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Artificial Respiration and AHN: Some Similarities and Differences

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1. Introduction

There are many similarities between the provision of artificial hydration and nutrition ("AHN") and the provision of artificial respiration ("AR"). Many ethicists cite these similarities in support of the conclusion that the provision of AHN for a patient diagnosed as permanently unconscious ("DPU patient")¹ is always morally optional.

Such conclusion regarding AHN is not persuasive to the extent it relies on the analogy to AR. Even if an individual's moral obligation to use food and water is evaluated in terms of the same principles applicable to the use of other medical treatments, such principles do not establish that the use of AR for nondying DPU patients is always morally optional and, therefore, they do not establish that the provision of AHN to nondying DPU patients is always morally optional.

In this paper I first review some of the literature wherein authors expressly compare AHN and AR. The views of those who consider AHN and AR morally and medically indistinguishable and those who consider AHN and AR fundamentally different are discussed.

Next, the validity of these two views is tested by a case involving each type of treatment.² The Karen Quinlan case is revisited as a vehicle for refining the ethical analysis of AR. The Nancy Cruzan case is used as a tool for studying the principles involving AHN. The study of these two cases enables us to draw certain conclusions regarding the principles governing the prolongation of life as they apply to DPU patients and the particular procedures of AR and AHN.

2. Literature on AHN and AR: Similarities and Differences

Cases over the last decade or so involving the withdrawal of AHN from DPU patients have forced ethicists to analyze the traditional principles regarding the prolongation of life in light of new circumstances. The development

of artificial methods of respiration necessitated a reassessment of the ethical obligations of individuals in the face of such new technology. Pope Pius XII's 1957 Address to Anesthesiologists and the case of Karen Quinlan represent landmarks in the formulation and resolution of the moral and legal issues involved with AR. For the most part, great uniformity of opinion evolved concerning the ethical obligations regarding AR.

In applying these same principles to cases involving AHN, ethicists have had recourse to the development that occurred in the debate over AR. Some ethicists have based, in part, their conclusions regarding AHN on their evaluation of the degree to which AHN should be treated as similar to or different from AR.

a) Similarities

Authors who consider AHN and AR morally indistinguishable base their conclusion on several factors.³ First, air is as essential to the maintenance of the patient receiving AR as food and water are to the patient receiving AHN. Although each of these necessities of life is essential to any person, whether sick or not, the individual's moral obligation to avail oneself of such necessities is governed by the same principles applicable to the duty to seek medical treatment. In this regard, food and water and air are similar to blood, insulin and a properly functioning heart. Each of these is necessary for the healthy person and for the sick person. One's duty to utilize the means of obtaining each such essential component of a healthy life (i.e., AHN, AR, transfusion, injection, transplant, respectively) is evaluated in terms of the usefulness of such means and the burdens associated with their use.

Second, both essentials of life, food and water and air, are delivered to the patient by artificial means made available through developments in medical technology.

Third, in the absence of either AHN or AR, the patient will die in a relatively short period of time. When a patient survives after the withdrawal of AR, as Karen Quinlan did, such survival is contrary to all reasonable expectations. Thus, from an ethical perspective, the death of the patient after the withdrawal of AR is to be treated as foreseen with moral certitude.

Fourth, both AHN and AR are provided to bypass or circumvent a condition of the patient which causes or results in the patient's inability to chew or swallow, in the one case, or to breathe, in the other case. In cases of DPU patients involving AHN, the inability to chew or swallow is caused by an injury or defect of the brain which prevents the alimentary system, which is otherwise intact and operable, from functioning. In cases of DPU patients involving AR, the respiratory system itself is inoperable or insufficiently operable to serve its normal respiratory function.

Fifth, the withdrawal of both AHN and AR can be characterized as allowing the patient to die rather than introducing a new cause of death. In

both cases the patient dies from a combination of the withdrawal of AHN or AR, as applicable, and the malfunctioning of the alimentary or respiratory, as applicable, system. Such malfunctioning is not attributable to any action on the part of those who withdraw the life support mechanism, but rather, to the pre-existing injury or defect of the patient.

b) Differences

Authors who consider AHN and AR fundamentally different base their conclusion on several factors.⁴ First, while AR is clearly medical treatment, AHN is a fundamental necessity of life and, as such, is provided as basic nursing or human care of the patient. The provision of food and water is analogous to other acts of simple compassion and care such as turning the patient to prevent bed sores, providing a proper room temperature and providing for the basic hygienic needs of the patient. The mechanism for delivering AHN, particularly in the case of a gastrostomy tube, is relatively simple and does not raise the spectre of excessive medical technology associated with the mechanism for delivering AR.

Second, AR generally constitutes extraordinary means, whereas AHN constitutes ordinary means, of sustaining life. Given that AHN is utilized in many cases involving patients who are in no sense terminal, AHN is viewed as a relatively simple substitute for the ordinary means of sustenance provided by food and water.

Third, the withdrawal of AHN introduces a new cause of death, namely, dehydration and malnutrition, whereas the withdrawal of AR allows the patient to die from an underlying condition. Questions regarding the withdrawal of AHN have arisen most prominently in cases of DPU patients. So long as AHN is provided, such patients are not expected to die from any underlying illness. AR, however, is associated with cases of patients who have incurable and untreatable conditions and who will die from such conditions notwithstanding the provision of AR.

Fourth, AHN is a supplement whereas AR is a substitute. The alimentary system of DPU patients is functional and such system will perform its biological role provided that the normal means of delivering food and water (i.e. through the mouth) is bypassed. In cases involving the use of AR, the patient's respiratory system is completely incapable of functioning.

Fifth, the withdrawal of AHN can have only one result — the death of the patient; the withdrawal of AR can result in the death of the patient, but such result is not inevitable and patients (such as Karen Quinlan) can live for years without AR.

Sixth, the provision of food and water to a person in need, whatever the means used, has important symbolic significance.

Seventh, if the withdrawal of AHN from non-terminal DPU patients is accepted, there will be no means of preventing society from accepting active euthanasia.

c) Comments

A thorough evaluation of the reasonableness of the proffered distinctions and similarities is beyond the scope of this paper. Rather, the effort here is to demonstrate that the argument for treating AHN and AR as indistinguishable is not sufficient to support the conclusion that AHN is always morally optional for a DPU patient.

Yet, such argument is made. Some of those who maintain that AHN is always morally optional frame the argument as follows:

The provision of AR for a DPU patient is always morally optional.

AHN and AR are morally and medically indistinguishable.

Therefore, the provision of AHN for a DPU patient is always morally optional.⁵

The argument contains at least one significant flaw. Even if one grants, for purpose of the argument, the validity of the minor premise, the validity of the major premise is questionable. The "general view" that AR for a DPU patient is always morally optional needs to be reassessed because it provides a significant foundation for the conclusion regarding AHN.

To that end, the cases of Karen Quinlan and Nancy Cruzan are reviewed as vehicles for the exploration of the ethics of withholding⁶ AHN and AR from DPU patients.

3. Karen Quinlan and Nancy Cruzan

a) Quinlan

On April 15, 1975 Karen Quinlan was involved in an automobile accident in which she sustained numerous injuries.⁷ The length of time she was without spontaneous respiration is unknown. Upon arrival at the hospital, medical personnel diagnosed her as being in a coma. She remained in this state for a period of time, after which time she entered a persistent vegetative state.

Ms. Quinlan's father sought to be appointed Karen's guardian with legal authority to direct the removal of her respirator. The New Jersey Supreme Court granted Mr. Quinlan's petition.

The New Jersey Supreme Court described Ms. Quinlan's condition as irreversible and terminal, with death being imminent. The court viewed Karen as having no reasonable "possibility of return to cognitive and sapient life."⁸ Based on the unanimous view of her physicians, the court stated that Karen would die in less than a year even with continued use of the respirator and that removal of the respirator would result in her death in a matter of minutes. In effect, the court viewed the respirator as prolonging the biological life of someone waiting to die.⁹

According to the court, the cause of Ms. Quinlan's terminal condition was her inability to breathe without the aid of the respirator. This inability was due to a "lesion on the cerebral hemispheres and a lesion in the brain stem." Based on this understanding, the court concluded that continued use of the respirator would constitute extraordinary means in that the treatment was

futile.¹⁰

Bishop Lawrence Casey, the Bishop of Paterson (the diocese in which the Quinlans resided), submitted a statement to the court in which he applied Church teaching to Ms. Quinlan's case.¹¹ Bishop Casey reviewed the principles set forth in Pope Pius XII's address to anesthesiologists concerning the use of artificial respirators. In that address, Pope Pius concluded that in the case of a person "in a state of deep unconsciousness" where "only automatic artificial respiration is keeping [the patient] alive" and where "the soul may already left the body", the use of a respirator was morally optional.¹² Bishop Casey expressly rejected euthanasia and defined euthanasia to include the causing of the death of a patient who is "deemed unable to live a so-called meaningful life."¹³

Bishop Casey viewed Miss Quinlan's condition as hopeless in that she had "no reasonable hope of recovery from her comatose state". He concluded that in such circumstances continued use of the respirator constituted extraordinary means and, therefore, was morally optional. There is no evidence from Bishop Casey's statement that he considered use of the respirator unduly burdensome. Rather, his conclusion seemed to be based on the judgment that her coma constituted a terminal condition and that continued use of the respirator was useless in that it was prolonging her dying.¹⁴

Leading theologians shared Bishop Casey's conclusions. Paul Ramsey and William May, for example, viewed Karen Quinlan as terminal and the continued use of the respirator as useless. They justified its removal on that specific ground.¹⁵

b) Cruzan

Nancy Cruzan was injured in an automobile accident on January 11, 1983.¹⁶ After her accident, she continued to exhibit brain stem activity and, thus, continued to breathe on her own without the aid of a respirator, but experienced damage to all other areas of the brain, including those areas which control swallowing and chewing.

At the time of the proceedings, she was unconscious, though no longer in a coma, unresponsive to her environment, except for reflexive responses to sound and perhaps to painful stimuli, and was a spastic quadraplegic. Her blood pressure was normal, her pulse was regular and her respiration was spontaneous. She had severe, irreversible upper hemispheric brain damage with progressive degeneration of the brain. Her condition was considered permanent. She received nutrition and hydration through a gastrostomy tube which had been surgically implanted. The experts agreed that she had no condition which would cause her death and that, if AHN was provided, she could continue to live for thirty years. The entire cost of her care was paid for by the State of Missouri.¹⁷

c) Quinlan and Cruzan

Many similarities exist between the cases of Karen Quinlan and Nancy

Cruzan. Some of the similarities in the physical condition of both patients have led authors to conclude that the cases are indistinguishable morally. Those who maintain this view focus on the hopelessness of the conditions.

Many of those who supported the decisions of the Quinlans and the Cruzans to seek withdrawal of life support measures did so on the ground that continued use of such measures was futile. In the Quinlan case, the parties based their conclusion on a belief that Karen was terminal, whereas in the Cruzan case, certain parties viewed Nancy as terminal (or dying) under an expanded definition of such term.

Since the notions of terminal and futile played such an important role in the analysis of the Quinlan and Cruzan cases, a reassessment of these terms is warranted. This reassessment begins with an analysis of the meaning of terminal in the Quinlan case and the grounds for the conclusion that AR was useless in her case. This review is followed by a similar analysis of the Cruzan case. Following these analyses, the burdensomeness of AHN and AR will be assessed.

4. Effectiveness: Principles and Application of Principles

a) Quinlan

The record in the *Quinlan* case reflects the confusion evident at the time in the understanding of Karen's condition. Initially, Karen's father sought an order declaring her brain dead. Both the lower court and the New Jersey Supreme Court consistently referred to Karen as being in an irreversible coma, notwithstanding that the medical experts, for the most part, described Karen as being in a persistent vegetative state.¹⁸ Bishop Casey described Karen as being in a coma, as did Prof. Ramsey.¹⁹

This confusion was not surprising; the medical community at the time had not agreed upon uniform terminology for describing the various conditions:

Beginning in the 1970's, however, neurological specialists began using the same term to apply to patients in the persistent vegetative state, such as Karen Quinlan. Thus, some physicians would use "irreversible coma" to mean brain death while others would use it to mean the persistent vegetative state. Even today, physicians use the term "irreversible coma" in at least three different ways: whole brain death, persistent vegetative state, or as a general term for all types of permanently unconscious patients.²⁰

Based on the testimony of the medical experts, Karen was not, at the time of the trial, in a coma, but rather, was in a persistent vegetative state. The difference is significant:

[Coma][p]atients ... often have impaired cough, gag, and swallowing reflexes with a resultant inability (involuntary) to clear the passages of the throat and lungs. This impairment leads to frequent, often fatal, respiratory infections — a common cause of death in comatose patients, and one of the major reasons why truly comatose patients typically do not experience the long-term survival period associated with the vegetative state. Thus, in one sense it is reasonable to describe comatose patients as "terminally ill," with death anticipated in six months to a year, unless

extremely vigorous therapeutic efforts are made to sustain life.²¹

The confusion over an accurate understanding of Karen's condition seems to have had a significant influence on the ethical analysis.

In hindsight, we now know that Ms. Quinlan had no underlying condition which would have resulted in her death in a relatively short period of time if treatment was provided. Her condition made her susceptible to deadly infections and use of the respirator increased her vulnerability. But, such conditions, when they arose, could be treated.²²

Karen Quinlan lived for nine years after the respirator was removed.²³ Karen Quinlan, and patients like her, are not terminal or dying, unless such terms are used in an unconventional way. A patient in Karen's condition is terminal if by terminal one means that there is no hope of recovery from the neurological damage sustained.²⁴ Treatment is futile for such patient in that life support measures are ineffective in restoring the patient to a certain level of cognitive functioning.

But, the purpose of life-sustaining treatments is to sustain the life of the patient, not to reverse neurological damage or restore cognitive functioning. As such, the use of life-sustaining treatments, such as AR or AHN, for a nondying DPU patient, is generally effective and useful in achieving the purpose of such treatments.

Two additional observations can be made with respect to the Quinlan case. First, on the basis of what we know now, continued use of the respirator was unnecessary to the maintenance of Karen's life; after the respirator was removed, Karen continued to breathe on her own for nine years. Thus, a decision to remove the respirator could have been made on the ground of its uselessness. The respirator was useless in that it did not contribute to maintaining Karen's life, not in that Karen's life was not worth maintaining.

Second, the basis for such decision is different from the grounds advanced at the time to justify removal of the respirator. At the time, those involved considered continued use of the respirator useless on two grounds: (1) that Karen would have died in a relatively short period of time even if the respirator were continued and (2) that the respirator could not restore Karen's life to a meaningful existence. The first ground turned out to be factually incorrect. The second ground is an unacceptable basis for a determination that life sustaining treatment is futile in that it requires such treatment to achieve an end which such treatment is neither designed nor intended to achieve.

b) Cruzan

The condition of Nancy Cruzan was such that, with treatment, she could have lived for thirty years. She, too, was not terminal or dying, in any customary sense of such terms. The provision of AHN to Nancy Cruzan was useless only in the sense that AHN would not cure or treat the injury to her brain and, therefore, would not improve her level of cognitive

functioning. The arguments set forth above against the reasonableness of such use of the terms terminal and useful are applicable with equal force to the Cruzan case.

5. Burden

a) Principles

The decision to discontinue the respirator in Karen Quinlan's case has also been justified on the ground of burden. Continued use of a respirator may be morally optional if it is unduly burdensome, whether or not the patient is terminal. Fr. John Connery, S.J. did not view Karen's condition as terminal. He considered the initial use of the respirator in her case to constitute ordinary means.²⁵ However, continued use of the respirator over a long period of time made it excessively burdensome:

[A]lthough procedures of this kind [giving oxygen, IV feeding, blood transfusions] would not be classified as extraordinary on a short term basis, e.g., to pull a patient through a crisis, if they had to become a way of life, even today they would fall into this class, e.g., long term or permanent use of an artificial respirator. The burden of such use could make them intolerable.²⁶

The burdensome nature of the treatment places a limit on one's duty to preserve life or health. A patient may decide to forego treatment on the basis of burden provided that the patient's intention is to avoid or relieve the burden, rather than to shorten one's life.²⁷ In order for a decision to reflect a choice to remove a burden rather than to shorten one's life, the treatment involved must be burdensome.

A treatment can be burdensome in several ways. A treatment may be burdensome to the patient if it is a burden to the patient, to the patient's family or to society.²⁸ A treatment may be burdensome if it imposes emotional, financial, psychological or physiological hardships. The assessment of burden may also involve a weighing of the pain or expense of the treatment in relation to the prospective benefit which the treatment offers.²⁹ The reasonableness of one's judgment regarding burden will depend upon the circumstances of the particular case and the type of life support treatment involved.

In the case of a conscious person, competent or incompetent, long-term use of life-sustaining treatments may be judged excessively burdensome on several grounds: cost of the treatment to the patient or his family, painfulness of the treatment to the patient, impairment of activity due to the treatment, psychological pain to the patient or his family, disruption to the lives of family members and distraction from attention to other important tasks or disproportion between the effort (use of resources, personnel, cost) involved in providing the treatment and the benefits to the patient.³⁰

The analysis of burden in the case of a DPU patient is further complicated by the condition of the patient. When the patient is diagnosed as permanently unconscious, caution must be exercised in determining whether the aspects of treatment that were burdensome to a conscious patient (competent

or incompetent) are also burdensome to an unconscious patient. This caution is warranted not because a patient loses rights when he becomes unconscious (he doesn't), but rather, because the basis for the conclusion that the treatment is burdensome may have been removed when the patient lost consciousness.

In the case of a DPU patient, it is difficult to argue that the patient experiences any burden associated with treatment, other than financial hardships in certain cases.³¹ DPU patients most probably do not experience pain or any emotional or intellectual distress. Treatment of DPU patients imposes no restrictions on liberty not already present due to the patient's condition. While the benefits reasonably to be expected from continued treatment are minimal, the burdens, to the patient, associated with such treatment may be virtually nonexistent.

The care of a DPU patient may be burdensome to the patient's family. The assessment of burden to the patient's family involves a review of many of the same factors which are relevant to the analysis of burden in the case of a conscious patient.

However, many times, burdens experienced by family members relate to the condition of the patient rather than the treatment.³² The experience of family members seeing a loved one in a state of severe disability is extremely painful. But the discontinuation of treatment would not relieve the family's burden. That relief would come only with the death of the patient. But to seek the death of the patient is to choose death, not to remove the burden of treatment. Furthermore, although the burdens associated with the patient's condition may be real and quite painful, generally, in the absence of a clear expression of the patient's wishes, they are not advanced as the reason for the discontinuation of treatment. More typically, the rationale is to the effect that the patient would not want to live under such circumstances.

b) Application of Principles

Based on the analysis outlined above we can apply such principles to the cases of Karen Quinlan and Nancy Cruzan.

If Karen were conscious, removal of the respirator could have been justified on the basis of burden to the patient. The burdensomeness of the treatment consisted not only in the use of the respirator, but also the hardships associated with intensive care.³³

But Karen Ann Quinlan was unconscious. She did not, to the best of our knowledge, experience the hardship associated with the respirator and intensive care. What aspects of her treatment were burdensome in her condition?

Germain Grisez identifies two factors that made Karen Quinlan's treatment burdensome: the cost of intensive care and the psychological burden to her parents who thought that the respirator was painful to Karen.³⁴ While the cost of ICU and the respirator was expensive and, as such, would constitute a financial burden if such costs were born by the

patient or the family, Karen's mother testified that the family did not bear such cost.³⁵ Thus, the ground of expense (to the patient or the family) is not sustainable in the Quinlan case.

The psychological burden to Karen's parents was real, whether or not Karen experienced pain, because they thought the respirator troubled her. This distress on the part of the family was distinct from and in addition to the pain associated with Karen's condition. Thus, it provides a legitimate basis for a determination of burden to the family. There is no evidence, however, that Karen would have decided to discontinue treatment for this reason or that the decision of her parents was actually made on this basis.³⁶ Further, to the extent that neurologists convincingly demonstrate that DPU patients do not experience any pain, the psychological burden to the family can be mitigated.

Thus, removal of the respirator could not be justified in the Quinlan case on the basis of burden to Karen (without consideration of the effects of the treatment on family or society). The treatment was not painful to her, either emotionally or physically, it was not financially burdensome and it did not restrict her liberty. The treatment was not disproportionate in that even though the benefits were minimal, there was no burden to her in continuing the treatment.

Continued use of the respirator could constitute grounds for a determination of burden to the family to the extent that the respirator, as opposed to Karen's condition of severe disability, caused psychological pain to her family. The evidence does not indicate that pain to the family was the basis for the family's decision.

Based upon the above conclusions regarding continued use of the respirator, we must next consider AHN. We can explore the question of whether AHN is morally optional for a patient in Karen Quinlan's condition by looking at Nancy Cruzan's case. Nancy Cruzan, in a sense³⁷, is Karen Quinlan after the respirator was removed.

Removal of AHN from Nancy cannot be justified on the ground of burden to Nancy (without consideration of the effects of treatment on the family or society). Given Nancy's condition, the provision of AHN was not painful to her in any emotional, physical or psychological sense. The treatment was not economically burdensome since the cost was paid for entirely by the state. Given the absence of any other burdens and the minimal benefit treatment provided, the provision of AHN was not disproportionate.

Nancy's family certainly bore the pain associated with attending to Nancy in her state of severe disability. But that pain was caused by Nancy's condition. There is no evidence that the treatment itself caused the family distress. In fact, in the Missouri lower court proceeding which authorized the discontinuation of AHN for Nancy, the doctors recommended that the gastrostomy tube be left in place after AHN was discontinued so as to facilitate the provision of medications.³⁸ If Nancy were alert, responsive and interacting with her family on an intellectual and emotional level, there

is little doubt that the family would have sought to continue the very same treatment they sought to discontinue. Nancy's condition was distressing; but to alleviate Nancy's condition by eliminating Nancy is to remove the burden of Nancy, not the burden of treatment.

6. Conclusion

Recent cases involving DPU patients have forced ethicists to revisit the ethics of prolonging life and to analyze more closely the meaning of the terms useless and burden.

In considering the ethical obligations surrounding AHN, many ethicists have analyzed the issue by comparing AHN with AR. Such effort has resulted in a conclusion by some authors that AHN and AR are essentially the same while other authors have come to the opposite conclusion. Ethicists on both sides of the issue, however, seem to begin with the premise that AR in such circumstances is always morally optional.

The "general impression" concerning AR developed in great part in response to the circumstances surrounding the Karen Quinlan case.

A review of the Quinlan case, however, shows that it does not support the proposition that AR is always morally optional for a nondying DPU patient. The conclusion reached by many at the time, that AR was morally optional on the ground of futility, was based on a combination of an incorrect understanding of Ms. Quinlan's medical condition and an unacceptable understanding of the meaning of usefulness. The record in the case shows that Karen was not a coma patient in imminent danger of death, but rather, was a nondying DPU patient who, like other nondying DPU patients, had no reasonable prospect of regaining cognitive functioning.

Thus, the use of life-sustaining treatments for such nondying DPU patients is generally effective and useful in achieving the purpose of such treatment. However, the provision of AR for Karen was useless in the sense that it was *unnecessary* for the conservation of Karen's life.

Moreover, the Quinlan case does not support the conclusion that AR is always morally optional on the basis of burden. While burden can be established in the Quinlan case, it rests on the particular circumstances of that case (e.g., emotional pain to the patient's family who thought the respirator was painful to Karen). The more common ground for demonstrating the burden of treatment, that is, burden to the patient, is not established by the Quinlan case.

The analysis of the effectiveness and burdensomeness of life sustaining treatment in the Quinlan case applies to the Cruzan case. Nancy Cruzan had no underlying condition which, if treated, would have resulted in her death. She was not terminal and the provision of AHN was effective in conserving her life. The provision of AHN to Nancy did not constitute a burden to her or her family.

Thus, even if it can be convincingly demonstrated that AHN and AR are morally and medically indistinguishable in cases of nondying DPU

patients, it does not follow that AHN is always morally optional in such cases because it has not been demonstrated that AR is always morally optional in such cases.

References

1. In this paper I use the acronym DPU to describe both coma patients and patients in a persistent vegetative state. The characteristic of such patients relevant to the moral analysis is their lack of consciousness, which condition is diagnosed as permanent. Use of this acronym avoids the dehumanizing term PVS.

2. I do not address the question of whether AHN should be considered medical treatment or basic health care. Many courts and authors have classified AHN as medical treatment, while others vigorously oppose such classification. AHN is a means of preserving life and once the issue is framed in terms of the limits on one's duty to prolong life, resolution of this controversy becomes less important. See Connery, S.J., John R., "The Ethics of Withholding/Withdrawing Nutrition and Hydration", *Linacre Quarterly*, 54:1 (February, 1987), pp. 17, 19 (hereinafter cited as "AHN Ethics"). Within the traditional approach the ordinary/extraordinary analysis applied to both the means of curing a disease and means which supplant a natural function. Cronin, Daniel A., "The Moral Law in Regard to the Ordinary and Extraordinary Means of Conserving Life", in *Conserving Human Life* (Braintree: The Pope John XXIII Medical-Moral Research and Educational Center, 1989) (hereinafter cited as *Conserving Human Life*), at 83.

3. Authors who consider AHN and AR indistinguishable include the following: Brock, Dan W., "Foregoing Life-Sustaining Food and Water: Is It Killing?", in *By No Extraordinary Means: The Choice to Forgo Life-Sustaining Food and Water* (Joanne Lynn ed., 1989) (hereinafter cited as *By No Extraordinary Means*), pp. 117ff; Cranford, Ronald, "Patients with Permanent Loss of Consciousness," *id.*, pp. 186-94, at 189-92; Paris, S.J., John J. and Richard A. McCormick, S.J., "The Catholic Tradition On the Use of Nutrition and Fluids," *America*, May 2, 1987, pp. 356ff; Moraczewski, O.P., Albert S., "The Moral Option Not to Conserve Life Under Certain Conditions," in *Conserving Human Life*, *op. cit.*, pp. 257-68; and Cahill, Lisa Sowle, "Bioethical Decisions to End Life," *Theological Studies*, 52:1 (March, 1991), pp. 113-14.

The discussion in parts (a) and (b) of Part 2 of the text is intended to set forth in summary fashion reasons representative of the arguments of those who consider AHN and AR indistinguishable and those who consider them essentially different. Each author referred to does not necessarily use all of the reasons discussed.

4. Authors who consider AHN and AR fundamentally different include the following: Barry, O.P., Robert, "Feeding the Comatose and the Common Good in the Catholic Tradition," *Thomist*, 53(1989), pp. 1-30; Grondelski, John M., "Removal of Artificially Supplied Nutrition and Hydration: A Moral Analysis," *Irish Theological Quarterly*, 55 (1989), pp. 291-302, at 298; Meilasder, Gilbert, "Caring for the Permanently Unconscious Patient," in *By No Extraordinary Means*, *op. cit.*, pp. 195-201, at 197; Weisbard, Alan J. and Mark Siegler, "On Killing Patients with Kindness: An Appeal for Caution," *id.*, pp. 108-16, at 111-12; Griesse, Orville N., "Feeding the Hopeless and the Helpless," in *Conserving Human Life*, *op. cit.*, pp. 149ff; and McHugh, James, "Artificially Assisted Nutrition and Hydration," *Origins* 19:19 (Oct. 12, 1989), p. 314.

5. For example, Moraczewski, *op. cit.*, at 268 states the following: "In a particular case, if one may morally remove the respirator, one also, by same principles, could morally remove the feeding tubes."

6. References in this paper to withholding or withdrawing treatment are meant to refer to the discontinuation of treatment once it has begun or to decisions not to initiate treatment.

7. The facts of the Quinlan case are described in detail in *In Re Quinlan*, 70 N.J. 10, 51, 355 A.2d 647 (1976) and in the testimony at the trial level, see "In the Matter of Karen Quinlan: The Complete Legal Briefs, Court Proceedings, and Decision in the Superior Court of New Jersey" (1975) (hereinafter cited as *Quinlan Proceedings*). The court referred

to Karen as terminal at least twice. 70 N.J. at 21, 39.

8. *Id.*, 70 N.J. at 24-26.

9. *Id.* at 26. Later cases cite *Quinlan* as a case involving a terminal patient. *E.G.*, *Cruzan v. Harmon*, 760 S.W. 2d 408 (Mo. banc 1988); *Matter of Conroy*, 98 N.J. 321, 486 A. 2d 1209, 1228 (1985).

10. *In Re Quinlan*, *op. cit.* at 48.

11. Bishop Casey's statement is contained in *Quinlan and Quinlan, Karen Ann: The Quinlan's Tell Their Story* (New York: Bantam Books, 1977), 309-18.

12. Pope Pius XII's Address to the Congress of the Italian Anesthesiological Society, on February 24, 1957, repr. in Horan, Dennis J. and David Mall, ed. *Death, Dying and Euthanasia* (Washington, D.C.: University Publications of America, 1977), p. 281.

13. Bishop Casey, *op. cit.* at 311.

14. The sources cited by Bishop Casey with terminal coma patients and the justification for foregoing extraordinary means on the grounds of both uselessness and burden, including burden to the family. See Pope Pius XII's address, *op. cit.*; Kelly, Gerald, S.J., "The Duty to Preserve Life", *Theological Studies*, 12 (1951), pp. 550ff.

15. May, William E., *Human Existence, Medicine and Ethics: Reflections on Human Life* (Chicago: Franciscan Herald Press, 1977), pp. 150-51; Ramsey, Paul, *Ethics at the Edges of Life* (New Haven: Yale University Press, 1978), pp. 268-69. Both Ramsey and May concluded that a decision to withdraw the feeding tube from Karen Quinlan would have been a morally acceptable choice. Ramsey, *op. cit.* at 270; May, *op. cit.* at 150-51. Both writers have opposed the withdrawal of AHN from a nondying DPU patient. See William E. May, Robert Barry, O.P., Msgr. Orville Griesse, Germain Grisez, Brian Johnstone, C.Ss.R., Thomas J. Marzen, J.D., Bishop James T. McHugh, S.J.D., Gilbert Meilaender, Ph.D., Mark Siegler, M.D., and Msgr. William Smith, "Feeding and Hydrating the Permanently Unconscious and Other Vulnerable Persons," *Issues in Law & Medicine*, 3:3 (1987), pp. 203-211 (hereinafter cited as the "1987 Statement"). Prof. Ramsey was a signatory to 1987 Statement and has objected to the use of his name as authority for extending his conclusion to non-terminal patients. See his letter to the editor in *America*, 156 (1987), pp. 449-50.

16. The condition of Nancy Cruzan is described in detail in the opinion of the Supreme Court of Missouri. *Cruzan v. Harmon*, 760 S.W.2d 408 (Mo. banc 1988), *aff'd sub nom.*, *Cruzan v. Director, Mo. Dept. of Health*, 110 S. Ct. 2841 (1990).

The Missouri Supreme Court held that since the burdens of her treatment were not excessive, in the absence of clear and convincing evidence of Ms. Cruzan's wishes, the interest of the State in life prevailed over her right to refuse treatment.

The United States Supreme Court affirmed and held that the State of Missouri may require an individual to give clear and convincing evidence of such individual's wishes regarding life support treatment decisions and that, in the absence of such evidence, the State may legitimately advance an interest in life by requiring the continuation of treatment.

Subsequent to the U.S. Supreme Court decision, petitioners submitted "additional" evidence to the Missouri Circuit Court. On December 14, 1990, the Circuit Court authorized the discontinuation of AHN. The Circuit Court's decision is reprinted in *Issues in Law & Medicine*, 6:4 (1991), pp. 433-36. Nancy died on December 26, 1990.

17. *Id.* The cost of Nancy's feeding formula constitutes 2.6% (*i.e.*, \$234 per month or \$7.80 per day) of the total cost of her care. See Harris, Curtis E. and Barry A. Bostrom, "Is the Continued Provision of Food and Fluids in Nancy Cruzan's Best Interests?" *Issues in Law & Medicine*, 5:4 (1990), pp. 415-436, at 425.

18. See *Quinlan Proceedings*, *op. cit.*, pp. 223 (Dr. Morse), 314 (Dr. Korein), 485 (Dr. Plum), 502 (Dr. Cook). However, in some instances, such description appears in the context of a discussion of coma, or comatose states. *Id.*, at 222-23 (Dr. Morse), 502, 504 (Dr. Cook). And, the attorneys summarize the testimony of the medical experts by describing Karen as being in a coma, or comatose. *Id.*, at 194 (Mr. Armstrong), 516 (Mr. Porzio, who uses the term interchangeably with the term persistent vegetative state).

19. Bishop Casey, *op. cit.* at 314; Ramsey, *op. cit.* at 269.
20. Cranford, Ronald, "The Persistent Vegetative State: The Medical Reality (Getting the Facts Straight)," *Hastings Center Report*, 18:1 (Feb./Mar. 1988), pp. 27-32, at p. 28.
21. *Id.*
22. *Quinlan Proceedings, op. cit.*, at pp. 469-71.
23. Karen died from pneumonia in 1985 at the age of 31.
24. For a more elaborate discussion of the meaning of a terminal illness as applied to DPU patients see Vaccari, Michael A., "The Inability to Swallow as a Fatal Pathology: Comments of the McHugh/O'Rourke Correspondence and the Removal of Life-Sustaining Treatment," *Issues in Law & Medicine*, 7:2 (1991), pp. 155-67.
25. Connery, S.J., John R., "Prolonging Life: The Duty and Its Limits", *Linacre Quarterly*, 47:2 (May, 1980), pp. 151-165, at p. 156 (hereinafter cited as "Prolonging Life").
26. *Id.* Germain Grisez analyzes the Quinlan case in a similar fashion. See Grisez, Germain, "Should Nutrition and Hydration Be Provided to Permanently Unconscious and Other Mentally Disabled Persons?", 5:2 *Issues in Law & Medicine*, 5:2 (1989), pp. 165-79 at p. 179.
27. Fr. Connery expresses this distinction as follows:
When one withholds or withdraws a means to preserve life because it is too burdensome, his intention is to spare the patient the burden somehow involved in the use of the means. There is no intention of bringing on the death of the patient. Even if the patient lives (as in the Quinlan case), the goal is achieved.
- Connery, AHN Ethics, *op. cit.* at pp. 22-23. Fr. Connery's next sentence in the passage quoted in the text is as follows: "He or she is spared the burdensome means." *Id.* at p. 23. However, this analysis should not apply to cases involving DPU patients since it is not their burden that one generally (absent a statement made by the patient before becoming unconscious) seeks to end.
28. The term "family" is used broadly to refer to loved ones, relatives and friends. The term "society" also is used broadly to refer to the relevant community and to include the hospital and its staff, the local community and state and national governments. The analysis of burden on the basis of burden to society is beyond the scope of this paper. See 1987 Statement, *op. cit.*, at p. 211; Connery, AHN Ethics, *op. cit.*, at pp. 21-22.
29. The proportionality analysis has received much attention since the Vatican used the concept in its Declaration on Euthanasia. Congregation of the Faith, "Declaration on Euthanasia," *Origins* 10:10 (May 5, 1980), p. 154. Proportionality is an additional, rather than the exclusive, basis for a determination of burden. A treatment may be burdensome *per se* to a patient, regardless of the benefits. See Connery, S.J., John R., "In the Matter of Clare Conroy", *Linacre Quarterly*, 52:4 (Nov. 1985), pp. 321-328, at p. 325.
30. E.g., the case of Lawrence McAfee, *Georgia v. McAfee*, 259 Ga. 579, 385 S.E. 2d 651 (1989), and the position of the Archbishop of Atlanta thereon, "Georgia Man Asks to Turn Off Life-Sustaining Ventilator," *Origins*, 19:17 (Sept. 1989), pp. 273-279. Cases of incompetent patients raise additional questions concerning surrogate decisionmaking. In addition, the incompetency of the patient may add to the burdensomeness of the treatment. E.g., *Superintendent of Belchertown v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977). See Connery, *Prolonging Life, op. cit.*, at p. 157.
31. While the cost of a respirator and ICU may be considerable, in most cases the cost of AHN is not significant. See note 17 *supra*.
32. See Grisez, *op. cit.*, at pp. 170-71, where he distinguishes between anguish over a patient's condition and anguish related to a patient's disability.
33. The catheter inserted in her bladder, the continuous administration of antibiotics, the routine testing to check for infection, the utilization of a urethral catheter, the treatment for her decubiti — all of these aspects of care, coupled with the prospect that her condition was irreversible, provided grounds for a decision to forego certain aspects of that treatment.

34. Grisez, *op. cit.*, at p. 179. See also Grisez, Germain and Joseph M. Boyle, Jr., *Life and Death with Liberty and Justice: A Contribution to the Euthanasia Debate* (Notre Dame: University of Notre Dame Press, 1979), at pp. 273-75.

35. *Quinlan Proceedings, op. cit.*, at p. 373. The cost was expensive to the State, and this could constitute grounds for a determination of burden to the community. There is no evidence that Karen would have discontinued treatment on this basis if she were conscious and no evidence that the decision of her parents was made on this basis.

36. *Id.*, at pp. 423-49.

37. There are many differences in the conditions of Karen Quinlan and Nancy Cruzan, such as the nature and origin of their injuries, the areas of the brain damaged and the length of the period of unconsciousness. Notwithstanding such differences, there are sufficient similarities in the conditions of the two patients for purposes of the analysis in the text.

38. See "Brief of the Medical Issues Task Force of the United Handicapped Federation and the Ethics and Advocacy Task Force of the Nursing Home Action Group as Amici Curiae," p. 30, filed in the Circuit Court rehearing.