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COMMENT ON:  
**Nutrition and Hydration: Moral Considerations**  
**A Statement of**  
**The Catholic Bishops of Pennsylvania**

by  
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This publication by the Pennsylvania Catholic Conference is an extremely timely and authoritative contribution to what has become one of the most crucial debates in bioethics. The emergence of the discontinuation of food and drink as a conflicted issue has been widely misinterpreted as a byproduct of recent developments in life support technology. The use of nasogastric and gastrostomy feedings are old technologies, however, dating back to the turn of the century. The new dimension to the current debate is not technology but cost benefit analysis. The focus of the debate should be kept where it belongs. It is not about the terminally ill patient who is imminently dying and who will die anyway whether or not food and drink are continued by whatever means. The issue relates to the patient who is not dying but rather is being provided food and drink by so-called "artificial" means because of inability to feed himself resulting from persistent vegetative state, coma, dementia, or other non-fatal disability. For such a patient, tube feeding is *useful*, in that it sustains his life and *is not excessively burdensome* because it can be provided at low cost and by unskilled personnel.

The question as to whether feeding by gastrostomy is a "medical procedure" is often raised. The placement of a gastrostomy or even a nasogastric tube may be a medical procedure. Feeding a patient through a gastrostomy tube is not a medical procedure since it can readily be carried out by near relatives in a home setting. One should also understand the motive for placing the feeding tube in the first place. Feeding tubes are frequently inserted in patients who are capable of swallowing (as in many patients in persistent vegetative states) because feeding through a tube is much less labor-intensive and time consuming than laborious assisted feeding by spoon. When Court-ordered discontinuation of artificial feedings are carried out (as in the Greenspan and Langway cases in Illinois) it is customary to leave the gastrostomy tube in place but to discontinue pouring nutrient fluids into the tube until such time as death results from starvation and/or dehydration.

It is inappropriate to characterize tube feedings as "forced feedings" as some theologians have done since the methods are passive and a truly

comatose patient would be unaware of the actual procedure being carried out.

The Catholic Bishops' Statement includes an important section in which distinctions are made among various states of unconsciousness. Recent statements by the A.M.A. Judicial and Ethical Council and legislative bodies refer to states of "permanent unconsciousness" and a "high degree of certainty that coma will last permanently without improvement." It is not possible, given our present prognostic ability to know early on after the onset of coma that the coma will be permanent. Whether we use the electro-encephalogram, the Glasgow Coma Scale, the Langsteth Awakening Score, or other clinical observations there are no data which will confidently predict permanency of unconsciousness. There are numerous reports in the medical literature of unexpected revivals after many years in coma. A recent report from Michigan told of a patient awakening after many years in coma after being given Valium by his dentist to abolish his grimace during a dental procedure as a case in point. It dramatizes the limitations of our understanding of basic aspects of coma.

Some medical and theological presumptions are made about the comatose state despite our rudimentary understanding of its physiology. It is presumed, for example, that the comatose patient would be incapable of experiencing the extreme discomfort resulting from a death from starvation and dehydration. It is also presumed that such a patient would be incapable of pursuing any meaningful spiritual goals. Recent studies, however, indicated that patients may be much more aware of their surroundings than previously appreciated. It has been shown, for example, that comatose patients have electroencephalographic responses to painful stimuli and that they respond physiologically to being spoken to at the bedside by near relatives. When conventional wisdom is put aside and aggressive attempts to treat comatose states is carried out, the prognosis may change. It has been shown by physicians treating Israeli combat casualties, that doubling caloric intake and keeping the comatose patient in an upright position can dramatically improve survival and restoration of consciousness.

The Statement wisely and sensitively discusses "Questions Related to Family and Caregivers." No one questions the basic principle that the patient's family is in the best position to make loving decisions in the patient's best interest. It must be recognized that our society has many dysfunctional families. To watch a loved one linger in a protracted illness may impair the judgement of the beholder in deciding what is in the patient's best interest. There may be times when the physician will feel that the family wants the patient dead for the wrong reasons. Laws empowering surrogate decision-making should leave the attending physician free to override ill-intentioned family directives.

The Catholic Church, both through individual theologians and statewide bishops' conferences has unfortunately given mixed messages on the matter of discontinuation of food and drink. Some statements have betrayed a lack of understanding of the principle that what is theologically sound is not

always good public policy. Politics as well as theology is a nuanced discipline and legal interpretations of legislation may not always make the distinctions requiring theological sophistication. The statement by the Catholic bishops of Texas really constitutes a rather superficial endorsement of the position of the A.M.A. or the American Academy of Neurology. The Illinois Catholic Conference, in endorsing the disastrous Health Care Surrogates Act, used a rationale which is ambiguous and totally rejected by all pro-life medical, legal and educational organizations in the state. The New Jersey Catholic Conference Statement and the Instructions to Health Care Providers by Bishop Meyers of Peoria make many important distinctions and rely on a much sounder and intuitive understanding of what actually happens at the bedside. This statement by the Pennsylvania Catholic Conference is the most helpful yet published as a set of guidelines for conscientious practitioners. The lucid set of principles laid down in the Conclusions section of this Statement embodies most of what is relevant to clinical decision making. This publication will hopefully receive the wide dissemination it deserves.

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