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# Foregoing Artificial Nutrition and Hydration: Some Recent Legal and Moral Implications for Catholic Health Care Facilities

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Due to the confusion concerning the state of the law regarding artificial nutrition and hydration, we propose to review some of the significant legal opinions and to outline some of the possible options for Catholic health care facilities in attempting to respond to the legal and ethical dimensions involved.

Until just a few short years ago, the mere suggestion, much less the actual act, of discontinuing the provision of artificial nutrition and hydration to a hospital patient would have sent shock waves through the medical and legal communities. This reaction was understandable because the provision of artificial nutrition and hydration was regarded not as just another treatment modality, but as basic, non-negotiable comfort care which would be provided as long as the patient was alive.

The movement away from artificial nourishment accelerated when *Barber vs. Superior Court* was decided in 1983.<sup>1</sup> This case involved two Los Angeles physicians who were being prosecuted for murder because they withdrew the artificial nutrition and hydration from a comatose adult patient, Clarence Herbert. In the appeal decision which exonerated the physicians, the justices refused to distinguish between artificial nutrition and hydration and artificial breathing or ventilator support:

Medical nutrition and hydration may not always provide net benefits to patients. Medical procedures to provide nutrition and hydration are more similar to other medical procedures than to typical human ways of providing nutrition and hydration. Their benefits and burdens ought to be evaluated in the same manner as any other medical procedure.<sup>2</sup>

The standard to be applied to evaluate the benefits and burdens of medical procedures including artificial nutrition and hydration, according

to the Barber decision, is whether the continued treatment is *proportionate* or *disproportionate* to the patient's recovery to cognitive and sapient life:

Proportionate treatment is that which, in view of the patient has at least a reasonable chance of providing benefits to the patient, which benefits outweigh the burdens attendant to the treatment.<sup>3</sup>

The court continues:

A treatment course which is only minimally painful or intrusive may nonetheless be considered disproportionate to the potential benefits if the prognosis is virtually hopeless for any significant improvement in condition.<sup>4</sup>

In 1984, while not directly addressing nutrition and hydration, the California Court of Appeals in the *Barling* decision extended the right to refuse disproportionate treatment to a competent, non-comatose adult.<sup>5</sup> This case was brought by the patient's wife who was seeking a court order to have the hospital remove an artificial breathing device. The court held that the right to refuse treatment was based on the constitutional right of privacy and was, in this case, superior to the interests of the state in preserving life, protection of innocent third parties, prevention of suicide and the preservation of the ethical integrity of the medical profession.

In 1985, the Supreme Court of New Jersey, the same court that decided the Karen Ann Quinlan case, in the *Matter of Conroy*, directly addressed the issue of artificial nutrition and hydration in an incompetent, non-comatose patient.<sup>6</sup> This court approved the foregoing of artificial feeding from Claire Conroy, an 84-year old bedridden woman who was incompetent, institutionalized with severe and permanent mental and physical impairments and had a limited life expectancy. The *Barber*, *Barling*, and *Conroy* cases laid the groundwork for a 1986 case, *Bouvia vs. Superior Court*, which put an end to the rationale that artificial nutrition and hydration were non-negotiable comfort care.<sup>7</sup>

### The Bouvia Case

Elizabeth Bouvia is a competent, non-comatose adult. She is a cerebral palsy victim who has been a quadriplegic since birth. She has been married and divorced, was pregnant but suffered a miscarriage. Three years ago, while in a Riverside, California hospital, she sought a court order directing the hospital to withdraw her artificial nutrition and hydration, and to keep her comfortable while she starved herself to death. The court refused to grant such an order and Ms. Bouvia eventually left the hospital. She lived with family and friends until December, 1985 when she was admitted to a Los Angeles County Medical Facility. While there her weight dropped and artificial nourishment was begun without Ms. Bouvia's consent because her condition was judged to be life-threatening by the physicians. She again went to court, but this time asked for an order to withdraw artificial nutrition and hydration in order to be relieved of the burden of that treatment. She denied that she was again intent upon suicide and stated

that she would take liquids normally if the artificial measures were discontinued. The trial court did not believe Ms. Bouvia and refused to grant her requested order. Ms. Bouvia appealed that decision.

On April 16, 1986, the California Court of Appeal reversed the decision of the trial court, stating that a competent adult patient has the right to refuse any medical treatment or medical service, even when such treatment is labeled "furnishing nourishment and hydration" and even if its exercise creates a "life threatening condition."<sup>8</sup> Calling this right to refuse medical treatment "basic and fundamental" and "part of the right of privacy protected by both the state and federal constitutions", the appellate court ruled that it "requires no one's approval" and is not "subject to being overridden by medical opinion". This court further ruled that a "constitutionally guaranteed right must not be abridged" and that "it matters not what its exercise".

In a separate concurring opinion, Justice Compton joined in the majority decision but, unlike the majority, directly addressed the issue of suicide.<sup>9</sup> After observing that the majority opinion danced around the issue, Justice Compton stated that the "right to die is an integral part of our right to control our own destinies so long as the rights of others are not affected". He further added that this right should "include the ability to enlist assistance from others, including the medical profession, in making death as painless and quick as possible".

This decision stunned not only the medical community but others including the County of Los Angeles which petitioned the California Supreme Court to review the case and to stay the decision pending the review. The Supreme Court, on June 5, 1986, refused to review the case and thereby let the decision stand.

The above review of some recent court cases indicates the complex assessment of values which enters into the legal appraisal of withdrawal of medical treatment, including artificial nutrition and hydration. Entering into this assessment are such concerns and "proportionate or disproportionate care", the value of patient autonomy, and legitimate state interests concerning the protection of human life. From a Catholic moral perspective, it is important to offer some reflections on these legal developments.

The terms "ordinary" and "extraordinary" means have enjoyed a long provenance in the ethical literature. However, there is an inescapable ambiguity inherent in the terms since consideration of perspective influences the extent to which medical treatments are deemed "ordinary" or "extraordinary". For example, from one perspective, namely the physician's, "ordinary" means are those dictated by the state of current technology. From the patient's perspective, however, a different perception can emerge. That is, "ordinary" means would constitute those measures which are minimally invasive and confer some discernible benefit irrespective of technical merit. Classically, the distinction between "ordinary" and "extraordinary" means has been elaborated from the

viewpoint of the patient on the basis of a "benefit—burden" test, that is, if the treatment does not confer a discernible benefit to the patient, or results in intolerable burden, the treatment may be refusable or "optional" and hence, "extraordinary".

### Adoption of Terms

In order to obviate some of the confusion surrounding the terms "ordinary" and "extraordinary", practitioners of ethics have adopted the terms "proportionate" and "disproportionate." This terminology appears not only in the Vatican *Declaration on Euthanasia* (1980), but also in the President's Commission Report, *Deciding to Forego Life-Sustaining Treatment* (March, 1983).<sup>10</sup> Discerning the proper "proportion" or "measure" of treatment requires careful ethical judgment in order to make the appropriate decisions about continuing or foregoing treatment. The merit of this language is that it focuses attention on the patient's total condition in order to assess whether treatment is obligatory or optional. If the treatment is judged to be "disproportionate" and hence optional, there is no obligation to continue the treatment. Moralists Kevin O'Rourke and Dennis Brodeur highlight this point:

If the means are determined from an ethical point of view to be extraordinary [i.e., disproportionate], they may or may not be employed.<sup>11</sup>

In a recent statement published by the Committee for Pro-Life Activities of the National Conference of Catholic Bishops, this perspective was held to be in keeping with the Church's moral tradition:

We maintain that one is obliged to use "ordinary" means of preserving life—that is, means which can effectively preserve life without imposing grave burdens on the patient—and we see the failure to supply such means as "equivalent to euthanasia" . . . . But we also recognize and defend a patient's right to refuse "extraordinary" means—that is, means which provide no benefit or which involve too grave a burden.<sup>12</sup>

We judge that these criteria provide some helpful guidance for the difficult questions concerning artificial nutrition and hydration, as well as the complex questions concerning withdrawal of life support presented by the Bouvia case.

Rather than focusing on the technology of artificial nutrition and hydration, we suggest that it may be more helpful to focus on the patient in order to determine whether or not the provision of artificial nutrition and hydration constitutes a burden or a benefit for the patient. The Christian notion of stewardship recognizes our responsibility to make reasonable provision for our physical, emotional and spiritual needs. Moreover, the notion of being a good "steward" implicitly recognizes that there are limits to the stewardship of our bodies. To make this claim is not to endorse an instrumental or utilitarian view of the body, but rather to recognize that bodily life may not be well served by securing its maintenance at the cost of other human goods. That is, at times we may find ourselves not in the

position of prolonging life, but rather of prolonging the dying process.

Under most circumstances, provision of artificial feeding and hydration will be given in order to express our commitment to the good of the patient and as an expression of our commitment to the symbolic value of nourishment as an expression of our obligations to care for human life. However, there may be *some* circumstances which call for a different assessment. For example, the patient who experiences great pain and discomfort with the feeding tube, or the terminally ill person who invariably becomes anorexic as the disease process takes its toll, or the patient whose protracted and irreversible coma offers no hope for any prognosis of recovery, can conceivably be viewed as *not* benefitting from the provision of artificial nourishment.

### Explanation of Circumstances

It seems to us that a reasonable interpretation of the meaning of "ordinary" or "proportionate" measures dictates the removal of the feeding tube when the circumstances have rendered it "extraordinary" or "disproportionate". The presence of pain or discomfort is not sufficient in and of itself to constitute such justifying circumstances. The criterion of "burden" to the patient must be such that in the particular circumstances of the patient, life's goals are no longer reasonably attainable. We judge that Father Kevin O'Rourke has captured this dimension well in his recent remarks:

One of the basic ethical assumptions upon which medicine and all efforts to nurse and feed people is based is that there is an obligation to prolong life because living enables us to pursue the purpose of life. Does this obligation ever cease? Clearly, it would cease if prolonging life no longer enables one to strive for the purpose of life. If efforts to prolong life are *useless* insofar as pursuing the purpose of life is concerned, or if prolonging life results in a *severe burden* for the patient insofar as pursuing the purpose of life is concerned, then the ethical obligation to prolong life is no longer present.<sup>13</sup>

A similar perspective can be seen in a recent statement published by the Committee for Pro-Life Activities of the National Conference of Catholic Bishops:

We maintain that one is obliged to use "ordinary" means of preserving life, that is, means which can effectively preserve life without imposing grave burdens on the patient, and we see the failure to provide such means as "equivalent to euthanasia" . . . . But we also recognize and defend a patient's right to refuse "extraordinary" means, that is means which provide no benefit or which involve too grave a burden.<sup>14</sup>

Father O'Rourke further specifies the application of these principles to the question of tube feeding, by appealing to the classic moral notion that "nemo tenetur ad inutile," that is, "No one is obliged to useless means" concerning medical treatment. The notion of "burden" is an important consideration, but in the case of irreversible coma, the notion that the treatment is "useless" due to loss of cognitive function, is more significant.

To pursue the purpose of life, one needs some degree of cognitive-affective function. Hence, if efforts to restore or develop cognitive-affective function can be judged useless and a fatal pathology is present, the person may be allowed to die because prolonging life would not enable the individual to strive for the purpose of life.<sup>15</sup>

It is clear that careful, prudent judgment is necessary concerning the issue of artificial nutrition and hydration. Withdrawal of treatment, as the citation from the Committee for Pro-Life Activities indicates, must not cross the line into endorsement of euthanasia. A particular aspect of recent court cases, notably *Bouvia*, is the alarming tendency to inflate the notion of patient autonomy to encompass a suicidal intent. This interpretation is clearly evident in the concurring opinion offered by Judge Compton in the ruling of the appellate court.

From an ethical point of view, autonomy is a crucial moral principle governing treatment decisions which respects the capacity for self-direction inherent in the dignity of the individual patient. However, it seems to us that the construction of patient autonomy to include the capacity to inflict harm on oneself, and to include caregivers and health care providers in the provision of such harm, erodes the very meaning of patient autonomy into a notion of individual preference without appropriate checks and balances.

### View of Patient Autonomy

At the very least, patient autonomy must be seen within the context of proper stewardship of the gift of life. While it is often difficult to know where to "draw the line" concerning decisions to withhold or withdraw treatment, it seems to us that Judge Compton's view clearly crosses the line into euthanasia and endorsement of suicide. If such a view prevails, implications for societal well-being are indeed grave. Catholic health care providers should be careful to attend to both the *legal* and *moral* dimensions of judicial decisions such as *Bouvia*.

The Archbishop of Los Angeles, Roger Mahony, released a strong statement on the *Bouvia* ruling and its alarming "invitations to euthanasia".<sup>16</sup> This statement, quite rightly, pointed out that the standard of determining the level of medical care provided should be the quality and proportionality of the *treatment*, not the life of the patient. It is morally acceptable to refuse *treatment*, including food, if that *treatment* "is a source of significant pain, discomfort, risk or even dehumanization *added* to what is already being experienced".<sup>17</sup>

On balance, then, we think that the question of foregoing artificial nutrition and hydration requires careful and prudential assessment. The quest for an absolute position on these measures beyond the traditional categories of "ordinary" or "extraordinary" means which invite persuasive moral argument is illusory and self-defeating. Father Richard McCormick S.J., in his thoughtful essay on this topic, cautions that there is a great potential for abuse of the patient when considering the withdrawal of

artificial nourishment. Accordingly, we should err, if possible, on the side of life.<sup>18</sup>

What are the implications of this discussion for hospitals, especially Catholic facilities? Because of the legal and moral complexities, each case must be decided on its merits with the help of legal and moral counsel when necessary. With this caveat in mind, the policy for providing or foregoing treatment must be consistent with *both* the applicable law within the hospital's jurisdiction *and* the moral principles of the institution. For example, since we are writing from the perspective of recent litigation in Southern California, some general treatment guidelines for consenting adult patients may look like the following:

1. Providing ordinary care is legally and morally acceptable.
2. Foregoing ordinary care in order to avoid the burden of the treatment is legally acceptable but morally unacceptable.
3. Foregoing ordinary care in order to avoid the burden of one's life is legally acceptable but morally unacceptable.
4. Foregoing ordinary care in order to end one's life is legally uncertain and morally unacceptable.
5. Providing extraordinary care is legally and morally acceptable.
6. Foregoing extraordinary care in order to avoid the burden of the treatment is legally and morally acceptable.
7. Foregoing extraordinary care in order to avoid the burden of one's life is legally acceptable but morally unacceptable.
8. Foregoing extraordinary care in order to end one's life is legally uncertain and morally unacceptable.

On the basis of the *Bouvia* decision, we make a distinction between the intent to avoid the burden of one's life (3 and 7), and the intent to end one's life (4 and 8). The majority opinion clearly held that the former is legally acceptable. How the former is distinguishable from the latter was not, however, as clear. As mentioned above, Justice Compton quite accurately described the majority opinion as dancing around the issue of suicide, and by doing so, left those of us facing these issues in our hospitals on uncertain legal ground.

In the face of what promises to be a situation of continuing conflicts and some uncertainty, we wish to underscore our position that treatment decisions must be *both* legally and morally acceptable. Those of us in Catholic health care are no strangers to conflict in this area. It has long been legally acceptable to have an abortion or sterilization procedure, but because these treatments are not morally acceptable to us, we do not perform them. A similar position may have to be taken in regard to artificial nutrition and hydration if presented with a factual situation comparable to that which provided the basis for the decision in the *Bouvia* case. While there may be *some* circumstances which call for the removal of artificial nutrition and hydration in patients with a fatal pathology (as Father O'Rourke carefully points out), we conclude that these

circumstances do not include the unwarranted intention of suicide apparent in the Bouvia decision.

### References

1. *Barber vs. Superior Court*, 147 Cal. App. 3d 1006.
2. *Ibid.*
3. *Ibid.*
4. *Ibid.*
5. *Bartling vs. Superior Court*, 163 Cal. App. 3d 186.
6. *Matter of Conroy*, 486 A. 2d 1209.
7. *Bouvia vs. Superior Court*, 86 Daily Journal D.A.R. 1317.
8. *Ibid.*
9. *Ibid.*
10. Vatican Congregation for the Doctrine of the Faith, *Declaration on Euthanasia*, June 26, 1980 as cited in *Moral Responsibility in Prolonging Life Decisions*, edited by Donald G. McCarthy and Albert S. Moraczewski, St. Louis: Pope John Center, 1981, pp. 290-297. See also, President's Commission for the Study of Ethical Problems in Medicine and Biomedical Research, *Deciding to Forego Life-Sustaining Treatment*, Washington, D.C.: U.S. Government Printing Office, March, 1983.
11. O'Rourke, Kevin D., and Dennis Brodeur, *Medical Ethics: Common Ground for Understanding*, The Catholic Health Association of the United States, St. Louis: 1986, p. 69.
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13. O'Rourke, Kevin, *Ethical Issues in Health Care: The AMA Statement on Tube Feeding: Ethical Analysis*, St. Louis University Medical Center, Center For Health Care Ethics, VII 8, April, 1986.
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15. O'Rourke, *Ethical Issues in Health Care*, *op. cit.*
16. *Extended Statement by Archbishop Roger Mahony on the Unanimous Ruling of the California 2nd District Court of Appeal on the Case of Elizabeth Bouvia*, Archdiocese of Los Angeles, April, 1986.
17. *Ibid.*
18. McCormick S.J., Richard, "Caring or Starving? The Case of Claire Conroy," *America* 152 (April 6, 1985): 269-273.