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Nutrition and Hydration: Should They be Considered Medical Therapy?

by

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Introduction

For the past two decades, physicians, attorneys, and moral theologians have debated whether the medically assisted supply of nutrition and hydration (ANH) to patients in a persistent vegetative state (PVS) can be discontinued and, if so, under what conditions.

Some legal trends supportive of withdrawing ANH

In the United States a number of highly publicized court decisions regarding patients suffering from a variety of illnesses established a legal precedent for withholding or withdrawing ANH. At the same time, legislatures enacted laws further enshrining this practice as a legal right. Today, advance medical directive statutes (providing for the execution of a Living Will or Durable Power of Attorney) are common throughout the United States. These statutes allow patients to forgo life-sustaining interventions, including ANH, if they should be incompetent and diagnosed with a qualifying condition. Initially, the only qualifying conditions were terminal illness of a persistent vegetative state. Predictably, however, other vaguely described conditions such as *serious debilitation* and the lack of *meaningful* consciousness were eventually added to the list. Consequently, some have advocated withholding or withdrawing ANH from patients with Alzheimer's disease and other forms of dementia.¹

Some medical assurances supportive of withdrawing ANH

In addition to these legal steps, changes in the medical landscape have also contributed to making the withdrawal of ANH seem more acceptable. Many medical professionals and the general public have great confidence that a reliable *diagnosis* of PVS can be made by tests developed in recent years and now in regular use. They are also convinced that studies of adults and children in PVS, caused either by traumatic or non-traumatic brain injury, provide a statistical basis for a practically certain *prognosis*.² These studies acknowledge that there are exceptional cases in which patients recovered consciousness after years in a PVS, but they emphasize that a return to consciousness is highly improbable after one year in this state. Without rejecting these findings, others have cautioned that our scientific knowledge of PVS is still rudimentary, and that newer methods of treating PVS patients may yield a more hopeful prognosis.³ All medical professionals agree that discontinuing nutrition and hydration will result in death. A task force of the American Academy of Neurology notes that "When artificial nutrition and hydration are withdrawn, patients in a persistent vegetative state usually die within 10 to 14 days. The immediate cause of death is dehydration and electrolyte imbalance rather than malnutrition: patients in a persistent vegetative state," they contend, "cannot experience thirst or hunger."⁴

Others have pointed out that "Pain studies on PVS patients... indicate that their electroencephalographic response to painful stimuli is similar to that of a conscious patient."⁵ These findings question the certainty of the claim that PVS patients cannot experience pain, and that they die of dehydration but not starvation. For the purposes of this presentation, it is enough to note that even if the immediate cause of death is dehydration alone, it occurs as a direct result of discontinuing the administration of food and fluids through the feeding tube.

Therapy or Care

I have been asked to address the question of whether the medically assisted supply of nutrition and hydration to PVS patients is medical therapy or care. As a moralist, I must also ask whether the determination of ANH as therapy or care would have any effect on the moral analysis of its use. The question of whether ANH is therapy or care is primarily a medical one, which has been indirectly addressed in some recent scientific studies.⁶ The Council on Ethical and Judicial Affairs of the American Medical Association considers it a life-sustaining treatment, which it defines as "... any medical treatment that serves to prolong life without reversing the underlying medical condition. Life-sustaining treatment may include, but

is not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics, and artificial nutrition and hydration.”⁷

While these measures all sustain life, they do so in different ways. Mechanical ventilation and renal dialysis substitute for a lost or compound function of a biological system. Chemotherapy is directed to curing or arresting a disease. Antibiotics treat infection. But ANH addresses no pathology. Unconsciousness is not a pathology, and, as the American Academy of Neurology notes: “In most [PVS] patients, the gag, cough, sucking, and swallowing reflexes are preserved. Except for a lack of coordination in chewing and swallowing, gastrointestinal function remains nearly normal. As the prolonged survival of some patients in a persistent vegetative state suggests, autonomic function is sufficient to maintain long-term internal regulation so long as external needs receive constant attention.”⁸ Various agencies of the Holy See recognize that ANH is not therapeutic but life-sustaining, and so have made statements categorizing ANH as a “normal treatment,” a “minimal measure,” or a form of “care.”⁹

Some authors, including Dr. Eugene Diamond, explain the apparent contradiction between ANH as a life-sustaining medical treatment and as a non-therapeutic form of care in this way: The insertion of the tube is a medical procedure that requires the skills of a surgeon, but it is not therapeutic since the tube is merely a vehicle for introducing food and fluids into the body. Yet food and fluids are not themselves therapeutic. Apart from the treatment of some eating disorders, they address no pathology.¹⁰ As one theologian put it: “Just as we do not define hunger and thirst as pathologies or clinical conditions, so we do not normally define the giving of food and water as treatments, even if it requires some medical assistance. Their teleologies are different. Giving food and water is not aimed at preventing or curing illness, retarding deterioration, or relieving pain and suffering.”¹¹ In this context, it is good to remember that a decision to withhold ANH requires no medical intervention: no tube or mechanical apparatus is removed. Instead, what happens is that care givers simply refrain from introducing any more food or fluids into the patient’s body through the tube. These facts highlight the importance of describing tube feeding as *the medically assisted supply of nutrition and hydration*, or more bluntly, as *the medically assisted supply of food and drink*.

When we feed those who cannot feed themselves – the infant, those who suffer from paralysis or the persistently unconscious – we do more than sustain their lives. We demonstrate our love and concern for them as fellow human beings and, from a specifically Christian perspective, as brothers and sisters in the Lord. By feeding those who cannot feed themselves we maintain communion with them, and give powerful witness

to our reverence for life, even a life as impaired as that of the PVS patient.¹² Is ANH therapy or is it care? I think it is most assuredly care.

However, the moral issue is not settled by the medical and legal assertions already outlined nor by designating ANH as care rather than treatment. Even if the diagnosis and prognosis of PVS is practically certain, and even if civil law allows for the discontinuance of this form of care, the question of moral justification still remains.

Discontinuing Care

The authors and magisterial statements which identify ANH as care do not exclude the possibility of discontinuing it in some cases. Rather, their point seems to be that the moral obligation to care for patients through ANH may continue even after other medical treatments have been judged extraordinary (disproportionate) and justifiably removed. Food and fluids may be discontinued when they are extraordinary or disproportionate, but should be continued otherwise. A significant number of bishops in the United States have made this point by insisting that there is "a presumption in favor of supply of nutrition and hydration, unless their supply can be shown to be futile or excessively burdensome."¹³ In so doing, these statements reject the claim that ANH is always or even generally a disproportionate or extraordinary means of sustaining the lives of PVS patients, as some authors maintain.¹⁴

To discontinue ANH when they are not extraordinary would be a form of passive euthanasia. As the Pontifical Council for Health Care Workers states: "The administration of food and liquids, even artificially, is part of the normal treatment always due patients when this is not burdensome for them: their undue suspension could amount to euthanasia in a proper sense."¹⁵ The Congregation for the Doctrine of the Faith defines euthanasia as "an action or an omission which of itself or by intention causes death, in order that all suffering may in this way be eliminated."¹⁶

Moral Analysis

As with all questions about treatment, it is essential to assess the patient's actual medical condition and the benefits and burdens associated with the use of the means being considered. These factors are crucial in determining whether the discontinuance of ANH for a PVS patient is a case of *passive euthanasia*, or one of *allowing to die*. Recalling that "Euthanasia's terms of reference... are to be found in the intention of the will and in the methods used,"¹⁷ our moral analysis of discontinuing ANH requires an examination of the agent's intention.¹⁸ As the Catholic bishops of Pennsylvania note:

Much of the contemporary discussion seems to have lost sight entirely of the difference between allowing to die when no treatment or care can any longer save the patient, and murder by omission. Recalling the moral truth that one is not obligated to employ means that are either futile or too burdensome, but must never intentionally act against innocent human life, we see a clear moral distinction between *intending* and *allowing*.¹⁹

With regard to the specific point of whether the agent's intention in discontinuing ANH for the PVS patient is to kill or to allow to die, two contradictory views have emerged within the Catholic community. One opinion is represented by Professor William E. May, et al. (hereafter referred to as the May position)²⁰; the other is that of Fr. Kevin O'Rourke, O.P., et al. (hereafter referred to as the O'Rourke position)²¹

The May Position

The May Position maintains that the supply of ANH which sustains the life of the persistently unconscious patient *is a real benefit* to the patient since life, irrespective of its quality, is a personal good with inherent value. Moreover, those who hold this view argue that a condition which causes only unconsciousness is not per se a fatal pathology, and that the unconscious patient – *without any such fatal pathology* – will live for an indeterminate time as long as he is not deprived of nutrition and hydration and other nursing care. They hold that to withdraw ANH from patients *who are not dying* constitutes an explicit choice to end their lives. This they judge to be a violation of the absolute prohibition against the taking of innocent human life – a case of passive euthanasia. The May opinion also recognizes that whenever medically assisted nutrition and hydration can be shown to be of no benefit or excessively burdensome, then it is *extraordinary*, and not morally obligatory.

The O'Rourke Position

The O'Rourke position is that the supply of ANH to the persistently unconscious patient is of *no real benefit* to the patient since it preserves the mere *biological* life, and does not restore the patient to a state in which he can pursue the higher goals of life, which requires cognitive-affective functioning.²² O'Rourke considers ANH not only as futile because it is ineffective in helping the patient pursue the higher goals of life, but as excessively burdensome because it maintains PVS patients in a condition in which this pursuit will never again be possible.²³ *Based on this evaluation, O'Rourke maintains that there should be a presumption against the use of ANH for PVS patients.*²⁴ O'Rourke sees a difference

between the medical cause of death and the moral one. Despite the findings of the medical studies which identify dehydration as the cause of the PVS patient's death when ANH is discontinued, O'Rourke points to a different cause. As he explains: "... removing ANH does not mean that the direct moral cause of death is starvation or dehydration. Rather, the pathology which directly causes death is the dysfunction of the cerebral cortex. Because of this pathology, the patient is unable to eat and drink on his own."²⁵ For these authors, the discontinuance of ANH is a case of allowing to die rather than passive euthanasia.

But the facts belie this conclusion. When ANH is discontinued PVS patients will still be unable to pursue the higher goals of life and will remain in a state in which their pursuit of these goals will remain impossible until death. It is only death, which may come 10 to 14 days later, that will end the futility and burdens that O'Rourke associates with the persistent vegetative state. The choice to stop giving PVS patients food and fluids through the tube is a choice to end their burden by ending their lives. This is the act which of itself causes their death in order that their suffering may be ended.

Some judgments on the two approaches

Twelve years ago, the late Fr. Richard A. McCormick, S.J., declared that the moral debate about withdrawing ANH from PVS patients had been settled in favor of the O'Rourke position, which he also held, and he criticized the Pennsylvania Bishops for addressing it again.²⁶ Recently, however, O'Rourke declared that the two contradictory views which we have examined are both compatible with Catholic moral teaching, although he considers the May position too restrictive.²⁷ There are reasons, however, to question his assessment of both matters.

The Pro-Life Activities Committee of the USCCB issued a statement in 1992 in which they accepted what they identified as the "more carefully limited conclusion" of those who hold that supply of ANH to the PVS patient is to be considered ordinary means, unless some other factor renders it futile or excessively burdensome. The bishops declared: "We reject any omission of nutrition and hydration intended to cause a patient's death. We hold for a presumption in favor of providing medically assisted nutrition and hydration to patients who need it, which presumption would yield in cases where such procedures have no medically reasonable hope of *sustaining life* or pose excessive risks or burdens."²⁸ (Although he is not named, this is the May position.) Addressing a group of U.S. bishops making their *ad limina* visit to the Holy See, Pope John Paul II referred to the Pro-Life Committee's document, noting that it "...rightly emphasizes that the omission of nutrition and hydration intended to cause a patient's

death must be rejected and that while giving careful consideration to all factors involved, the presumption should be in favor of providing medically assisted nutrition and hydration to all patients who need them."²⁹

It is impossible to know whether or not the Holy Father intended to correct those few bishops who have affirmed the O'Rourke opinion or approved the actions of parishioners who acted in accord with this opinion. This conclusion was advanced by one theologian and rejected by O'Rourke.³⁰ What is clear is that both the Pro-Life Committee and the Pope consider it necessary to continue supplying food and fluids to PVS patients, unless it can be shown in a particular case to be futile or excessively burdensome. The text of the Pro-Life Committee's statement, which the Pope cites with approval, refers to the *sustenance of life* as the benefit provided by ANH.

The Pro-Life Committee also offered a judgment about the position advanced by O'Rourke (though he is not named). The bishops write: "While this rationale is convincing to some, it is not theologically conclusive and we are not persuaded by it."³¹

Conclusion

ANH to PVS patients – a witness to love

If I may make one final point. The late Fr. Richard McCormick, S.J., presented a scenario, and asked what I suppose he considered the most obvious question. He writes:

Imagine a 3-bed Catholic hospital with all beds supporting P.V.S. patients maintained for months, even years by gastrostomy tubes... An observer of the scenario would eventually be led to ask: "Is it true that those who operate this facility actually believe in life after death?"³²

Now, looking at the same scenario, I can imagine observers making quite a different remark: "Look how these Christians love one another. This is an extraordinary testimony to the faithfulness and selflessness of Christian love; it is truly edifying to see that Christian love can be so genuine and disinterested that such care continues to be given even when those who receive it can show no appreciation. Even when they are totally unaware of this loving presence."

References

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2. The Multi-Society Task Force on PVS, "Medical Aspects of the Persistent Vegetative State (First of Two Parts)," *The New England Journal of Medicine*, Vol. 330, No. 21, (June, 1994) pp. 1499-1508.
3. Eugene Diamond, "Medical Issues When Discontinuing AHN," *Ethics and Medics*, Vol. 24, No. 9, (September, 1999).
4. The Multi-Society Task Force on PVS, "Medical Aspects of the Persistent Vegetative State (Second of Two Parts)," p. 1578.
5. Eugene Diamond, "Medical Issues When Discontinuing AHN;" Robert J. White, "A Note on the 'Vegetative' State," *Ethics and Medics*, Vol. 24, No. 7.
6. Cf. Council on Ethical and Judicial Affairs of the American Medical Association, "Report on Decisions Near the End of Life," *Journal of the American Medical Association*, Vol. 267, No. 16 (April, 1992), p. 2229-2233. Cf. also, The Multi-Society Task Force on PVS, "Medical Aspects of the Persistent Vegetative State (Second of Two Parts)," *The New England Journal of Medicine*, Vol. 330 (1994), p. 1577.
7. Council on Ethical and Judicial Affairs of the American Medical Association, "Report on Decisions Near the End of Life," p. 2229.
8. The Multi-Society Task Force on PVS, "Medical Aspects of the Persistent Vegetative State (First of Two Parts)," p. 1501.
9. Cf. The Pontifical Academy of Sciences, "On the Artificial Prolongation of Life," *Origins* (December 5, 1985), which states: "If the patient is in permanent coma, irreversible as far as is possible to predict, treatment is not required, but all care should be lavished on him, including feeding." The Pontifical Council of Health Affairs states: "... there remains the strict obligation to continue by all means those measures which are called 'minimal,' which are intended normally and customarily for the maintenance of life (alimentation, blood transfusions, injections, etc.)." This text is quoted in Orville N. Griese, *Conserving Human Life*, (Boston: Pope John XXIII Center, 1989), p. 172.
10. Cf., for example, Eugene Diamond, "Medical Issues when Discontinuing AHN;" and Anthony Fisher, O.P., "On Not Starving the Unconscious," *New Blackfriars*, Vol. 74, No. 869, (March, 1993).

11. Anthony Fisher, O.P., "On Not Starving the Unconscious." *New Blackfriars*, Vol. 74, No. 869, (March, 1993).
12. Cf. Germain G. Grisez, "Should Nutrition and Hydration be Provided to Permanently Unconscious and Other Mentally Disabled Persons?" *Linacre Quarterly*, Vol. 57, (May, 1990) and *The Way of the Lord Jesus Christ, Vol. III* (Quincy, Ill: Franciscan Press, 1997), Question 47. See also Anthony Fisher, O.P., "On Not Starving the Unconscious." *New Blackfriars*, Vol. 74, No. 869, (March, 1993).
13. James T. McHugh, "Artificially Assisted Nutrition and Hydration," *Origins* (September 21, 1989), pp. 314-316. The position is best articulated by the Bishops of Pennsylvania, "Nutrition and Hydration: Moral Considerations," *Origins* (January 30, 1992), and by the Pro-Life Activities Committee of the United States Conference of Catholic Bishops, "Nutrition and Hydration: Moral and Pastoral Reflections," *Origins* (April, 1992). Several State Catholic Conferences including New York, New Jersey, Delaware, Maryland, and Florida all recognize a presumption in favor of the supply of nutrition and hydration, while allowing for its withdrawal if it should become futile or excessively burdensome. This position is stated in a normative form in Directive 58 of the *Ethical and Religious Directives for Catholic Health Care Facilities*, last issued by the United States Conference of Catholic Bishops in 2001. It should be noted that the Bishops of Texas (save two who dissented) and five or six individual bishops who have commented on specific cases, do not hold a presumption in favor of the supply of ANH to PVS patients.
14. Cf. Kevin O'Rourke, O.P. and Patrick Norris, O.P., "Care of PVS Patients: Catholic Opinion in the United States," *Linacre Quarterly*, Vol. 68, No. 3, (August, 2001), pp. 201-217. These authors identify three theological positions, but they dismiss one of them which "seems to prohibit the removal of ANH in all circumstances" as outside the realm of Church teaching. The other two positions which represent opposing views on the withdrawal of ANH from the PVS patient, are viewed by these authors to fall within the realm of Church teaching "insofar as the general principles for removing life support are concerned," and at the present time when the Magisterium has not yet rendered a judgment on this specific question.
15. The Pontifical Council for Pastoral Assistance to Health Care Workers, *Charter for Health Care Workers*, (1995) no. 120.
16. The Congregation for the Doctrine of the Faith, *Declaration on Euthanasia* (May, 1980), Section II.
17. The Congregation for the Doctrine of the Faith, *Declaration on Euthanasia*.
18. St. Thomas Aquinas, *Summa Theologica*, Part I of the II Part, Questions 6-19. For an analysis of the application of St. Thomas' thought on the role of the will in human action see: William E. May, "Aquinas and Janssens on the Moral Meaning of Human

Acts," *The Thomist*, Vol. 48, No. 4 (October 1984). Pope John Paul II emphasized that human intentionality is present in the object of the act and not just in the motive for which the act is performed (see *Veritatis Splendor*, August, 1993), numbers 78-82.

19. The Catholic Bishops of Pennsylvania, *Nutrition and Hydration: Moral Considerations* (December 12, 1991), printed in *Origins* (January 30, 1992).

20. For a recent summary of this position which has been presented in numerous articles in various journals over the past twenty years see: William E. May, "Tube Feeding and the 'Vegetative' State," *Ethics and Medics*, Vol. 23, No. 12 and Vol. 24, No. 1 (December, 1998 and January, 1999). Cf. also May, *Catholic Bioethics and the Gift of Human Life* (Huntington, IN: Our Sunday Visitor, 2000), pp. 268-270.

21. For a recent summary of this position which has been presented in numerous articles in various journals over the past twenty years see: Kevin O'Rourke, O.P., "On the Care of 'Vegetative' Patients: A Response to William E. May..." *Ethics and Medics*, Vol. 24, Nos. 4 and 5 (April and May, 1999). Cf. also Benedict Ashley, O.P. and Kevin O'Rourke, O.P., *Health Care Ethics* (4th ed. Washington, D.C.: Georgetown University Press, 1997), pp. 421-426.

22. Kevin O'Rourke, O.P., "Should Nutrition and Hydration be Provided?" *Issues in Law and Medicine*, Vol. 5, No. 2 (1989), p. 188. Here O'Rourke refers to Pope Pius XII, "On the Prolongation of Life," *The Pope Speaks* 393 (1958).

23. In support of this position, O'Rourke cites Pope Pius XII's description of ordinary means as those "that do not involve any grave burden for oneself or another. A more strict obligation would be too burdensome for most men and would render the attainment of the higher, more important good too difficult" (Pius XII, "On the Prolongation of Life.") William E. May considers O'Rourke's representation of the papal teaching as a misinterpretation, noting that "It is surely true that a means imposes a grave burden on a person (and is hence extraordinary or disproportionate) if it prevents him from pursuing the spiritual goal of life. But one cannot declare a means burdensome if it is ineffective in helping a person pursue this goal." Cf. William E. May, "Tube Feeding and the 'Vegetative' State," *Ethics and Medics*, Vol. 23, No. 12, p. 2. In his response to May's article, O'Rourke does not address this objection. Cf. Kevin O'Rourke, O.P., "On the Care of 'Vegetative' Patients: A Response to William E. May..." *Ethics and Medics*, Vol. 24, Nos. 4 and 5. (April and May 1999).

24. Kevin O'Rourke, O.P., "Applying the Directives," in *Ethical and Religious Directives for Catholic Health Care Services: Seeking Understanding* (St. Louis, MO: The Catholic Health Association of the United States, 2003) p. 43.

25. Kevin O'Rourke, O.P. and Patrick Norris, O.P., "Care of PVS Patients: Catholic Opinion in the United States," 204.

26. Richard A. McCormick, S.J., "Moral Considerations, Ill Considered," *America*, Vol. 166, No. 9, (March 14, 1992), Cf. also Kevin T. McMahon, "What the Pennsylvania Bishops Really Said: A Reply to Richard A. McCormick, S.J.," *Linacre Quarterly*, (August, 1992).
27. Kevin O'Rourke, O.P. and Patrick Norris, O.P., "Care of PVS Patients: Catholic Opinion in the United States."
28. The Pro-Life Activities Committee of the United States Conference of Catholic Bishops, "Nutrition and Hydration: Moral and Pastoral Reflections," Conclusion (emphasis added).
29. Pope John Paul II, *Address to the Bishops of California, Nevada and Hawaii*, October 2, 1998.
30. Kevin O'Rourke, O.P. and Patrick Norris, O.P., "Care of PVS Patients: Catholic Opinion in the United States," p. 208, footnote 43 in which he identifies Edward Richard as reaching this conclusion.
31. The Pro-Life Activities Committee of the USCCB, "Nutrition and Hydration: Moral and Pastoral Reflections," *Origins*, April 1992, section 6 (emphasis added).
32. Richard McCormick, S.J., "Moral Considerations, Ill Considered," *America*, Vol. 166, No. 9, (March 14, 1992), p. 214. Citing this scenario, other authors have made the same argument. Cf. Kevin O'Rourke, "On the Care of 'Vegetative' Patients," (second of two parts), *Ethics and Medics*, Vol. 24, No. 5 (May, 1999), p. 4; Michael R. Panicola, "Withdrawing Nutrition and Hydration," *Health Progress* (November-December, 2001), p. 31.