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The Ethics of Withholding/Withdrawing Nutrition and Hydration

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Respect for life has been traditional in human society. It is based on recognition of human life as a basic good. Life is basic to any other good a human may have or acquire. Truth demands that one respect life as such a good. In our Judaeo-Christian culture this has carried with it several demands. It has traditionally demanded that no one take innocent human life. This included not only the life of other innocent people but that of the person himself or herself. Suicide has been considered as much a violation of respect for life as homicide.

Euthanasia

It has also been recognized that taking a human life by omission is just as wrong as taking it by commission. Thus no distinction has been made, e.g., between intentionally starving a person and stabbing him to death. Even if this is done with a good intention, e.g., out of mercy, it has been considered wrong. So what is called euthanasia has always been condemned in our society, and this is true of voluntary as well as involuntary euthanasia. The only difference between the two is that voluntary euthanasia would constitute suicide as well as homicide.

Duty to Preserve Life

Respect for life has also had another dimension. A positive duty to preserve life has been part of the tradition. This is a duty which runs through the whole spectrum of human activity. It affects what one eats, what one drinks, what he wears, what kind of work he does, what kind of recreation he takes, whenever it involves some risk or danger to life. Again,

it affects what he does as well as what he does not do. A person can show his lack of respect for life by omission as well as by commission.

From what has been said above, it should be clear that respect for life demands that what the person does or does not do never falls into the category of suicide or homicide. This can happen in two ways: (1) if death is the only immediate effect of some act or omission; or (2) if death is intended either as a means or an end.

If death is the only immediate effect of the act or omission, it must obviously be intended, and therefore must constitute suicide or homicide. While this is a possibility, it may happen only rarely, since it does not often happen that an act has only one immediate effect. The more usual case would be one in which, although the act may have other effects, death is intended either as a means or an end.

Granted that what is done does not fall into either of these categories, it has generally been admitted that one does not have to do everything possible to preserve life. In other words, there are limits to what the person must do or not do to fulfill this duty. Thus, one does not have to rule out all danger or risk in the work he does, or even in the recreation he takes. Nor does one have to take all treatment necessary to preserve or prolong his life.

Principle of Double Effect

How does one decide, in these cases, what is of obligation and what is optional? In technical language we are dealing here with what is called the principle of double effect. In other words, we are dealing with an act which has a bad effect, and we are asking about the morality of such an act or omission. We have already pointed out that respect for life does not demand that we avoid any act or omission that carries with it risk or danger to life (bad effect). We have also pointed out that it would not be permitted to engage in such activity with the intention of bringing on death. But what if the act or omission is placed for some other reason? How would one determine its morality?

Besides the requirements already mentioned regarding intention, this principle requires that the reason for placing the act or for the omission be sufficient to justify the evil effect. We can illustrate with the example of the space shuttle. Those who have gone up in it were certainly aware of the risk to life, yet none of them went up with the intention of ending their lives. They went up because of the good this program gave hopes of accomplishing. It was generally felt that this was sufficient to warrant the risk to life involved. I think it would be generally agreed that, presuming that known risk was reduced to a minimum, the conditions of the principle of double effect were verified, and going up was morally permissible.

Nutrition and Hydration

Our concern here is not with any or every act or omission that carries

with it risk to life, but with a specific act. We are concerned with foregoing eating and drinking with resulting risk to life or even certain death. The question is whether and under what circumstances one may withhold/withdraw nutrition and hydration from a patient.

This question has arisen in recent times in the context of the discussion that has taken place over the past ten or more years regarding the obligation to take medical treatment. It is generally agreed that the obligation to take medical treatment, like the obligation to preserve life, has its limitations. The question now being asked is whether the duty to eat and drink has the same limits as medical treatment. Or is there a difference?

There is clearly a difference between eating and drinking, and medical treatment. Medical treatment is aimed at curing a disease. Eating and drinking are not aimed at curing disease, but at sustaining life. Medical treatment is therapeutic; eating and drinking are not basically therapeutic. So there is no doubt that eating and drinking, and medical treatment are two different procedures, although artificial feeding seems to be a combination of both.

But this does not answer our question, which is whether there is a difference in the obligation to eat and drink, and the obligation to take medical treatment. The pertinent question is whether the differences pointed out above are morally relevant, that is, whether they would affect the moral obligation. Would it, for instance, make the obligation to take food and drink an absolute one, whereas the obligation to take medical treatment would remain limited?

Unique Obligation?

It is my contention that there is no difference between these obligations. As already pointed out, there is one duty to preserve life and that duty affects everything we do insofar as it involves danger or risk to life. We are not speaking of two distinct duties, one to eat and drink, the other to take medical treatment. There is only one duty, the duty to preserve life, and this duty must be taken into consideration in anything a person does which involves risk or danger to life. Since this duty has its limitations, these limitations as well as the duty itself affect everything we do. As pointed out, it would obviously not be permissible to forego eating and drinking to bring on death. But if some other reason were present, it could be justified. I think everyone would admit, for instance, that if there were only enough food and drink for one person, a grandparent could forego eating in favor of a grandchild, just as he could forego medical treatment, etc. So I do not think one can say that it would be intrinsically evil to forego eating and drinking even to the point of death. If the omission can be justified according to the principle of double effect, it would be morally permissible. We are not asking here whether foregoing food to save the life of another can be justified, but whether other reasons can be offered, and

if so, what reasons.

The moral norm that has been generally accepted is that if what is omitted is useless in prolonging life or excessively burdensome, and is omitted for this reason, it would be morally permissible.[1]

Useless Means

If what was omitted was useless, that is, if it would not prolong life perceptibly, there would obviously be no obligation to use it. If morality is to be reasonable, one cannot impose an obligation on a person to do something useless. This would make no sense. Today, however, this principle is not being properly used. It is used to free one of an obligation to use means if it would not cure some disease. Thus, if a particular disease is irreversible, some would want to argue that it would be permissible to withdraw even nutrition and hydration, since they could not reverse the disease. But this ignores the whole meaning of the question, which is about the duty to prolong life, not the duty to cure disease. Obviously, if one were talking about the latter, one could not directly impose an obligation to eat and drink . . . since it would not cure the disease. In fact, one could never impose an obligation to eat and drink on this score, since eating and drinking, as such, are not therapy.

So it makes no sense to relate the obligation of nutrition and hydration to whether the disease can be reversed or not. The only legitimate reason for withdrawing it would be that it would not prolong life perceptibly, so that the patient would die within a short space of time whether he ate or not.

Burdensome Means

What if a means is excessively burdensome? In that event a patient would be permitted to forego the means. This is permissible because a humane morality does not place on a patient an obligation that would be too difficult for him to bear or fulfill. I do not think that any distinction can be made here between treatment and feeding. For a particular patient eating can be just as difficult as treatment. It would not be reasonable to demand that such a patient accept one and not the other. Indeed, foregoing either would be wrong, as pointed out above, if death was the only immediate effect, or if it was intended. But the assumption is that neither is or has to be the case. Death is not the only immediate effect. If a means (treatment or feeding) is excessively burdensome, refusing treatment has another immediate effect . . . avoiding the burden of the treatment or feeding. If this is what he intends, omitting eating and drinking could be justified as a legitimate application of the principle of double effect. He is not doing something wrong in itself, he does not intend the evil effect, and he avoids the burden which eating involves.

When theologians speak of a means to preserve life that is excessively burdensome, they usually break it down into hardship, pain, cost or danger. If the use of some means involved what would be judged excessive

in any of these areas, a patient would not be obliged to take it. It would be optional.

Burden to the Family

Ethicians are obviously speaking of burden to the patient. If the burden is to the patient, he is relieved of any obligation to use the means. But option is not limited to the patient. A patient would be free to omit a means to preserve life even if he did so to remove a burden from the family. If a patient had no insurance, and he wanted to spare the family the astronomic costs some treatments involve today, it would be permissible for him to do so. In fact, he might be more concerned about the burden to his family than the burden to himself.

Burden to Society

In today's society, the burden of cost is usually shifted to some insurance company or to society, if he is on medicare or medicaid. So the patient cannot often omit treatment because of the burden of cost to himself. Would it be permissible for him to omit treatment because of the cost to the insurance company, or to society? This is certainly a possibility. But it is not likely to happen. At least I have never heard of anyone who refused treatment because of the cost to an insurance company, or to society, if he was on medicare or medicaid. So although it could happen, it would be difficult to make any such presumption in the case of an incompetent patient.

Scarce Facilities

What about society itself? Could it terminate treatment even against the wishes of a patient? Society has the right and duty to distribute its own funds. Since it never has enough funds to cover all the needs of a community, it must set limits. It would be permissible for society then to limit the funds given to health care both in general and in particular cases . . . as long as it observes distributive justice. But even in a situation where it might legitimately limit funds, it could not legitimately stop treatment itself. If the treatment could be provided from other funding, society could not stop it. The only situation in which society could stop treatment would be one in which treatment facilities themselves were scarce. There society could set limits.

Even in this situation, however, society would be bound by moral norms. It would be no more permissible for society to intend the death of a patient than it would for the patient himself. So while society may limit treatment, it may not do so with the intention of ending the life of a patient. Society also has the obligation of not discriminating against patients.

The fact is that society has not set such limits, so the above discussion is purely theoretical. I do not think that a court could make a decision on this basis. Since it is dealing with only one case, it would be impossible to

avoid discrimination.

Briefly, what we are saying is that it is permissible to forego means to preserve life when the use of such means would not appreciably preserve life or when, even if it would, it would be excessively burdensome. It would not be permissible to forego means to preserve life with the intention of bringing on death.

Quality of Means vs. Quality of Life

Today this whole discussion has entered into a new phase. In the past, as described above, the emphasis was on the means. Sometimes the distinction was made between ordinary and extraordinary means to clarify the obligation of preserve life. In the past five or ten years a new emphasis has been added. Some are looking not only at the means, but the person. They would like to distinguish between ordinary and extraordinary patients, as well as ordinary and extraordinary means. The underlying reason is that they would like to make an allowance for extraordinary patients, just as they make for extraordinary means. In other words, they would like to withhold or withdraw treatment on the basis of the quality of life of the patient as well as the quality of means. Thus, if the quality of life of the patient was below a certain standard they would argue that the means of preserving life could be withheld or withdrawn.

Superficially, it would seem that if one could withhold means on the basis of the quality of the means, it could be done on the basis of the quality of the patient's life. Thus, if one could withhold means because they are useless or excessively burdensome, it would seem that one should be able to withhold them if the patients's life itself is useless or excessively burdensome. Actually, I know of no one who would want to make this simple transfer. In general, advocates of this approach are usually much more demanding in dealing with quality of life than they are with quality of means. They would argue, for instance, that if a person were in an irreversible coma or a persistent vegetative state, it would be permissible to withhold means to preserve life, including food and hydration. They would not include other incapacitating handicaps. Similarly, they might argue that if the patient's life was extremely burdensome, not just excessively burdensome, it would be permissible to withhold means to preserve life.

New Moral Category

What about the morality of this argument? As already indicated, it might look as though this was just another step in the same direction. And this is part of the problem . . . the move may not be recognized for what it is. Actually, it represents a quantum leap from what is and has been considered acceptable. It is not in any way in continuity with past practice, but involves a move into an entirely different category of moral act. Let me illustrate. 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. He or she is spared the burdensome means.

But if one omits some necessary means because of the patient's low quality of life, the intention is to bring the life of the patient to an end, since this is the only solution of the problem. Presumably, the patient's condition cannot be reversed, so the only solution is the death of the patient.

What this means is that we are omitting treatment, etc., with the intention of bringing on death. In other words, we are violating our duty to respect life. As we mentioned earlier in this paper, respect for life demands that we do nothing (and omit nothing) that involves danger or risk to life with the intention of bringing on death. The fact that it is being done with good intention, to end the patient's pain, does not change the basic nature of the act. It is euthanasia. This has been defined as an act or omission which by nature or by intention brings on the death of the patient out of mercy.[2] Both the moral and civil law have always abhorred euthanasia. Killing is killing whether it is done with a good intention or not.

Moral Sensitivity

Awareness of the magnitude of the step from quality of treatment to quality of life is crucial to moral sensitivity in this area. The introduction of moral evil into society can be and often is imperceptible, and one can easily be lulled into a false sense of security if he underestimates what look like small steps. The astronaut who first stepped on to the moon said that it was just a small step for a man, but he and everyone else knew that it was a giant step for mankind. The same has to be said for the step into quality of life reasoning. It may look like a small step, but in reality it is a giant moral step. One is entering into an entirely different category of moral act . . . intentionally bringing on death. If one makes this move under the illusion that it is a small step and in continuity with the past, he will be blissfully, but also sadly, ignorant of the disastrous implications of what he is doing. He is leaping in the dark. What is even worse is the failure to realize that this leap will land him on a slippery slope, and with no braking power.

It would be bad enough if we could limit this quality of life move to an extreme case of rare occurrence. For the reason given above, the truth is that we have no effective way of controlling it, or of drawing a legitimate line. In other words, there is no acceptable or manageable criterion that can be used to justify withdrawal of treatment in some cases and legitimately exclude it in others. Once the line between quality of treatment and quality of life is crossed, there is no effective way of drawing another line. As pointed out above, we are on a slippery slope with no braking power. Today, we are intentionally ending the life of a person in an irreversible coma or a persistent vegetative state. Tomorrow, it will be the person with Alzheimer's disease. The next day, any Alzheimer's chronic

mental patient will qualify. Then, or even before, incapacitating physical handicaps will be considered. There is no way in which one can take the first step, or the second step and stop there. This threat is aggravated by the fact that the judgment in these cases is made mostly by third parties, with all the hazards this implies. We will eventually or sooner find ourselves in a society in which only those with an optimal quality of life will be secure . . . the opposite to a democratic society in which all are considered equal.

That this is not all just fantasy is clear from a recent article in the *New England Journal of Medicine.*[3] There the statement is made that it is ethically permissible to withhold nutrition administered by . . . gastric tube from "severely and irreversibly demented patients" as well as from the "pleasantly senile."

Wishes of Patient

What if the patient had made a living will, or indicated in some other way that if he or she is ever in an irreversible or incurable condition, he does not want treatment, even artificial feeding? It is quite true that the decision regarding treatment is up to the patient. But from a moral perspective, the patient is not at liberty to decline all and any treatment, especially nutrition and hydration. If a patient foregoes treatment that is not burdensome and will prolong life, he is going beyond his legitimate option, and violating his duty to respect life. Even if a patient were to make such a request, those responsible for her could not condone it or freely cooperate with it. This, of course, puts the attending physician in a difficult position, at least from a legal perspective. What is clear is that a request by the patient will not justify the omission of treatment when this would be immoral.

Hopeless Case

Advocates of a quality of life approach to justify withdrawing means to preserve life will frequently give as their reason the fact that a particular case is hopeless. Hopeless can frequently mean many things. If it means that there is no hope of cure, it cannot be a valid reason for withdrawing the means to preserve life. Many diseases are incurable, e.g., diabetes, but no one would suggest that one should not give a diabetic insulin because the disease cannot be cured. So the fact that the condition cannot be cured is not in itself the reason for withdrawing treatment. When a case is called hopeless in the present context, it seems to mean not only that the condition is not curable, but that the quality of life of the patient is so low that it is useless to continue it. Again we are dealing with a quality of life reason in which the solution is the death of the patient.

It is also argued that means to preserve life, including feeding, may be removed when the patient is in what is called a persistent vegetative state. Whether a human being who is still alive can be said to be in a persistent vegetative state can be seriously challenged. As long as a human soul is present (and this is the case until the patient is at least brain-dead) human

life is present. It is not just vegetative life. Also, the only thing we are sure about in these cases is that the patient cannot communicate with the outside world. We are not at all sure that he or she cannot receive some communication from outside. Nor can we rule out some kind of interior life. To say that there is only vegetative life in a human being who is still alive goes beyond any evidence we have.

'Natural' Death

Some will want to argue that prolonging life by treatment or artificial feeding is putting off the natural time of death, and so cannot be obligatory. Before accepting this objection, which really proves more than the opposition would want, one would have to know the answer to the question: when is death natural? If we go back into the Old Testament, we will come to a time when any kind of human intervention in disease was considered interfering with Divine Providence. I believe it was the prophet Sirach who argued that God created the herbs and the drugs, just as He created food and drink, and endowed the doctor with knowledge to cure the sick, and so wanted us to use them just as we use His other gifts. So prolonging life by using these gifts is not interfering with Divine Providence, but really cooperating with it.

No one today would argue that all therapy involves interference with nature or Divine Providence. But some even today seem to want to maintain that there are times, such as in the case of a person in a persistent vegetative state, when one should withdraw and let nature take its course. We have already pointed out that there are times when treatment is optional, but this is because the treatment is useless or excessively burdensome. We do not judge it optional because, in a particular case, we think a judgment can be made that death is natural. I know of no way of making such a judgment except in the case where death is going to occur in a short time whether treatment is used or not. But this kind of judgment is neither necessary nor helpful. So it makes no sense to talk about putting off natural death.

Intending Death or Letting Die

In the same vein, some will maintain that in these cases they are not intending death, but letting death occur or letting nature take its course. There is certainly a clear distinction between intending and permitting or allowing. One who omits a burdensome treatment to spare the patient the burden of the treatment does not intend the death of the patient. If death happens, he merely permits it. But one who withholds or withdraws the means to preserve life to let death occur is not just a passive observer. What he does or fails to do is instrumental in bringing about the death of the patient. This is especially true in the case of feeding. If the patient dies, one cannot say that the death comes from the original disease. He dies of starvation. And even in the case where some treatment is stopped, although the disease may ultimately account for the death of the patient,

the omission of the treatment brings it about sooner, thus shortening the patient's life. It is quite true that an act or omission from which death results is not in itself immoral. It is when this is done precisely to end or shorten the life of the patient that it becomes immoral. Since this is what happens when some means to preserve life is not provided or withdrawn, it is our contention that it constitutes intentional euthanasia by omission.

Briefly, then, even if one does not place some positive act of violence, but simply omits something necessary to preserve life, he cannot say that he is just letting death occur, or letting nature take its course. If death results from his failure to do something he can easily do, and this is his intention, he is doing more than just letting it happen. He intends what happens because this is the solution to his problem. And this is immoral.

REFERENCES

1. Such a means has been traditionally called an "extraordinary" means. A means which was useful and not burdensome was considered "ordinary" means, and obligatory. This distinction means different things to different people, and so has gone out of favor.

2. This definition was given in the *Declaration on Euthanasia* of the Sacred Congregation for the Faith (1980) but it is commonly accepted.

3. *The Physician's Responsibility Toward Hopelessly Ill Patients*, Sidney H. Wanzer et al., 310:15 (April 12, 1984), 955.