state (P.V.S.).

The majority of philosophers and theologians—along with most courts—had concluded that the provision of such nutrition and hydration is not morally mandatory because it can no longer benefit the patient.

Now along comes the Dec. 12, 1991, statement of the bishops of Pennsylvania entitled "Nutrition and Hydration: Moral Considerations" (Origins, Jan. 30, 1992). What have the bishops said? First, they have stated that "in almost every instance there is an obligation to continue supplying nutrition and hydration to the unconscious patient." Second, the only exceptions to this conclusion are instances when death is imminent or the patient is "unable to assimilate what is being supplied." Third, outside of these two cases of "futility," withdrawal of nutrition and hydration from a P.V.S. patient is "euthanasia by omission," "killing by omission." As the bishops word it: "Sad to say, the intent is not to relieve suffering but, rather, to cause the patient to die. Nor can it be argued that it is merely the intention to 'allow' the patient to die, rather than to 'cause his death.' The patient in the persistent vegetative state is not thereby in a terminal condition, since nutrition and hydration and ordinary care will allow him to live for years. It is only if that care is taken away—and barring any other new disease or debilitation—that the patient will die. It is the removal of the nutrition and hydration that brings about the death. This is euthanasia by omission rather than by positive lethal action, but it is just as really euthanasia in its intent."

Finally, the bishops turn to advance directives such as the living will and durable power of attorney. "Neither the patient nor the surrogates of the patient have the moral right to withhold or withdraw treatment that is ordinary." But artificial nutrition and hydration for a P.V.S. patient is (except in the two instances noted above) ordinary care. Therefore, it may not be withheld or withdrawn. Briefly, the bishops state that it is immoral to specify in one's living will or to one's durable attorney "no artificial nutrition and hydration if I am in a P.V.S." For this would be to refuse an ordinary means, one that is neither futile (in the bishops' sense) nor excessively burdensome.

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Now, what have the bishops of Pennsylvania done? As I read their document, they have, 1) appealed to their teaching prerogatives and responsibilities, 2) to impose a concrete application of more general principles, 3) that represents one side of a disputed question, 4) and used a questionable analysis, 5) to arrive at extremely questionable conclusions. A word about each is in place if my criticism is to stand up.

A Teaching Statement.
"Nutrition and Hydration: Moral Considerations" is not a casual white paper floated to facilitate discussion groups. It is, as Cardinal Anthony Bevilacqua of Philadelphia states in the foreword, "an effort on our part to fulfill our responsibilities as bishops to give guidance to all the Catholic faithful of this state who are entrusted to our care." He concludes: "Our statement is intended to express, as well as we are currently able, the teaching of the Catholic Church as it affects these admittedly difficult cases." These statements are self-explanatory. The bishops view their reflections as a teaching statement.

A Concrete Application.
Catholic moral teaching, at the level of general principle, maintains that life is a basic good but not an absolute one and that, therefore, not all means must be used to preserve it. As Pope Pius XII noted in 1957: "But normally one is held to use only ordinary means - according to the circumstances of persons, places, times and culture - that is to say, means that do not involve any grave burden for oneself or another. A more strict obligation would be too burdensome for most and would render the attainment of the higher, more important good too difficult. Life, health, all temporal activities are in fact subordinated to spiritual ends."

When these general statements are fitted to specific instances, we are dealing with applications.

The Florida bishops noted this in their statement on treatment of the dying: "The application of these principles to a patient who has been diagnosed with medical certainty to be permanently comatose, but whose death is not iniminent, has aroused controversy" (Origins, June 1, 1991).

Why is it important to note that discussion surrounding treatment of P.V.S. patients is an application? For the simple reason that the bishops do not, indeed cannot, claim the same authority for applications as they do for their statement of general principles. They noted this in "The Challenge of Peace": "We stress here at the beginning that not every statement in this letter has the same moral authority. At times we reassert universally binding moral principles (e.g., noncombatant immunity and proportionality). At still other times we reaffirm statements of recent Popes and the teaching of Vatican II. Again, at other times we apply moral principles to specific cases." The bishops then note that, where applications are concerned, "prudential judgments are involved based on specific circumstances which can change or which can be interpreted differently by people of good will." They note that their judgments of application should be taken seriously but are "not binding in conscience." Notwithstanding its juridical ring, this last statement wisely withdraws from the type of magisterialty that would expect the Pope or bishops to dot every moral "i" and cross every moral "t" regardless of specificity.

Yet phrases used by Cardinal Bevilacqua such as "fulfill our responsibilities as bishops," "give guidance to all the Catholic faithful of this state" and "express ... the teaching of the Catholic Church" fairly droop with authoritative accents. That is why above I used the word "impose." Such weighted phrases could easily mislead people into thinking that what the bishops say is "the teaching of the Catholic Church." It is not. It is an application that involves us in circumstances that "can be interpreted differently by people of good will." Judgments of application should, as "The Challenge of Peace" notes, be "taken seriously." One of the ways to do that is to point out their weaknesses and inadequacies where they exist. And that brings us to the next point.

Artificial Nutrition and Hydration as a Controverted Subject.
By saying that withdrawal of nutrition and hydration is controverted, I refer to philosophical-theological controversy. Most courts and several medical groups (e.g.,
Artificial nutrition-hydration that 'simply puts off death by maintaining physical existence with no hope of recovery ... is useless and therefore not ethically obligatory,'

The American Medical Association, The American Academy of Neurology) have approved such withdrawal, as did the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research.

Writing in Issues in Law and Medicine (1987) a group of ethicists (including William May, Germain Grisez, William Smith, Mark Siegler, Robert Barry, O.P., and Orville Griebel) argued: "In our judgment, feeding such patients [who are permanently unconscious] and providing them with fluids by means of tubes is not useless in the strict sense because it does bring to these patients a great benefit, namely, the preservation of their lives." They go on to note that the damaged or debilitated condition of the patient has been the key factor in recent court cases and conclude that decisions to withdraw food have been made "because sustaining life was judged to be of no benefit to a person in such poor condition. These decisions have been unjust."

On the other hand, bioethicists such as the Rev. Dennis Brodeur, Kevin O'Rourke, O.P., Albert S. Moraczewski, 0.P., John Paris, S.J., James Walter, James Bresnahan, S.J., Daniel Callahan, Albert Jonsen, Thomas Shannon, George Annas and James Drane—to mention but a few—have come to a different conclusion.

Let Father Brodeur be a single example here. Artificial nutrition-hydration that "simply puts off death by maintaining physical existence with no hope of recovery ... is useless and therefore not ethically obligatory" (Health Progress, June 1985). It is "vitalism" to think otherwise. Brodeur correctly rejects a notion of quality of life that states that a certain arbitrarily dermed level of functioning is required before a person's life is to be valued. But if this notion refers to the relationship between a person's biological condition and the ability to pursue life's goals, it is critical to good decision-making. "In some circumstances" he concludes, "science's ability to respond helpfully to allow a person to pursue the goals of life is so limited that treatment may be useless."

This controversy is manifested even at the episcopal level. The Texas bishops (Origins, June 7, 1990) do not agree with the Pennsylvania bishops. Neither do the bishops of Washington and Oregon. After noting the two different approaches outlined above, these latter urge that there "should be a presumption in favor of providing patients with these necessities of survival." They finally conclude: "In appropriate circumstances, the decision to withhold these means of life support can be in accord with Catholic moral reasoning and ought to be respected by medical caregivers and the laws of the land" (Origins, Nov. 7, 1991). The same conclusion is drawn by Bishop John Leibrecht (Springfield-Cape Girardeau) in his comments on the Nancy Cruzan case. He discusses the two different approaches and says of the second that it is "a valid Catholic position which approves removal of Nancy Cruzan's tube." He concludes: "Unless there is an official and binding decision from church authorities, Catholics would be mistaken to hold that only one or the other line of Catholic moral reasoning is correct" (Origins, Jan. 11, 1990).

I recently discussed the Pennsylvania document with 19 physicians responsible for ethics committees around the country. They were in unanimous disagreement with the conclusions of the Pennsylvania bishops.

Why underline the controverted character of withdrawal of nutrition-hydration from P.Y.S. patients? The answer can be found in the old (1948) "Ethical and Religious Directives for Catholic Hospitals" drawn up by the eminent Gerald Kelly, S.J. Directive No. 3 reads: "As now formulated, the directives prohibit only those procedures which, according to present knowledge of facts, seem certain wrong. In questions legitimately debated by theologians, liberty is left to physicians to follow the opinions which seem to them more in conformity with the principles of sound medicine."

This directive may sound a little quaint to contemporary ears. But it embodies the centuries-old wisdom of probabilism. As Father Kelly explains in his commentary: "The provisions of directive three are but concrete applications of the sound general principle that obligations (i.e., precepts and prohibitions) are not to be imposed unless they are certain."

We must remember that the question of artificial nutrition-hydration is extremely practical. It affects physicians, nurses, families, hospitals, legislators, etc. It touches every individual who constructs advance directives. If it is indeed "legitimately debated"—as it is—it is beyond the competence of a group like the Pennsylvania bishops to settle the debate.

Questionable Moral Reasoning.
The guidance provided by the Pennsylvania bishops is based on very questionable reasoning. They argue that withdrawal of artificial nutrition-hydration involves, in
most cases, the intent to kill. It is "murder by omission." How do they arrive at that stark judgment? As follows. The PVS patient is not in a terminal condition. It is only if nutrition-hydration is removed that the patient will die. "It is the removal of the nutrition and hydration that brings about the death." This is not merely "allowing to die." The bishops believe it involves the "clear intent to bring about death."

Is this the proper way the situation of PVS should be analyzed? Not according to the Texas bishops. They note that life-sustaining means, including artificial nutrition and hydration, may be omitted "under conditions which render those means morally non-obligatory." Certainly diagnosed PVS is one of those conditions in their view. They then add interestingly: "In those appropriate cases the decision maker is not guilty of murder, suicide, or assisted suicide, since there is no moral obligation under these circumstances to impede the normal consequences of the underlying pathology. The physical cause of death is ultimately the pathology which required the use of those means in the first place."

The Texas bishops then do not view the PVS patient as non-terminal. They see such a person as "stricken with a lethal pathology which, without artificial nutrition and hydration, will lead to death." The moral question is when should we intervene to prevent the "normal consequences of a disease or injury." When it is decided that the patient can no longer benefit from the intervention, the underlying pathology is allowed to take its natural course. This does not involve the intent to bring about death.

This is the analysis proposed by Kevin O'Rourke, O.P (AMERICA, Nov. 22, 1986). Father O'Rourke, in an analysis almost identical to that of the Texas bishops, observes that "withholding artificial hydration and nutrition from a patient in an irreversible coma does not induce a new fatal pathology; rather it allows an already existing fatal pathology to take its natural course." Therefore, Father O'Rourke argues that we should not be discussing whether death is imminent, but "whether a fatal pathology is present." If it is, the key moral question is "whether there is a moral obligation to seek to remove the fatal pathology or at least to circumvent its effects."

This is also the approach of Daniel Callahan in his book What Kind of Life. Dealing with exactly these cases Callahan asks: "On the level of physical causality, have we killed the patient or allowed him to die? In one sense, it is our action that shortens his life, and yet in another sense it is his underlying disease that brings his life to an end. I believe it reasonable to say that, since his life was being sustained by artificial means (respirator or tube), and that was necessary because of the fact that he had an incapacitating disease, his disease is the ultimate reality behind his death" (p. 234).

Because of this decisive causal role played by the underlying disease, Callahan states: "To allow someone to..."
die from a disease we cannot cure (and that we did not cause) is to permit the disease to act as the cause of death" (my emphasis). In brief, those who argue that by withdrawing nutrition-hydration we introduce a new cause of death and therefore kill the patient have overlooked the lethal causal character of the underlying pathology. This is precisely the point urged by Sidney Callahan. Persons who believe we must sustain a body in an endless limbo "confuse withdrawing the feeding tube with active killing partly because they refuse to take into account that it is an injury or disease that has ended the person's human future" (Health Progress, April 1999).

The origin of the analysis adopted by the Pennsylvania bishops must remain somewhat speculative. But one would not be too far off in thinking that the late John R. Connery, S.1., was influential here. Father Connery argued that when quality of life is the central focus, then "the intention is not to free the patient of the burden of using some means, but the burden (or the uselessness) of the life itself. The only way to achieve this goal is by the death of the patient" (Linacre Quarterly, February 1988). Therefore, "the intention is the death of the patient" — which Father Connery regarded as "euthanasia by omission," though I am told that he changed his view shortly before his death.

Actually the situation need not be conceptualized in terms of life as a burden. All we need say is that life in a P.V.S. is not a benefit or value to the patient. Therefore, withdrawing nutrition-hydration is withdrawing something from which the patient does not benefit.

This brings us to the central issue in this debate, the notion of benefit. William May, et al., see nutrition-hydration for a P.V.S. patient as providing a "great benefit," the preservation of life. So do the Pennsylvania bishops. Father O'Rourke, on the contrary, believes that mere "physiological function bereft of the potential for cognitive-affective function does not benefit the patient" and is, in this sense, useless. Daniel Callahan, the Rev. Dennis Brodeur, John Paris, S.J., the Texas bishops and many others share Father O'Rourke's assessment. So do I.

In deciding what is truly beneficial to a patient, it is useful to distinguish with Lawrence Schneiderman, Nancy S. Jecker and Albert R. Jonsen (Annals of Internal Medicine, June 15, 1990) between an effect and a benefit. The authors argue that the goal of medical treatment is "not merely to cause an effect on some portion of the patient's anatomy, physiology or chemistry, but to benefit the patient as a whole." They believe that nutritional support can effectively preserve a host of organ systems of a P.V.S. patient but remain futile. This they conclude because "the ultimate goal of any treatment should be improvement of the patient's prognosis, comfort, well-being or general state of health. A treatment that fails to provide such a benefit— even though it produces a measurable effect— should be considered futile."

This point was made recently by Bishop William Bullock of Des Moines (Origins, Jan. 30, 1992). Noting that God gives us life to carry out human activities, Bishop Bullock asserts that "the benefit of care or treatment to prolong the life of a dying person, or of a person for whom these human activities have become very difficult, or even no longer possible, diminishes in proportion to what remains possible for them." Benefit, he states, refers to "possible recovery or a prolongation of at least minimally conscious life," When such a benefit is absent, to omit nutrition-hydration "is not to intend the patient's death but to permit nature to take its inevitable course."

THE DETERMINATION of what is truly beneficial to us as human persons is a broad human judgment. In all the groups I have polled on this matter, I have found only one person (of thousands) who wished to be maintained indefinitely in a P.V.S., and he did not understand the condition. This should not be taken to suggest that we determine right and wrong by head-counting. That misses the point. The significance of this virtual unanimity is that people do not regard continuance in a P.V.S. through artificial nutrition-hydration a genuine benefit. Effect, yes. Benefit, no.

Let me conclude with a fanciful scenario. Imagine a 300-bed Catholic hospital with all beds supporting P.V.S. patients maintained for months, even years by gastrostomy tubes. Fanciful? Not if the guidelines of the Pennsylvania bishops are followed. Appalling? In my judgment, yes—not least of all because an observer of the scenario would eventually be led to ask: "Is it true that those who operate this facility actually believe in life after death?"

Family Photograph

In the photograph, faded to yellow as the first Colorchrome prints mellow, I am ten years old, chubby, with one hand drawn to my shirt, the other behind Mother. Sister's thin arm encircles a shoulder. Aunt Thelma wears shorts, Uncle Dimps dark glasses. We were ending our summer vacation. Framed by two palms, an overhead sun crossed by shadows resembling tarantulas, the five of us face the photographer. She was shaking—the picture is blurry. Behind us is the Gulf of Mexico. We couldn't know what she saw, for no one had yet thought of death. Here everyone is smiling. Everyone is waving goodbye.

STELLA NESANOVICH