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The ethical analysis provided by the Center for Health Care Ethics concerning the AMA statement on tube feedings, makes some important distinctions, but also raises some issues of concern.

One important obligation is to define the specific population addressed by the AMA. The category of patients for whom the withholding of nutrition and hydration is recommended, consists of those in irreversible coma for whom death is not imminent. As AMA publications have further clarified, the statement applies specifically to the estimated 10,000 patients in the country who are in a "persistent vegetative state". It is not to be presumed that every patient in a persistent vegetative state is suffering from the same underlying pathology, but rather that they have in common certain clinical features of irreversible coma. The AMA statement would seem to be unrealistic in laying down the conditions that the accuracy of the diagnosis be "insured" and the coma irreversible "beyond doubt".

Such degrees of certitude are largely unachievable through the art of medicine in the real world. Putting aside such uncontrollable variables and assuming an accurate diagnosis, an important question which arises is whether irreversible coma truly constitutes a fatal disease. This is pertinent in view of the principle applied by the Center for Health Care Ethics which asks "whether there is an obligation to seek to remove or circumvent a fatal pathology in order to prolong life". Coma, even when irreversible, does not constitute a uniformly fatal pathology. In the various litigated cases (Quinlan, Brophy, Herbert, Jobes, etc.), the comas resulted either from drug ingestion, anesthetic reactions or surgical catastrophes. In each instance, severe central nervous system damage was inflicted on the patient, but in no instance was a fatal pathology produced. Indeed, if there were a fatal pathology, there would have been no need for litigation.

Decision on Life Supports

The controversy arises when a decision has to be made regarding various kinds of life support for a patient who is comatose but likely to survive for a prolonged period or until such time as death results from a fatal event unrelated to the cause of the coma. If the patient were suffering from a fatal

pathology, feeding him or her would allow the underlying fatal process to run its course and end his or her life. In the usual type of persistent vegetative state, such an underlying fatal pathology does not characteristically exist. Withholding food and nutrition over time, on the other hand, will have uniformly fatal results. There would be no need for an AMA statement if the population at issue were those patients who lapse into coma in the terminal stages of fatal disorders such as carcinomatosis, sepsis, or organ system failure. Such patients will die with or without feeding in a short time, usually less than a fortnight. As was the case with Karen Quinlan and Clarence Herbert, discontinuing respirator support may not result in death, especially as pulmonologists become more skilled at weaning certain patients off of respirators. For the patient in a persistent vegetative state, induced by a non-fatal cerebral insult, discontinuation of food and drink will terminate the coma in death from starvation.

Three Fundamental Fallacies

There are three fundamental fallacies in the rationale developed for the discontinuation of feedings in the population under discussion. The fallacies are 1) The allegation that the "fatal pathology" in patients with persistent vegetative state is the inability to swallow, 2) The interpretation of the discontinuation of feedings as an unwillingness to "circumvent" this fatal pathology, and 3) The requirement that the patient be capable of "cognitive-affective" function in order to pursue the purpose of life and the implication that a life devoid of cognitive-affective function at a certain unspecified level is a life unworthy to be lived.

It is medically inaccurate to characterize the inability to swallow as a fatal feature of irreversible coma. Most patients in a persistent vegetative state, aside from a small percentage who might have bulbar paralysis, can swallow and do swallow most of their spontaneously produced secretions. They are incapable of neo-cortical functions and are therefore incapable of eating, an action much more complex than mere swallowing. Eating involves the identification of food, seeking out food and ingesting it and synchronizing the acts of mastication and swallowing, as well as the avoidance of aspiration. Many individuals capable of the act of deglutition will, nevertheless, have to be fed in order to survive. Infants will need to be fed; patients who are alert but paralyzed will have to be fed; patients with obstructive lesions in the upper gastrointestinal tract will require feeding techniques which bypass the obstruction. The patient in a persistent vegetative state will be incapable of numerous other basic comfort and self-protective functions. He will be unable to dress himself or to protect himself against extremes of temperature. He will be unaware of threats of bodily harm and will be incapable of aversive or escape movements. It would be inaccurate to suggest that the inability to avoid exposure is a fatal pathology which we bypass when we dress the comatose patient or cover him with blankets. If there were to be a fire in a hospice, no one would deny that, when the comatose terminal patients were removed, we would do so

as a matter of obligation, rather than as an optional circumvention of a potentially fatal inability to flee from danger.

Patients in a persistent vegetative state cannot legitimately be said to be suffering from a fatal pathology. Feeding patients cannot be properly said to be treating disease or bypassing a fatal pathology. Various basic care measures avoid the possibility that a non-fatal incapacity become fatal. Food and drink sustain all persons, in or out of coma, and their elimination can only intend an inevitable death.

Added Rationale

An additional rationale must be adduced for the withholding of feedings from a patient in a persistent vegetative state. The New Jersey Supreme Court, in the Quinlan case, cited the hopeless prognosis for a return to a "cognitive and sapient state." In the Center's statement, Father Kevin O'Rourke refers to a basic ethical assumption that there is no obligation to prolong life unless living "enables us to pursue the purpose of life." He further elucidates that "to pursue the purpose of life, one needs some degree of cognitive-affective function." It is not clear what constitutes a sufficient degree of cognitive-affective function in a patient in order for the physician to incur an obligation to prolong life. What is clear is that there are formidable numbers of patients who have a severe compromise of cognitive-affective function. The AMA has identified the 10,000 patients in irreversible coma. There are additional large populations such as 1) the class of patients suffering from various forms of dementia, including Alzheimer's disease and true senile dementia; 2) the severely mentally retarded population in institutions; 3) psychotic patients, particularly those such as schizophrenics who have grossly disordered thought processes and markedly blunted affect. When these three categories are lumped together, we are talking about hundreds of thousands, if not millions, of people. They are unquestionably alive, not dying and not "pursuing the purpose of life" if to do so requires cognitive affective function at a significant level. All of the above classes of patient require specific feeding strategies for their survival. Many will require artificially administered nutrition; most will have to be fed by others as a minimum. Even when deinstitutionalized, psychotic patients, who comprise a large percentage of homeless street people, will depend on the logistic provision of soup kitchens and public food pantries for their survival.

The AMA refers to technologically supplied nutrition in its statement. The New Uniform Living Will Act, however, specifically removed the distinction between the withholding of naturally and artificially supplied nutrients, as a result of an intense lobbying effort by the Right to Die Society at the conference to draw up the Uniform Act.

There is little controversy regarding patient autonomy, where a competent patient suffering from a fatal disease declines certain life-prolonging therapy for good reason. There is great potential for controversy regarding decisions made by surrogates on behalf of incompetent patients.

Agonizing Deaths

Starvation and dehydration lead to agonizing deaths in conscious patients. Is it safe to assume that such a death is without discomfort in a comatose patient? Probably not, although we have little testimonial evidence one way or another. In the recent decision in the Jobes case, the judge ordered tube feeding discontinued, even though attending nurses and two expert medical witnesses testified that Mrs. Jobes responded appropriately to commands to move her extremities and protrude her tongue. Levels of coma vary and survivors of comatose states usually attest to a gradual, rather than an abrupt, attainment of consciousness. In a recent highly publicized case, Sgt. David Mack of Minneapolis awoke after 22 months of coma to reveal that he had been aware of activities around him for about six months.

A national policy of approval for the withholding of nutrition from a whole class of comatose patients would be both hazardous and premature. The degree to which cost-containment considerations enter into the debate must be accurately ascertained. The AMA would have been well advised to continue an active patient advocate posture at this stage of the debate.
